

A REFORM PROPOSAL FOR MATERNITY SERVICES IN AUSTRALIA

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Introduction

The purpose of this paper is to outline a policy framework for improving the standard of maternity services in Australia. This framework does not address many of the longer-term issues under consideration by the Rudd government's current review of maternity services – the consistently poorer outcomes for rural and Indigenous women, limited access to health professionals and maternity services in rural and remote areas, the high proportion of births taking place in hospitals, high caesarean and intervention rates, and low breastfeeding rates (1). While the overall goal for maternity services in Australia is to ensure seamless and coordinated antenatal, birthing and postnatal care for women and babies, this paper focuses specifically on risk management and better integration of care during pregnancy and birth because these two critical issues are amenable to change in the short-term.

This paper outlines a framework for service provision by detailing three clinical pathways for maternity care – one each for low, moderate and high-risk mothers and/or babies. This framework is not designed to be a 'one size fits all' solution. It will need to be modified to suit conditions in each state and territory, and different regions within them. It will also need to be modified over time, as existing problems, such as workforce shortages and the lack of maternity units in many rural areas, are gradually resolved. The framework does, however, provide the basis for developing more integrated, more efficient, and safer maternity services in Australia.

To implement the framework, it is necessary to develop clear, consistent, mandatory protocols for consultation and referral between health professionals, and the introduction of integrated clinical networks (2) for maternity care in each state and territory.

Background

While infant and neonatal health outcomes in Australia have improved dramatically over the last 100 years, recent comparative data show that Australia lags behind many other comparable countries on these indicators. In 2005, Australia ranked 16th out of 23 OECD countries on infant mortality, and 17th out of 21 countries on neonatal mortality. Our rank of 9th out of 25 countries on the proportion of low birth weight babies was a little better (3).

The trends, however, are particularly disturbing as they show Australia's performance compared with other countries slipping over time. Our ranking on infant mortality dropped from 11th out of 29 countries in 1995 (5.7 deaths/1000 births) to 16th out of 23 countries in 2005 (5.0 deaths/1000 births). Our ranking on neonatal mortality slid from 9th out of 28 countries (3.7 deaths/1000 births) in 1995 to 17th out of 21 countries a decade later (3.6 deaths/1000 births). While the proportion of low birth weight babies increased in Australia between 1995 and 2005, our relative ranking remained much the same. It was 9th out of 28 countries in 1995 (5.9% of total live births) and 9th out of 25 countries in 2005 (6.4% of total live births) (3).

Australia's maternal mortality figures stand in stark contrast to those for neonates and infants. In 1995, Australia had a maternal mortality rate of 9.4 deaths/100,000 live births and ranked 19th out of 27 countries. By 2005, maternal mortality was reduced to 3.5 deaths/100,000 live births, and improved its ranking 5th out of 22 OECD countries (3).

It is not clear why Australia has managed to substantially improve its maternal mortality figures compared with other countries while falling behind on neonatal and infant mortality. Australia's lacklustre performance in these areas is especially concerning because the number of high-risk pregnancies and births (due to advances in medical technological, such as in vitro-fertilisation (IVF) and foetal surgery) is increasing, and the recent 'baby-boom' coupled with workforce shortages and distribution problems has placed additional strain on existing maternity services.

High-risk pregnancies and births

A number of factors have made maternity care in Australia more complex over time. Steady increases in the average maternal age, higher rates of multiple births, and growth in the number of pregnancies resulting from assisted reproduction technologies (ART) are amongst the most important ones.

The average age maternal age of Australian mothers has been steadily increasing over the last few decades. In 1980, for instance, the average maternal age was 26.7 years, and the average age of first time mothers was 25.2 years. By 2005, the average maternal age had increased to 30.7 years, and the average age of first time mothers to 30.5 years (4). Increased maternal age has been shown to increase the risk of serious adverse events, such as miscarriage (5) and foetal death (6).

The number of pregnancies in Australia resulting from assisted reproduction technologies has also increased over time. In 2002, 2.3% of all births were the result of ART (7). In 2006, the proportion had increased to 3.1% (8). Pregnancies and births resulting from ART are likely to be higher risk because mothers tend to be older, and multiple births are more common. A study released by the Australian Institute of Health and Welfare in 2002 found that on average, babies born as the result of ART were more likely to suffer adverse outcomes. Compared with data on all births in Australia, babies born as a result of ART were more likely to be born prematurely (21% versus 7%), have a low birth weight (24% versus 7%), and be delivered by caesarean section (49% versus 27%) (7).

The rate of multiple births in Australia has also risen over time. In 1991, multiple births accounted for 1.3% of total births (10). By 2006, the proportion had increased to 1.7% (8). Multiple births are more likely than singleton births to be premature (i.e. at less than 37 weeks gestation) (11) and have low birth weight (12), which increase the risk of adverse outcomes. In Australia during 2005, 53% of twin and 96% of higher order multiple births were pre-term compared with only 7% of singleton births. In the same year, 50% of twin and 96% of higher order multiple births were low birth weight (9).

Survival rates for low birth weight babies have increased substantially since the introduction of neonatal intensive care units. While increasing survival rates undoubtedly has great benefits, there are also some costs, particularly in the case of very low birth weight babies. Medical advances enable smaller and smaller babies to survive but many have serious disabilities, such as cerebral palsy (13).

As a result of these changes, as well as many others, pregnancy and birth in Australia has increasingly involved sophisticated medical interventions. This is reflected most clearly by data on caesarean rates, which have increased dramatically over time. In 1991, only 19.0% of births were via caesarean section. By 2006, 31% of all births were via caesarean (8).

The unexpected baby-boom

The number of babies born in Australia dramatically increased in 2005. By 2007 the birth rate had reached a 30-year high (4). This 'baby-boom', however, caught many health service planners unprepared and left maternity service providers struggling to cope with the sudden increase in demand.

After a string of negative stories in the press about maternity services in Victoria, the Victorian Minister for Children and Early Childhood Development admitted that the 'baby-boom' took the Victorian Government by surprise. She revealed that the number of births in the state was:

“ way, way above any predictions that any of the demographic work that had been done by the Commonwealth and by our own State demographers. So we were surprised. We were completely shocked.” (14).

The chairman of the Australian Paediatric Society, Dr Peter Eastaugh, claims that the Victorian government was caught unawares because in 2002 it accepted advice from the Australian Bureau of Statistics that the birth rate would decline by 7% by 2010 instead of listening to a Department of Human Services advisory committee (15).

Regardless of the reason, the failure to predict or foresee the beginning of a new baby-boom in Australia has had serious consequences for health services, in particular for public hospitals and birthing services providing maternity care. According to Genevieve Heard from Monash University's Centre for Population and Urban Research, staff from maternity hospitals were contacting her and asking: *“What's going on? We seem to have ever-increasing numbers of births and we thought there was still a decline”* (14).

Victoria has not been the only state struggling to keep up with increasing demand for maternity services. The director of the Royal Prince Alfred (RPA) Mothers and Babies Hospital in NSW, Dr Andrew Child, confirmed that health service planners in NSW were equally unprepared for a baby-boom because all the indicators suggested that Australia's birth rate was declining. The RPA Mothers and Babies Hospital, which was only opened in 2002, was designed to deliver 3600 babies a year. In 2008 it will deliver over 5500 babies (16).

The impact of the baby-boom has been felt more severely because of shortages in the maternity workforce. In 2007, the Department of Education, Employment and Workplace Relations' state and territory Labour Economics Offices found there were shortages of midwives right across Australia (17). This was primarily because the number of registered midwives had been steadily falling in most states and territories while the number of births began increasing in 2004.

Although the number of midwifery graduates in some states and territories has increased in recent years, shortages looked certain to continue in the short term because many midwives work part-time, have significant breaks from the labour market, are leaving the profession, or approaching retirement age (17). Midwifery recruitment and retention problems are made worse by the fact that indemnity insurance is expensive and exempt from existing medical indemnity subsidy schemes, and midwives are only able to claim rebates under the Medical Benefits Scheme if they are working under medical supervision.

Similar problems exist with the obstetric workforce. In 2004, the Australian Medical

Workforce Advisory Committee reported that there were 1,160 practicing specialists in obstetrics and gynaecology in the previous year, which represented a 10.6% increase since 1998. The Committee identified maldistribution as the most significant problem with the obstetric workforce. It argued that projections about future workforce requirements should take into account the fact that demand for services was being moderated by declining total fertility and birth rates (18).

However, an academic survey conducted in Victoria in 2003 foreshadowed serious shortages in the obstetric workforce. It found that large numbers of GP obstetricians (GPs who have also completed postgraduate training in obstetrics) and specialist obstetricians had retired from practice in the late 1990s. It also found that 56% of GP obstetricians continuing to practice intended to cease within 7 years. The authors of the survey predicted (before the onset of the baby-boom) that increasing retirements, combined with falling intention rates to practice obstetrics, and a feminisation of the workforce would all contribute to serious shortages of experienced practicing obstetricians in the near future (19).

The 2003 Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) workforce survey led to similar predictions about the specialist obstetric workforce after finding that the number of practicing obstetricians would fall by 20% over 5 years. Medico-legal concerns, the cost of medical indemnity, and the impact of practice on lifestyle were cited as factors influencing the decision to cease practicing (20).

Current challenges for maternity services in Australia

Many of the challenges for maternity services in Australia were outlined in a discussion paper released by the Department of Health and Ageing in September 2008 (1). The paper forms the basis of an Australian government review into maternity services and has invited submissions on a range of issues, including:

- High maternal mortality rates for Indigenous women and women living in rural and remote areas
- The need to identify models of maternity care that work well in rural and remote areas
- The reasons for Australia's comparatively high rates of intervention during birth
- Funding arrangements, particularly restrictions that prevent midwives in private practice from being reimbursed under the Medical Benefits Scheme
- Serious shortages in the maternity workforce
- The need to expand midwifery-led care and deliver better integrated services

The poor health outcomes for Indigenous women and babies are also well described in the paper. For example, maternal mortality rates two and a half times higher than those for non-Indigenous women and infant mortality rates are more than 3 times higher in some parts of Australia (the Northern Territory, for instance) (21).

Addressing the issues in risk management

All health professionals working in maternity services should be able to operate autonomously and exercise their clinical judgement, but it is equally important that they practice within the bounds of prescribed roles. Much of the controversy in maternity services in recent years has been about the role of midwives in Australia's

health system. Midwifery groups, such as the Maternity Coalition, argue that midwives should be able to practice independently of doctors like they do in other countries; the Netherlands and New Zealand are notable examples. Doctors groups, such as the Australian Medical Association and Royal Australian College of Obstetricians and Gynaecologists (RANZCOG), argue that extending the role of midwifery along the lines suggested would lead to poorer health outcomes for both mothers and babies (22,23).

In an effort to diminish the dispute over the respective roles of various maternity services health professionals, the Australian College of Midwives (ACM) produced a set of guidelines for consultation and referral in 2004. After an extensive review process, a second edition was released in 2008. While these guidelines may improve risk management practices in Australian maternity services, they remain contentious. Neither the ACM or the Australian Nursing and Midwifery Council, which is responsible for developing and maintaining competency standards for nurses and midwives, has the statutory power needed to enforce them (24). The disclaimer at the front of the guidelines makes it clear that they are not “designed to be prescriptive” and cannot be “used as a substitute for an individual midwife’s decision making and judgment in situations where care has been negotiated within the context of informed decision making by the individual woman” (25).

Other midwifery groups agree that the guidelines should not be binding. In its submission to the ACM’s review of the guidelines, the Victorian group, Midwives in Private Practice, suggested that the 2008 edition place more emphasis on the midwives duty of care to promote normal birth because this would be:

“potentially useful to midwives who may consider that, in a particular professional situation, their advice and actions are consistent with the promotion of normal birth rather than strict adherence to a professional Guideline”. (26).

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) also has reservations about the value of referral and consultation guidelines. In its submission to the Productivity Commission’s 2005 report on Australia’s health workforce, RANZCOG’s Provincial Fellows Committee cautioned against an over reliance on guidelines and protocols. It claimed that ‘clinical best practice protocols’ had significant limitations as a method of simplifying health service provision because the evidence base was often seriously flawed, changed quickly and *“reduced health care provision to a series of recipes”* (pp 223) (27).

The Productivity Commission, however, disagreed with RANZCOG’s view. It pointed out that the College was in fact doing was making an argument for *“effective evidence-based protocols that are regularly evaluated and adjusted as appropriate, not against the use of protocols per se.”* (27).

In an environment where there is a lack of trust, and sometimes even hostilities, between health professionals, relying on voluntary guidelines for referral and consultation between these professionals is a woefully inadequate approach. To ensure the highest quality of in maternity care in Australia, it is vital that procedures for risk assessment and management are clear, accepted and recognised nationally, and mandatory for all health professionals working in obstetrics. The negotiations required to reach this point will undoubtedly be extremely difficult. It is critically important for patient safety, however, that these protracted demarcation disputes over health professionals’ roles are shifted from the world of clinical silos to an integrated policy level that focuses on the needs of the pregnant woman and the best

outcomes for her and her baby. Until health professionals, midwives and obstetricians in particular, can agree upon sensible and safe practice boundaries, it will be impossible to ensure best practice risk assessment and management procedures in Australia.

Moving towards more integrated care

Numerous reviews of maternity services in Australia over the last 20 years have identified the problems with fragmented nature of care and made recommendations on how to fix it. Regrettably, there has been little or no action on these recommendations.

In 1989, the NSW government commissioned a major review of maternity services, which was chaired by Professor Rodney Shearman (28). The final report made it clear that in order to ensure equitable access to quality care in the future, it was necessary to develop *“an integrated network of community and hospital based antenatal care and education services”* (pp 1). The report highlighted the lack of continuity of care for women in the public system as an important issue for maternity services at that time, and recommended (amongst other things) the expansion of shared care between GPs and midwives for low and moderate risk women (pp 8).

A decade later in 1999, the Senate Community Affairs Committee conducted a review of maternity services on behalf of the federal government. It found that the problem of fragmented care was not confined to NSW but existed across the nation (29). The Committee’s final report explained that:

“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).” (pp 135).

It went on to say that:

“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.” (pp 135)

Considerable blame for the fragmentation of maternity services was attributed to funding arrangements. The report stated that:

“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.” (pp 165).

Despite the thorough inquiry and comprehensive recommendations made by the Senate Community Affairs Committee, major problems with fragmentation of services

in Australia still exist. Some state and territory governments have made progress, but none have managed to fully-integrate maternity services.

The Northern Territory appears to be most advanced along the pathway to integrated maternity services. In response to the recent review of maternity services, the Northern Territory government has begun to develop an integrated maternity services framework (30). It outlined its proposed framework for integrated maternity services in early 2008, and has now committed to ongoing development by *“considering models of best practice, the unique issues facing the Northern Territory, [and] establishing agreed implementation timeframes”* (pp 5). Perhaps even more important, however, is the government’s acknowledgement that many interested parties still have divergent views. As a result, the government has made it a priority to:

“establish a process to collectively work through these divergent positions to develop a service model that is underpinned by client-centred care that is inclusive, participatory, and provides improved continuity of care across the health system.” (pp 5)

Australian proposals for integrated clinical networks

The NT government is currently developing a proposal for integrated care networks (as outlined above). The idea, however, is not new. The 1989 Shearman report recommended that a network linking general maternity units to specialist obstetric units be developed in order to facilitate referral and transfer both ante- and post-natally (28).

More than a decade later, the NSW Department of Health made another attempt to develop a networked maternity services system. Its 2003 report, *Models of Maternity Service Provision Across NSW*, aimed to facilitate the implementation of a classification system for primary, secondary and tertiary maternity services, and credentialing system for health professionals working in maternity services (31).

While the report outlined the core principles underpinning the network model proposed (such as matching services to clinical need, taking a lead maternity carer approach, and ensuring continuity of care), it stopped short of specifying exactly what was required to implement it. The report, for example, recommended that:

“all maternity, neonatal and community health care services must maintain effective linkages and networks across primary, secondary and tertiary levels of care, focusing on prevention, early recognition of risk, timely referral, consultation and clinical effectiveness” (pp 11).

It did not, however, attempt to outline how this could be done in practice. Currently, maternity services in NSW has an Emergency Obstetric and Neonatal Referral Policy (which outlines a communication path for facilitating transfers in the case of emergencies), a Framework for Maternity Services (which helps Area Health Services plan their services but does not formally link them), and a Pregnancy and Newborn Services Network (which has some responsibility for service coordination, monitoring and evaluation). Despite these advances, NSW still does not have a fully integrated and network for maternity services for all women in the state.

Proposals for the development of an integrated maternity care system have not been

confined to governments. In 2005, the Maternity Coalition published outlined a framework for sustainable maternity care where women were able to: choose primary maternity care from midwives or GPs; the place of birth (home, hospital, or birth centre); and the model of care (depending on location, workforce availability, and other local community needs) (32). The framework also proposed that referral pathways to secondary and tertiary care be “*determined by agreed consultation and referral guidelines*” (pp 13). Like other proposals for integrated care, the Maternity Coalition’s proposal also stopped short of developing detailed care pathways and outlining the policy and practice changes needed to implement them.

An international example of integrated maternity services

The Netherlands

Advocates of maternity services reform frequently point to the Dutch system of maternity care as a model of success. This is partly because of the prominent role of independently practicing midwives and high proportion of home births. Under the Dutch system, midwives or GPs provide primary obstetric care and obstetricians provide, or supervise, secondary obstetric care. Both midwives and GPs are able to provide care at home and in most general hospitals. Sickness funds (which fund primary and health hospital care) only provide funding for obstetric care, which is mostly carried out in hospitals, if there are medical indicators suggesting a need for it (33).

Under this system, risk assessment and management is critical to ensuring high standards of care. Referral and consultation guidelines, which are issued by the Health Care Insurance Board, are designed to regulate referrals to obstetricians. In the past, obstetricians have rejected the guidelines because they believed they should be responsible for risk assessment, and that women should have the right to choose their own carer (33). However by 1999, all professionals involved in maternity care reached an agreement and a new list of detailed guidelines for referral and consultation – the Obstetric Guide – was drawn up and issued by the government (34). Efforts were also made at this time to improve the working relationships between health care professionals by introducing obstetric cooperation groups. They were initially trialled in 10 regions. Unlike the case with most integrated clinical networks, participation in the Dutch model was voluntary, and the nature of the co-operative relationship determined by the participants.

A review of the Dutch obstetric system and Obstetric Guide, which was published by the Obstetric Working Group of the National Health Insurance Board of the Netherlands in 2003, found evidence of high levels of cooperation between obstetric practitioners in many parts of the Netherlands. The review also outlined a proposal to further develop cooperative relationships between practitioners (Obstetric Working Group of the National Health Insurance Board of the Netherlands- original in Dutch) (35).

Although not all agree about the effectiveness of risk assessment procedures and the value of voluntary cooperation groups (36), the Dutch example shows that it is possible to establish collaborative and productive working relationships between health professionals in maternity services.

Outline of proposed protocols

The following section aims to develop further the work done in past proposals. It specifies three different clinical care pathways for maternity care in Australia – one for low risk mothers and babies, one for medium risk, and one for high risk.

In their recent submission to the Federal Government's *Review of Maternity Services*, the RANZCOG highlights the challenges associated with classifying risk, and the speed with which it can often change. It also makes it clear that it objects to the idea of classifying women as 'high' or 'low' risk because it is "*not possible*" and "*creates more problems that it is worth*" (pp 4) (23). Central to its objections is the idea that labelling a woman as low or high risk may have the consequence of determining whether they receive a midwifery or medical model of care.

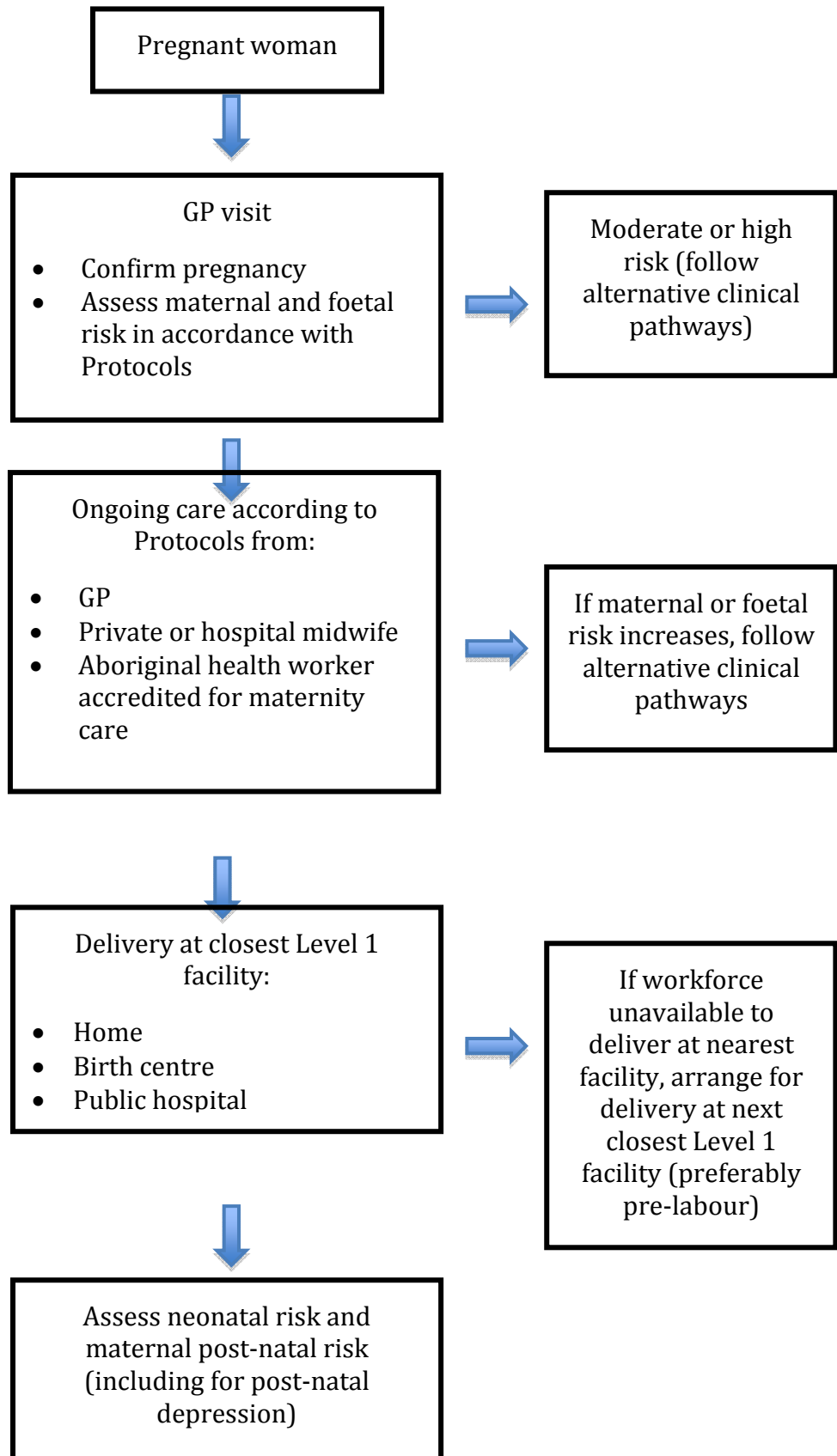
The pathways outlined in this position paper take these challenges into consideration, along with those concerning critical workforce shortages, particularly in rural and remote areas. They strike a balance between safety and a woman's right to choose her preferred model of maternity care because they: require all health professionals to adhere to accepted Protocols for consultation and referral; offer all women a choice of practitioners for antenatal care and delivery, regardless of risk status; and require transfer of care to an alternative, suitable practitioner if risk status changes or there are workforce shortages in the local region. If women are unable to access their preferred practitioner in the local region, they have the option of choosing an alternative practitioner, or opting out of the public system for private care.

In order to minimise the potential impact of workforce shortages during delivery, women in the early stages of pregnancy should be encouraged to prepare a birthing plan in consultation with their GP. This plan should make contingency arrangements for delivery if it becomes clear close to the expected due date that workforce shortages are likely to prevent delivery in the closest facility. In order to minimise the need for transfers during labour, every effort should be made to inform women as soon as possible about workforce shortages and the need to give birth in an alternative location.

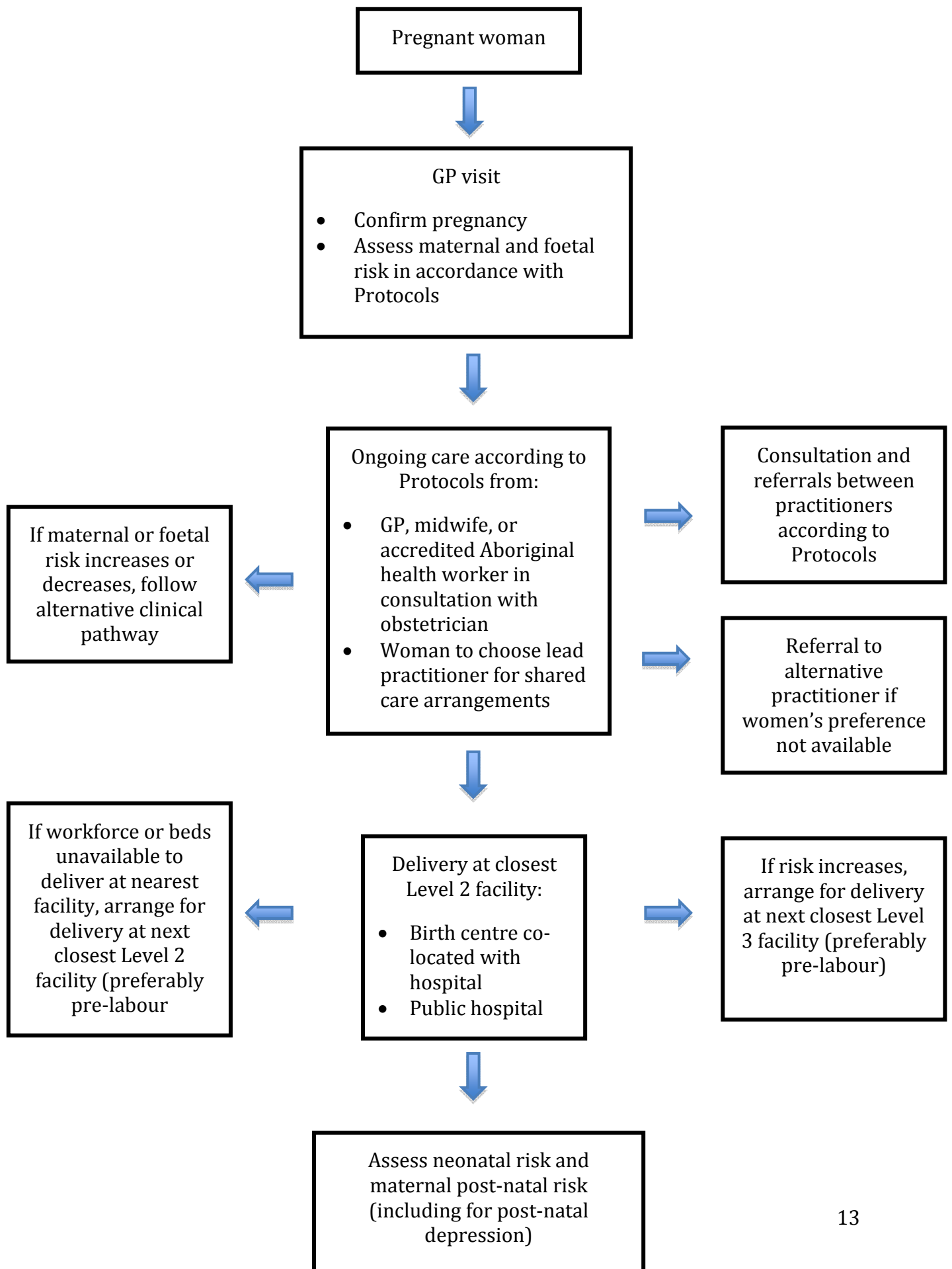
The numerous changes to policy and practice required to successfully implement these pathways are outlined in the following section.

Integrated clinical pathways

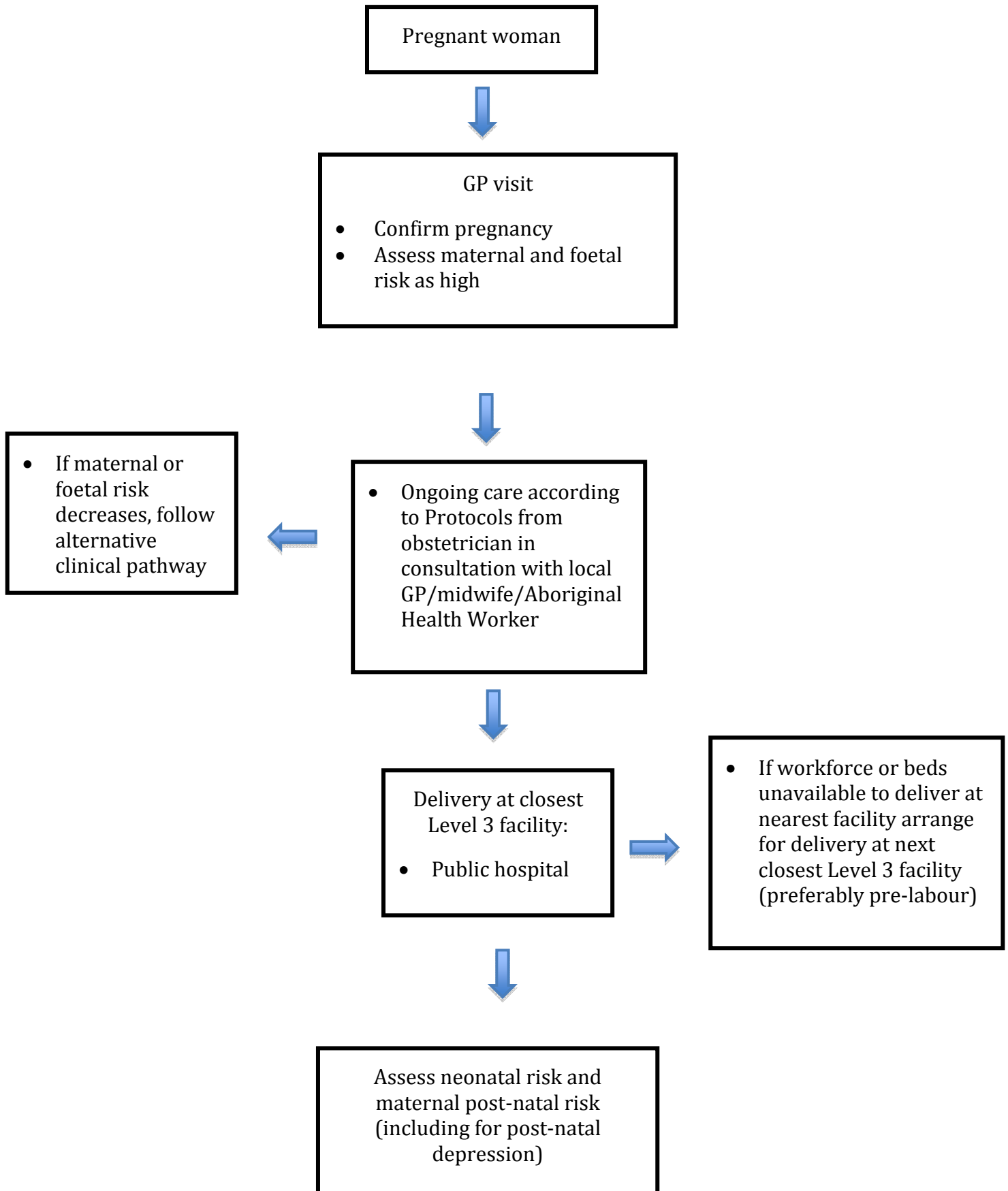
1. Clinical pathway for low-risk women and babies in public system



2. Clinical pathway for moderate-risk women and babies in public system



3. Clinical pathway for high-risk women and babies in public system



Policy and practice changes

A number of policy changes will be needed to successfully implement integrated clinical pathways.

Protocols for consultation and referral

1. An agreed national system for classifying maternal, foetal and neonatal risk needs to be developed. The ACM Guidelines for Consultation and Referral are the best available to date, but they need to be reviewed and endorsed by all major parties in maternity services, including state and federal governments, the ACM, and RANZCOG. Once ratified, all practising health professionals would need to comply with these protocols. Each state and territory would be required to assess and monitor compliance with the Protocols and develop a system for dealing with complaints and non-compliance.
This work would be best done as part of the federal government's current Maternity Services Review.
2. All undergraduate and post-graduate education for health professionals working in maternity services need to be reconfigured so that courses include a module on the Protocols. Students would be accredited prior to graduating. This work needs to be done at the state and territory level, although the federal government has an oversight and coordination role.
3. All health professionals currently practicing in maternity services would need to be accredited.
This could be done through existing continuing education programs organised and administered by the relevant professional boards.

Integrated clinical networks

4. Each state and territory needs to develop clear arrangements for fully integrated clinical networks in public maternity care. These networks should take into consideration state demographics, the type and distribution of maternity facilities, availability of maternity beds and workforce. They should outline detailed procedures for responding to changes in maternal and/or neonatal risk, and outline transport options for women and babies requiring non-urgent transfer to another facility (for example community transport schemes and neonatal transport services), and urgent transfer (for example using land and air ambulance services). The private sector would also be strongly encouraged to develop integrated care networks along the lines of those in the public system.
This work would be best overseen by the state and territory health departments, with a leadership and coordination role for the federal health department.
5. Under the integrated care networks, women choosing the public system would have the right to choose their care provider in the local region (in accordance with their level of risk). Women would be required to deliver in the closest appropriate maternity facility (for low-risk women, this may include home births, birth units, or public hospitals). If this was not possible because of bed or staff shortages, arrangements would be made for delivery at the next closest appropriate maternity facility.

6. Plans for urgent and non-urgent transfer of care to another health professional or facility should be developed with a woman and her family early in pregnancy. If transfer is required (because of changes in risk, or bed or workforce shortages in maternity facilities) the women should be informed as soon as possible and the plan activated.
7. In order to ensure these networks operated efficiently and safely, each state and territory health department would be required to develop and implement a centralised system for collecting and distributing data on workforce and bed availability in each region. Data would need to be kept up-to-date and include current contact details for maternity services and practitioners. This data should be publicly accessible.
8. All birthing facilities need to be assessed and classified into categories specifying the level of care they are equipped to safely provide (level 1 is the lowest level of care and level 3 the highest). To ensure ongoing compliance, facilities would need to be re-assessed at regular intervals. This could be done as part of the existing hospital accreditation system.
9. Each state and territory health department needs to develop and use standardised assessment and referral forms. These could be developed alongside the Protocols for consultation and referral. Both would need to be reviewed and updates at regular intervals.
10. A national, or at the very least state-based, electronic health record system needs to be developed and implemented. In the interim, a comprehensive patient-held obstetric record system needs to be implemented across Australia.
11. A national, means-tested travel assistance scheme needs to be developed for women who are unable to access services in their local region because of bed and/or workforce shortages, or there are no appropriate facilities. Patient assisted travel schemes already in each state and territory, but they vary considerably.
The best option would be for the Federal Department of Health and Ageing to assume responsibility for funding and administering this scheme.

Funding and insurance

12. The Medical Benefits Scheme (MBS) needs to be extended so that self-employed midwives and accredited Aboriginal Health Workers practicing in accordance with the Protocols and without the supervision of a medical practitioner would be entitled to make claims. This should be done in conjunction with a review of existing MBS benefits for all midwifery and obstetric services. Any fees for midwifery or obstetric services in excess of MBS benefits should be eligible for inclusion under the Medicare Safety Net scheme.
13. Insurance – all self-employed midwives and accredited Aboriginal Health Workers practicing midwifery (that is, those not employed by public or private facilities) would be required to hold current indemnity insurance for a specified amount. Existing federal government subsidies (such as the Premium Subsidy Scheme, High Cost Claim Scheme, and Exceptional Claim Scheme) should be expanded to include health professionals other than doctors.

Conclusion

Most of the proposals outlined in this position paper are not new. In fact, nearly all were proposed nearly two decades ago after the Shearman review of maternity services in NSW. This review, for example, proposed the introduction of: integrated clinical networks for maternity services; a classification system for maternity units; accreditation for maternity services health professionals; regional self-sufficiency in maternity services for low and moderate risk women; the introduction of state wide protocols for in-utero transfer and newborn transport; an expanded role for midwives and GPs; improved community transport arrangements; universal use of a ante-natal care card, and; guidelines for clinical privileges (these would help clarify the roles and responsibilities of various maternity services health professionals) developed collaboratively by midwifery and medical groups (28).

The main reason most of these proposals have not been implemented is that maternity services health professionals, or more precisely their professional associations, have been unable to reach any agreements on how to work together collaboratively. Risk assessment and management, and therefore role delineation, is at the heart of their longstanding disagreement (37). In its recent submission to the Maternity Services Review, the RANZCOG stated that *“improving harmony within the maternity workforce should... be a high priority of the Maternity Reform Agenda”* (pp 32), but it went on to harshly criticised the notion of independent midwifery practice by saying that:

“Independent’ midwives often practise in high risk settings (home birth or rural and remote communities) and with patient selection criteria ‘bent’ beyond anything considered reasonable e.g. twin delivery, breech delivery or vaginal birth after caesarean section. Such a model encourages the woman to develop a mindset of ‘low risk = no complications’ leading to frequent disappointment when expectations are not realised.” (pp 17) (23).

The submission concluded that *“independent’ professional practice of any craft group does not have a place in maternity care”* (pp 32).

In contrast, numerous submissions to the Review from individuals and midwifery groups advocated expanding the role of midwives to include independent practice. Some, such as the Australian Society for Independent Midwives, criticised current models of care claiming that they: did not provide true continuity of care; had rigid medical controls; and were dominated by GPs in rural areas, which lead to a deskilling of the midwifery workforce and increase in the number of roadside births (38).

Others, however, were optimistic about the prospects of establishing collaborative working relationships with the medical profession. In its submission to the Rudd Government’s National Health and Hospital Reform Commission, the Maternity Coalition acknowledged that expanding the role of midwives risked flaring up “conflict over professional turf”, but believed medical resistance to its proposal would be manageable (39).

Over the last two decades, a pattern of reviewing but not reforming maternity services has evolved in Australia. This paper proposes a way forward – the introduction of mandatory protocols for consultation and referral between health professionals, and the development of integrated clinical networks for maternity

services.

While many of the ideas outlined need further development, the policy and practice changes proposed in this paper will be the biggest hurdle to successful implementation. It will require strong political leadership to resolve the inter-professional disputes over risk management and role delineation that have plagued maternity services in Australia for so long. Using both 'carrots and sticks', political leaders will need to ensure that the various parties in maternity services develop collaborative working relationships and are prepared to make compromises so that protocols and care pathways can be successfully negotiated.

With strong leadership and a renewed focus on the goal that all maternity service professionals share – ensuring the safety of mothers and babies – it should be possible to reach a consensus about maternity services policy and practice that will lead to better health outcomes.

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Appendix: Maternity Services in Australian states and territories

State	Current policy/framework	Policy area	Year published	Existing networks	Proposed developments
NSW	Emergency Obstetric and Neonatal Referral Policy Framework for maternity services	Appropriate communication path for facilitating emergency obstetric or neonatal referrals. Devised to assist area health services plan their maternity services.	2005 (due for review 2010) 2000	Pregnancy and Newborn Services Network (established 1991). Responsibilities include service coordination; monitoring and evaluation of health services to mothers and infants; planning; policy development and implementation; education and research (not an integrated clinical network).	
ACT	Shared care guidelines	Relevant only to low and some moderate risk women in public care. Includes schedule of visits and division of responsibility. Clearly classifies levels of risk and outlines clinical pathway for breech presentations	May 2008		
Victoria	Future directions for maternity services	Includes a framework for rural birthing	2004	Maternity and Newborn Clinical Network (established 2007).	Maternity and Newborn Clinical Network aims to standardise practice across the state.

Tasmania	State health outlines which hospitals will provide what type of maternity services.		May 2007		
SA	Operational Policy Guidelines and Standards. State health plan 2007-2016 outlines where various services are located.	Establish the minimum professional, quality and safety standards for the provision of maternity and neonatal services.	1995		State Health Plan aims to ensure local integrated health services will be equipped for low risk deliveries. Rural and remote communities will continue to be supported by tele-medicine and the Royal Flying Doctors Service.
WA	Guidelines for Rural Obstetric and Midwifery Services. Maternity services framework.	Specifies what is required to ensure safe management and birthing at different types of health services. Sets out goals and objectives for developing further.	2000 2007	Women's and Newborns Health Network (established 2006). Purpose is to help plan services, develop protocols etc.	

NT	Integrated Maternity Services Framework that covers all government services for antenatal, birthing services and post-natal outlined in Maternity services review accepted by government		December 2007		<p>Will establish a clinical reference group to refine the Framework.</p> <p>Various professional groups and organisations have agreed to work towards established agreed protocols and guidelines.</p>
Queensland				Statewide maternity and neonatal clinical network established in 2008. It aims to develop, review and authorise for statewide use, evidence based standards of care, guidelines and pathways.	A models of care implementation guide was produced in 2008. It proposes a rural cluster or network model, but it is only in the early stage of development.