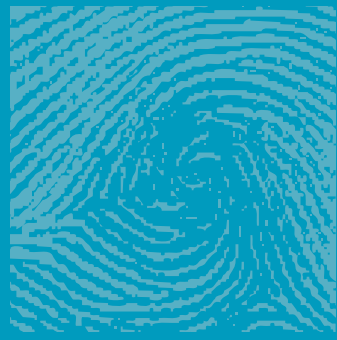


Future directions for Victoria's maternity services



Future directions for Victoria's maternity services



Foreword

Birthing services are always very important to the community. For a long time, many women have been calling for more control over this important life event. There are also a range of views amongst the professional groups involved in providing birthing services.

The Government's purpose in initiating this statement is to offer a leadership role in setting an agenda for future directions in birthing services. In our statement, we set out a framework for gradual but strategic changes that will guide developments over the next 5-10 years.

We must work towards high quality birthing services where providers have a multidisciplinary approach and where women are informed and have choices.

We are very encouraged by the increased appreciation of the need for health care professionals to work together and coordinate birthing services.

I look forward to Health Services and Hospitals incorporating these future directions into their planning for the provision of birthing services.

I thank the members of the Maternity Services Advisory Committee who have contributed to the development of these future directions.

Bronwyn Pike
Minister for Health





A new focus on what women want

Women must be the focus of maternity care. They should be able to feel they are in control of what is happening during pregnancy and childbirth, based on their individual needs and having discussed issues fully with their care providers. For women to feel this control, we must recognise that pregnancy and childbirth, while requiring quick and highly specialised responses to complications, are a normal physiological process, not a disease.

Approximately 60,000 births occur in Victoria each year, with three quarters of women giving birth in public hospitals. The Bracks Government's vision for our public maternity services is a more integrated service that provides increased choice and encourages informed consumer involvement in decisions about care.

Victoria's maternity services are as safe as any elsewhere in the world. Our commitment is to build on this standard by increasing quality service options for women, in line with community expectations. Australian women have come to associate childbirth with care provision under a medical model. But there is also a growing call for innovations in maternity care in line with the care provided in comparable countries.

Providing continuity of carer through a teamwork approach

Consumer surveys¹ conducted over the past 13 years have revealed an increasing demand for maternity care models based on continuity of carer. Ensuring continuity of carer and providing choice thus underpin the new framework for maternity services.

Seeing the same caregiver throughout pregnancy, labour, birth and afterwards was important to many women. Without this continuity women often felt less confident to ask questions of care givers, and more apprehensive about what to expect when they went into hospital in labour.

¹ Centre for the Study of Mothers' and Children's Health, Victorian Survey of Recent Mothers 1990, 1995, 2000.

The work of obstetricians and general practitioners is fundamental to high quality care, and the government wants to enhance their role. Midwives also play a crucial role, which will be increased through continuity of care models in partnership with other health care providers. The maternity team is paramount to achieving optimal outcomes and meeting the needs of women and their families.

Additionally, Victorian women deserve to be able to make informed choices about the form of their maternity care, knowing that health care professionals with different and complementary expertise are working together in their best interests.

Midwives provide a psychosocial, clinical and educative role across the pregnancy–parenting continuum. The presence of known midwives during pregnancy, labour, birth and post-birth supports women and contributes to their preparedness for birth and parenting. In this way, midwives help women to be actively involved in decision making about their care.

Focusing on primary maternity services

Women want choice, continuity and safety in their childbirth experiences. In response, the government will introduce a system of maternity care provision that is woman centred and informed by the needs of the women who use it. The framework will consist of three levels of care based on services for women, not facilities.

First, the government will acknowledge and enhance primary maternity services as a fundamental element of maternity care throughout Victoria. The average woman experiencing an uncomplicated pregnancy does not require ongoing specialist supervision and this is recognised within primary maternity services. All women will be able to access this level of service unless their circumstances warrant transfer or referral to a specialist level of care. The service providers in this level are usually general practitioners and midwives, although obstetricians too in some locations may participate in providing primary care.

These primary maternity services will recognise that we can use midwives effectively in all aspects of maternity care in normal pregnancy and childbirth, to meet the needs of most women. In line with progressive maternity care worldwide, we will make better use of midwifery skills to provide women with the type of care they are increasingly demanding.

These primary maternity services will be available over time in all public health facilities that offer maternity services. There may also be opportunities to extend pregnancy and post-birth care to smaller rural communities that have an identified demand. While women may need to travel a distance to give birth, antenatal and postnatal care will be provided more locally where feasible.

Women will be referred as needed to secondary or tertiary level services (or service providers) that provide a higher level of medical care. These services may be provided at the same hospital or through a woman's transfer to another hospital (either antenatally or during labour).

Secondary maternity services will meet the needs of women who develop complications and require transfer or referral to specialist medical care. This level of care will be targeted at women who experience moderate complications—for example, women with high blood pressure. These women are not at the highest risk, but need medical input. Midwives will still be involved, both during the antenatal period and in providing continued clinical care in labour and the postnatal period.



Tertiary maternity services will provide multidisciplinary specialist care for women and babies with complex and/or rare maternal-fetal needs; care that the three tertiary hospitals currently provide. Obstetricians are particularly essential to continued service provision at this level of care.

The government believes the role of midwives and general practitioners in labour and birth needs to be encouraged and extended. A shared care approach between midwives and medical practitioners is encouraged, where this suits local circumstances. Where midwives provide the primary care, we encourage a team or caseload approach, with an individual or small group of midwives providing all pregnancy, labour, birth and postnatal care, using defined guidelines and protocols.

The government acknowledges that the majority of women do not require medical attendance at the birth, but that this need is not always predictable. It is also acknowledged that even with medical cover, some women will need to be transferred to a tertiary service in emergency situations. In all circumstances, adherence to referral guidelines is of course required to ensure safe and effective care.

Continuity of care refers to the care of a woman by a consistent or known carer/s throughout all stages of pregnancy, birth and the post birth phases including referral to maternal and child health services (the continuum). There are various continuity models:

- *Shared care model*—care is shared between two health professionals, with in most cases a midwife and a doctor sharing the carer role.
- *Caseload midwifery model*—involves one midwife in a primary or lead role.
- *Team midwifery care*—a small team of midwives care for the woman.



Benefits of the service framework

Increased options for women

The development of mainstream primary care services will provide choice and encourage consumer involvement in decisions about care. By maintaining the *Having a Baby in Victoria* website at www.health.vic.gov.au/maternity, the government is providing women with the information they need to make choices about their model of care. And extending maternity services to include continuity of care across all three levels of care will mean women have a new option similar to care available in many comparable countries.

The National Health and Medical Research Council's review of services offered by midwives (1998) noted that evidence from national and international randomised controlled trials suggests that midwifery led care does not have an adverse impact on the health outcomes of women and babies when compared with conventional care. In addition there is Level 1 evidence of an associated benefit reflected in women's greater satisfaction with midwifery care—ED Hodnett 1996, 'Alternative versus conventional delivery settings', The Cochrane Library, issue 2,2004.

The new service framework will achieve the right balance in providing women with (1) greater choice and control of their birthing experience and (2) access to appropriate and needed levels of medical expertise. The system will ensure safety and quality, and respect the need for women to be able to choose how their pregnancy and birth experience is managed.

Support for rural services

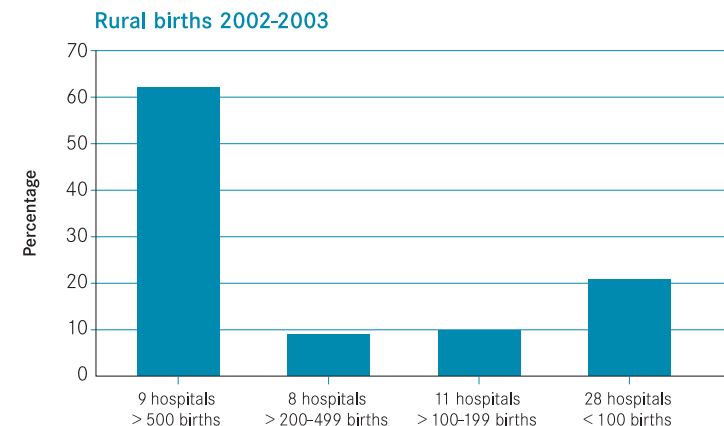
In the majority of rural locations care is provided by general practitioner proceduralists and obstetricians. These roles are threatened by increasing workloads (which have an impact on lifestyle) and decreasing numbers of general practitioner obstetricians. The new service framework will support the provision of maternity services in rural communities, to ensure women continue to have access to quality maternity care.

The majority of rural and regional hospitals provide birthing services. Rural hospitals provide for nearly 14,000 births per year across over 50 towns. However, while it is important that women have access to local services in rural communities, women are more likely to give birth in the major regional centres. Over 60 per cent of all births in rural hospitals occur in just nine regional centres. It is important to these women that the majority of their care, both during pregnancy and immediately following birth, is provided close to where they live, preferably by a known practitioner.

A workforce working together for the benefit of women

This model will make the best use of the complementary skills of midwives, general practitioners and obstetricians, while promoting multidisciplinary learning, respect and trust among these different disciplines. This approach will assist women to move seamlessly through the levels of care they require.

Australia is facing significant workforce shortages in each of the professional groups that provide maternity care. By using our skilled workforce to best effect, we will provide more satisfying roles for these groups, while ensuring safe and effective care for women.

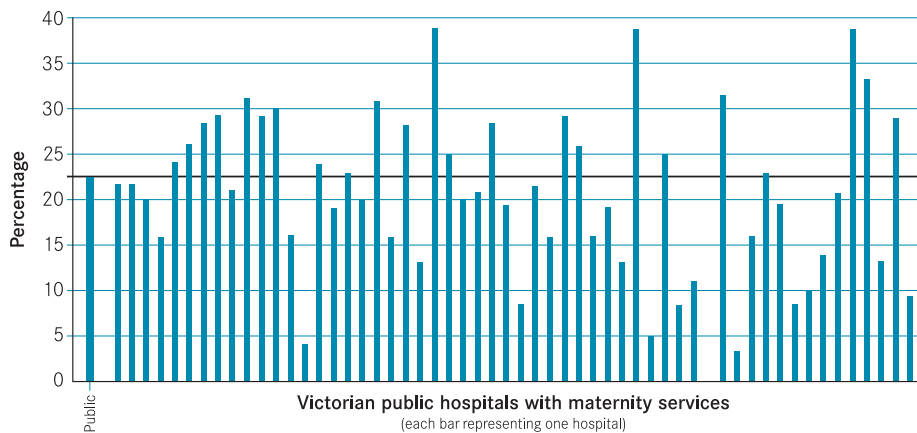


Safety and quality of care

Intervention rates for the induction of labour and caesarean section vary considerably around the world. Studies and experiences from within Australia and overseas suggest maternity services that adopt a continuity of care approach to service provision can expect lower rates of intervention, without jeopardising safety.

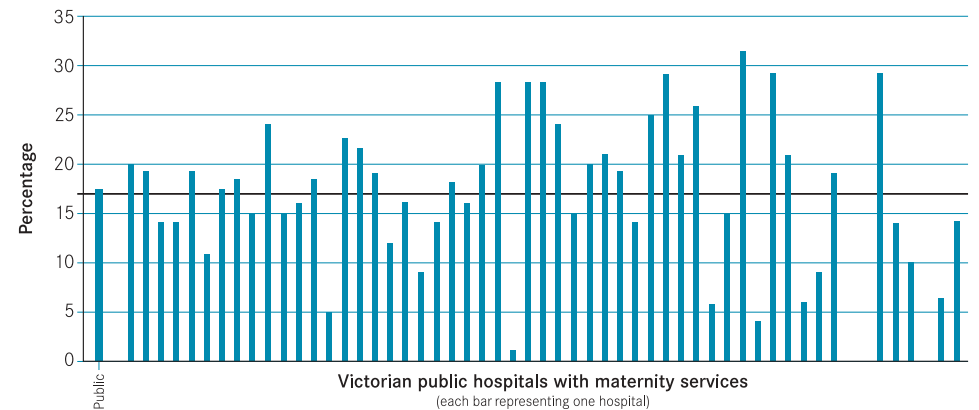
In Victoria, we can now compare intervention rates adjusted to the risk level of women, rather than to the type of hospital in which women give birth. The first two years of available data demonstrate an enormous variation in intervention rates among a similar group of women—for example, risk adjusted induction rates varied from 3 per cent to 38 per cent across hospitals, as indicated in the table below. While there is no agreed, clinically appropriate rate for these indicators, analysis of this data is important to understanding the reasons behind birth interventions.

Standardised Rates of Induction of Labour by hospital amongst women assessed as likely to have uncomplicated pregnancies (2001 & 2002)



There is growing concern about rising caesarean rates and questions are being asked as to whether women requesting caesarean sections are actually making informed choices. The caesarean rate for Victoria has increased substantially from 16 per cent in 1986 to 28 per cent in 2002. As indicated in the table below, there is also considerable variation between hospitals in caesarean rates, even after excluding high risk cases. These patterns suggest the variation may be influenced by individual hospital practice, and not solely relate to the specific needs of women.

Standardised Rates of Caesarean Section by hospital amongst women assessed as likely to have uncomplicated pregnancies (2001 & 2002)



The Maternity Services Advisory Committee is working with health services to support analysis of intervention rate data, to ensure interventions such as caesarean section are used appropriately.



How will we get there—the six point plan

The Victorian Government's vision for maternity services will be implemented according to the following principles:

- ensuring safety and quality
- providing women with informed choice and greater control of their birthing experience
- achieving the right balance between primary level care and having access to appropriate levels of medical expertise when it is needed
- making the best use of the complementary skills of midwives, general practitioners and obstetricians
- enhancing a maternity team approach.

While the government recognises that full implementation of this vision is a five to 10 year agenda, we commit to having primary maternity services established in selected locations across metropolitan, rural and regional Victoria by 2006. Already moving in this direction, we will pursue it through the following six point plan.

1. Establishing primary maternity services in metropolitan Melbourne

Many of the metropolitan health services have over recent years taken steps to increase the level of team based care and continuity of care that reflect the principles of the primary care model. As they develop their strategic service plans over the next six months, each health service will now be expected to address how they will respond to the future directions for maternity services and in particular how they will implement a primary maternity service.

Casey Hospital has been built with 10 self-contained labour, delivery and recovery rooms and an additional 13 maternity beds in a contemporary facility. During the first 12 months there will be 500 births at Casey, from March 2005.

The hospital will provide care for women meeting low risk pregnancy and birth criteria within a primary maternity model. Women developing complications after booking will be transferred to Dandenong Hospital or Monash Medical Centre, Clayton.

Women wishing to book to receive care at Casey Hospital will telephone a central Southern Health booking service, where they will be able to discuss options of care in line with their risk status.

During labour and birth the low risk profile of Casey should minimise the need for emergency interventions. However where required there will be appropriate medical back-up and/or transfer to Dandenong Hospital or Monash Medical Centre, Clayton.

The new Casey Hospital in Berwick will open later this year and provide accessible public maternity services for the outer southeast community.

Western Health suspended obstetric services at Williamstown in January this year, due to the inability to provide adequate anaesthetic cover. Preliminary work on a Clinical Services Plan for Williamstown, proposes that options for establishing a primary maternity service be explored, where a midwife known to the woman cares for her during pregnancy, labour, birth and the postnatal period. In deciding how medical cover will be provided, one option would be to develop referral mechanisms to Sunshine Hospital, along the lines of the Ryde Hospital model in NSW. The development of this model would require close consultation with the relevant professional colleges to ensure the protocols for referral are appropriate and supported. The Maternity Services Advisory Committee would oversee this consultation process and evaluate its implementation and outcomes to ensure a safe and effective service.

2. Supporting the provision of maternity services in rural Victoria

In rural areas, the government is committed to maternity services being provided in a way that meets the needs of women and the workforce. We will implement a \$4 million program - the Rural Maternity Initiative - to support rural services in providing continuity of midwifery care within a collaborative framework. Evidence based care, referral and consultation guidelines will underpin these models. Rural general practitioners have traditionally been the major maternity care provider in rural areas, and we plan to continue to support this role. A recently established model in Portland demonstrates how the proposed model will work.

Portland District Health Service is located in the far southwest of Victoria and performs around 180 births per year. The continuation of the maternity service was under threat due to a midwife shortage. Retention and recruitment of skilled midwives had been challenging, as many midwives were not prepared to work across midwifery and general nursing areas, as was required at Portland District Health like many rural hospitals.

A creative solution has been to implement a collaborative maternity model of care. Local medical practitioners continue to work closely with midwifery staff, and the model enables midwives to be allocated to the women, not rostered to the ward. This model requires fewer midwives, and as the team of midwives are responsible for the delivery of midwifery care only, increases job satisfaction. Core midwives who are rostered on the ward support this 'team'.

The assigned midwife and other members of this small 'team' get to know the woman. Women and their individual needs become well known to the midwives throughout pregnancy, birth and the days following the birth. This includes visiting them when they return home. Doctors, specialists and midwives work collaboratively to deliver consistent, individualised, woman-centred care.

West Gippsland Healthcare Group is a rural hospital with 650 births per year, employing 33 midwives, two obstetricians and three general practitioners/obstetricians.

Primary level care: The hospital agreed to a request from the obstetricians to introduce a midwifery continuity of care model. Initially, the model will be trialled with a small cohort of women, with a planned expansion if the trial outcomes are favourable. The midwives will work in a modified caseload model, whereby they are allocated to a specific number of women with low risk pregnancies, providing those women with all pregnancy, labour, birth and post-birth care. A medical practitioner will not be present at the birth unless a complication arises; the medical staff provide back-up for the midwives. A medical practitioner will assess all women on their suitability for the midwifery led model.

Secondary level care. The general practitioners/obstetricians will be the primary carer for women with higher needs; the midwives will work in a modified caseload model with a specific number of women. The allocated or known midwife will provide continuity of care during a woman's pregnancy, labour, birth and post-birth, in partnership with the medical practitioner/obstetrician. Medical staff will be present at birth.

A number of other health services are actively pursuing participation in the Rural Maternity Initiative program with the support of local obstetricians, general practitioner obstetricians and midwives. Under this initiative West Gippsland Healthcare Group (Warragul) will soon offer some women a new continuity of midwifery care model within a primary and secondary service framework. This new service will operate in conjunction with the current secondary level of service.

The Department of Human Services is developing a Rural Birthing Services Planning Framework to support rural hospitals to determine how they wish to provide services in future. The framework will provide agreed minimum standards to support optimal birthing services. These standards will help rural health services to achieve the best balance between (1) meeting safety concerns for women giving birth in rural areas and (2) ensuring Victoria has responsive health care as close as is feasible to where women live.

The framework will support new models of care as they are developed. It will also support collaborative arrangements among services, including the continued provision of pregnancy and post-natal care in rural hospitals, which may involve birth occurring at a neighbouring hospital.

A discussion paper released in 2003 outlines the objectives of the project and the proposed framework. An expert reference group is working to finalise the planning framework by June 2004. The Department of Human Services will then work with health services to review their current service and determine their capacity to meet the nominated standards. This work will be conducted alongside ongoing area based planning to ensure an appropriate and sustainable spread of services throughout rural Victoria.

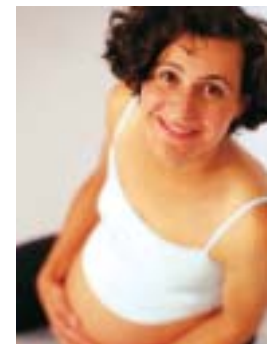
3. Undertaking workforce training and support

We need to support and recruit more general practitioner proceduralists in obstetrics and anaesthetics as they play an essential role in maternity care, particularly in rural birthing services.

Almost half of all rural general practitioners with obstetric qualifications are not practising obstetrics. To address this issue, we are funding general practitioner training posts in rural Victoria and working with rural general practitioners to examine how we can support them to deliver obstetric and anaesthetic services. We have established a working party to explore influences on the recruitment and retention of general practitioners who are qualified as obstetricians and anaesthetists, and we will soon launch a package of recruitment and retention measures in rural areas.

The government is conscious, however, that the issue is not simply about creating more positions, but about better understanding the reasons that doctors are not choosing to train and practice in these areas. For this reason, we are funding a study of the obstetric workforce in rural and urban Victoria. The study will improve our understanding of the barriers and incentives to obstetric practice, and of how we can encourage doctors to resume or commence this area of practice. This information will provide a basis for developing further programs to address these workforce issues. In addition, we have convened a Medical Workforce Training Advisory Committee made up of representatives from all stakeholder groups to examine the broader issues that affect the supply and distribution of the medical workforce.

A new group of midwives, educated solely as midwives, will enter the workforce in 2005 and will be keen to work across the entire scope of their expertise rather than within a limited practice framework. The new service framework will enable these and other midwives to practise across the full childbirth continuum.



The government recognises that other midwives may not feel that they are adequately prepared to assume their full scope of practice as expected of them in a primary maternity service. A planned approach to education and skills enhancement of midwives across both metropolitan and rural Victoria will thus be required. We will work with the Australian College of Midwives (ACMI) and other relevant bodies to ensure midwives in all practice domains are able to provide care within the new framework.

We will also support midwives and medical practitioners to develop within a team based primary maternity environment, by providing enhanced training and skills development. Our aim is to work with all maternity care providers, their professional colleges and regulatory authorities, to ensure the maternity workforce is skilled to work across the continuum of care. One example already underway is the development of a *Fetal Surveillance Education and Credentialing Program* to increase the skill level of all doctors and midwives in managing fetal monitoring during labour and birth. Supporting this, the current development of a statewide Maternity Record, will enhance communication between maternity care providers, and also improve information for women. This record will help achieve optimal outcomes for women by streamlining service provision and women's involvement in their own care.

The above guidelines, communication tools, education opportunities and referral systems are essential elements of our new approach to maternity care.

4. Investing in the tertiary maternity services

The government is investing hundreds of millions of dollars in improving the facilities of The Mercy Hospital for Women and The Royal Women's Hospital. Our three tertiary maternity hospitals in Victoria, including the Monash Medical Centre, are progressively taking a stronger leadership role in the maternity services system. They participated in an Australian first collaborative breakthrough in developing and implementing evidence based guidelines for antenatal care.

The birth rate has been declining, and women are generally giving birth later in life. As a result, the likelihood of complications in pregnancy is increasing. We need to recognise that this continuing trend is increasing pressure on neonatal intensive care services. And we acknowledge the need to expand our capacity in the neonatal intensive care area. The government has announced in the 2004/5 budget that it is funding an additional nine neo-natal intensive care cots, including providing \$2.5 million for equipment.

5. Providing emergency consultation and co-ordination

An integrated maternity service requires excellent coordination to provide access to specialist workers and its tertiary hospitals when required. Emergencies can occur anywhere and are not always predictable.

The government will give priority to the establishment of a system to provide perinatal emergency referral and advice along the lines of the current *Newborn Emergency Transfer Service*. This perinatal emergency referral service would provide ready advice to maternity care providers, assisting them to make decisions about possible transfers and to provide more comprehensive care before, during and following transfer.

6. Calling on the Australian Government

Many of the issues in maternity services are national issues. While the Victorian Government would like to take this model further by establishing primary maternity services at all sites, we can do only a limited amount without federal support.

We call on the Australian Government to work with us by agreeing to fund antenatal care more flexibly. All women deserve appropriate antenatal care, regardless of their choice of service providers or their ability to pay. As a first step to providing antenatal care in small or isolated rural communities we request the Commonwealth look at the opportunity of either pooling funding to allow antenatal care to be provided in the public hospital system in place of Medicare services or creating the option of funding midwives under Medicare.

These issues need to be pursued as part of the broader national health reform agenda. With federal assistance, we need to ensure sufficient midwives are being trained and all health professionals are suitably skilled to assume the roles required for a more flexible and responsive maternity service.



Summary

In summary, we need take a new approach to the provision of maternity services, recognising the challenges confronting us. We have made many advances and, in recent years, have been laying the foundations to support the changes now required to sustain a new model of maternity care.

The new model will achieve the right balance in providing women with (1) greater choice and control of their birthing experience and (2) access to appropriate and needed levels of medical expertise. It will make the best use of the complementary skills of midwives, general practitioners and obstetricians, in an environment of a declining number of these valued professionals. We need to ensure safety and quality, while providing women with greater informed choice and control of their birthing experience. Importantly, the new model will promote multidisciplinary learning and trust, so women will be able to access levels of care, as they require them.

The government acknowledges there is much to do in building a system that is more responsive to the individual needs of women and that most effectively uses the complementary skills of all maternity care providers. This shift requires significant cultural change in health services.

We believe this six point plan provides the building blocks to improve maternity services in Victoria for the benefit of all.

Feedback on this future directions document is welcome and should be directed to:

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Melbourne Victoria

or via email at noreen.dowd@dhs.vic.gov.au.

The Maternity Services Advisory Committee will assist in the implementation of these future directions, and addressing any issues raised in feedback.

The Maternity Services Advisory Committee brings together service providers and key stakeholders to provide expert advice to the Department of Human Services on matters relating to maternity services policy. It includes consumers, midwives, obstetricians, general practitioners, health administrators, researchers, and representatives from rural health, women's health, Koori and culturally and linguistically diverse communities.





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