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Submission Cover Sheet

Inquiry into Maternity Services in the ACT

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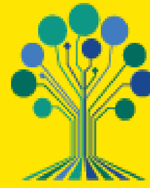

Submission to the Inquiry into Maternity Services in the ACT

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We welcome the opportunity to contribute to this review examining the operation of maternity services across the ACT. Our submission addresses the following aspects of the review:

a) Models of care for all maternity services offered at the Centenary Hospital for Women and Children (CHWC) and Calvary Public Hospital (CPH), including, but not limited to, the Birth Centre, the Canberra Midwifery Program, and the Home Birth Trial and whether there are any gaps in care

Our submission draws on a study we are conducting at UNSW Canberra into a community-based, midwife and GP shared-care, homebirth program that operated in the ACT from 1976 to 2001 and supported 1200 births over that period. The model of care has some features not found in any program available in Australia today. A full description of the model and its outcomes is expected to become available in 2019.

Four observations are of key relevance for this submission.

- The national policy goal for woman-centred care within a wellness paradigm is not being met by the range of models currently on offer.
- Lack of access in the ACT to non-medicalised, woman-centred, midwife-led, 'holistic' models of maternity care has the potential to drive women towards alternative forms of maternity care that do not include professional supervision and are widely regarded as dangerous.
- Access to the ACT homebirth trial is currently restricted due to program eligibility criteria that go well beyond health requirements
- Research is increasingly focused on examining benefits and harms associated with different models of care, including the physiological and psychological harms of interventions, both long and short term, to women

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and infants.

Recommendations

1. As a matter of urgency, woman-centred midwife-led continuity of care with continuity of carer models should be made widely available throughout the ACT.
2. Access to publicly funded homebirth models should be increased.
3. The eligibility criteria of the ACT publicly-funded Homebirth Trial should be restricted to clinically relevant indicators as are commonly found in non-hospital birthing models in other Australian and international jurisdictions.
4. Investment in research that focuses on evaluating models of maternity care and the outcomes they achieve for women and infants within their operational context should be a priority.

1. Woman centred continuity of care, and carer

In over thirty years of maternity services' reviews (at both state and federal levels), Australian women have consistently called for woman centred maternity care within a wellness paradigm as an alternative to medicalised maternity care options. The key demand is for woman-centred care, where the woman is supported to make her own decisions based on good-quality, unbiased evidence, and those choices are respected by her birth attendants. Woman-centred care is central to the holistic model. Continuity of care, including continuity of carer, has been shown to have a strong positive influence on birth outcomes for both women and babies. Sandall et al. 2016 [1] provide a recent international review of the advantages of midwife-led continuity of care models over other models.

The recent National Maternity Services Plan [2] did support woman-centred care within a wellness paradigm and called on Australian governments to increase access to midwifery-managed models of care, including continuity of carer models and independent midwifery models. Increased access to homebirth, to community-based antenatal and postnatal care, and to community-based and outreach maternity services in rural areas, were identified as indicators of success. Some few community-based midwifery services were established, offering out-of-hospital support to women birthing in hospital, and a small number of small-scale birth-at-home trials were also established, including in the ACT.

Despite offering a range of care models in the ACT however, continuity of carer models that operate within a wellness paradigm remain largely unavailable since a small percentage of births actually take place within midwife-led birth centres and even fewer as planned homebirths. Recent written submissions to the Australian Health Ministers Advisory Council Consultation Paper [3] suggest that midwifery led care remains widely unavailable. One submission estimated that midwife led continuity of care is available to no more than 8% of women in Australia.

Barriers to midwife led care are well known and operate across both supply and demand side factors. These include:

- Widespread fear of birth
- Evidence based information is not routinely or widely available to women

- Limited hospital visiting rights to private midwives
- Professional indemnity insurance has not been available to independent midwives since 2001.
- Scope of practice limits midwife's ability to order tests, prescribe medicines, and to practice in partnership with another midwife.
- Every private midwife must practice in collaboration with a named obstetrician.

Many of these problems are structural problems and are resolvable. Others such as fear of birth will require community wide strategies. Submissions to the Federal inquiry point the ways. In making midwife led continuity of carer models available to women in the ACT, the ACT government must act on factors that are in its remit to address. These include extending midwife visiting rights to ACT hospitals, expanding birth centre and homebirth places and options, establishing avenues for providing women and families with independent evidence based information through NGOs such as the women's Centre for Health Matters or the ACT Primary Health Network.

2. **Homebirth in the ACT**

The majority of homebirths in the ACT are now birth-at-home trial births. Prior to this, the ACT had a relatively homogenous and comparatively well supported model of homebirth practice, which operated from 1976 until 2001 when the medical indemnity crisis precipitated its demise. The model was supported by the Canberra Homebirth Association (CHA), an incorporated community association that provided support and information for women and families, referred women to practicing homebirth midwives and doctors, and hired birthing kits to women and families planning a home birth. Participating private midwives and GPs provided professional services. Midwives were paid privately by the client families but GP doctors were remunerated via the Medicare schedule. The program thus ran a mixed private-public homebirth model unlike any other in Australia that we are aware of. An archive of CHA 1976-1991 exists as an historical record. An analysis of the model and its outcomes is forthcoming (Trueman & Gardner).

In comparable countries, safe homebirth is provided as a routine care option. In New Zealand 70% of birthing women have midwife-led care and from 3-14% of births take place at home, the proportion varying by geographical region in line with local service variation (NZ Ministry of Health 2017 [4]). The UK has moved to re-establish homebirth as an option for all women with healthy pregnancies and the rate, currently around 5%, is rising (National Maternity Review UK 2016 [5]). Holland, where community-based midwifery has long been a mainstream model, sees 50% non-medical births, at least one-third of which take place in the home and the rest in midwife-run community birthing centres. In Australia, in contrast, homebirths account for fewer than 0.3% of all births and the trend in recent decades has been downwards, particularly since changes to insurance arrangements have led to the demise of many private midwifery practices.

Continued provision and expansion of homebirth options should be supported in the ACT. Given the current rate of intervention in birth in Australia, the focus on hospital-provided care and documented failure to expand access to the full range of birth models over 30 years, safe, well organised and supported homebirth could provide access for women to midwife led continuity of care and carer. It is particularly important in a system that currently provides such limited access to midwife led care

and planned homebirth that experts have reported an observed rise in the number ‘free-births’ (Dahlen et al. 2011 [6]). Freebirth, without a qualified midwife, appears to be unknown in countries that support a fuller range of birth models, with homebirth as a mainstream funded option.

3. Eligibility criteria to the publicly funded ACT Homebirth program should be reviewed

Aggregated preliminary outcomes of some Australian homebirth trials were reported by Catling-Paull et al. (2013) [7] but the trials themselves were a heterogeneous mix and some, including the ACT trial which takes 1-2 women per month, are too small to be interpreted individually.

The ACT trial in its first stage, only took multiparous mothers with no history of medical problems or caesarean, within a limited age range, with their own transport and a driver, who resided within a 15 minute drive of the hospital. This limited the trial to six clients in its first two years. The current (2018) version offers 1-2 home births per month.

Program eligibility criteria go well beyond health requirements (age, body mass index, at least one but not more than four previous uncomplicated pregnancies, normal vertex presentation) to include rules about pets, birth helpers, parking for midwives, private ambulance insurance and driveway access for an ambulance.There is a need to review the eligibility criteria to align them with clinically relevant indicators used in homebirth programs in other Australian and international jurisdictions.

4. The need for greater investment in evaluating maternity care models

An extensive international literature identifies two main ideologies of maternity care, often termed the medical and the holistic approaches (e.g.Pincus 2000 [8]). Medical models take a bio-technological approach to achieving effective parturition. Holistic models seek first to encourage the focussed emotional state in which a hormone-driven physiological birth is possible, and from that to achieve a non-interventionist or 'natural' delivery, while protocols for safe and effective medical support are held in reserve for use if required. The care offered in hospital birthing suites and by specialist obstetricians is typically medical in its general approach, while midwife-led care, especially in any non-hospital setting, tends to be more holistic.

The Maternity Services Review Report (Bryant Report 2009 [9]) identified twelve models of maternity care in use in Australia. Eleven were hospital-based, although one, birth centre care, features principal supervision by midwives, and in some others the birth itself may be attended by midwives alone if there are no complications. The twelfth model was a form of planned homebirth.

The Australian Institute of Health and Welfare (AIHW) developed a classification scheme for the models of maternity care in use in Australia (Donnolley et al. 2015 [10]). The variables relate to obstetric risks accepted into the program, the professional qualifications and mode of working of the service providers, the procedures undertaken and the facilities where care is given. A validation study

(Donnolley et al. 2017 [11]) identified 129 models of care in a single NSW hospital in a single year, arguably showing its usefulness as a reporting tool. However, that so many recognisably different types of care can be identified in such a narrow sample shows that this concept of "model" is far removed from that which is used by most other authors. Significantly, it also alerts us to the possibility that the fine detail of how a program is structured or implemented may influence its results.

There is an almost complete lack of information about how midwife-led, out-of-hospital maternity care has been organised in Australia, and what its outcomes have been. Contra Bryant but perhaps pro Donnolley there has never been one standard model, and anecdotal evidence indicates strong heterogeneity in eligibility criteria, in the care regime, and in clinical and social outcomes.

Research into homebirth in Australia including an early paper by Bastian et al. (1998) [12] has widely been cited as providing evidence that homebirth in Australia is inherently unsafe. Bastian et al. reported an excess of perinatal deaths associated with intrapartum asphyxia and with overdue births (>42 weeks gestation); a pattern that is not matched in homebirths elsewhere. Subsequent critiques (Kierse 2013 [13], Homer date [14]) suggest that their sample included a very mixed set of practices such that their conclusions were not scientifically valid.

Very recently, Davis-Tuck et al. (2018) [15] found homebirths in Victoria 2000-2015 to have been as safe as hospital births for low-obstetric-risk mothers, with no excess asphyxia and better outcomes for both the mother and the baby. However, they reported a higher rate of perinatal mortality for high risk mothers at home than for high-risk mothers in hospital. On examination, this pattern occurred because the chief risk in the high-risk homebirth cohort was gestation >42 weeks while the chief risk in the high-risk hospital cohort was BMI>30. While Davis-Tuck et al. concluded that only a low-risk mother should contemplate birth at home, our analysis of their data suggests instead that gestation >42 weeks should trigger a switch from home to hospital delivery.

Recent studies also show that many of the common interventions of childbirth, as are now practiced in the vast majority of Australian births, can have adverse medical consequences, both short and long term, for the mother and baby (Peters et al. 2018 [16]; Mueller et al. 2017 [17]; Dahlen 2016 [18]; Yang et al. 2016 [19]). In addition, unnecessary caesarean cannot be explained by population characteristics or demand side factors, and current high rates have not been accompanied by significant maternal or perinatal benefits and are associated with short and long term risks that can extend many years beyond the delivery and affect the health of the woman, child and future pregnancies (WHO 2018 [20]). But data in written submissions to the recent Federal enquiry suggest as few as 5% of Australian births are completed without medical intervention. This is a shocking indictment of the current state of Australian maternity care.

The social and mental health consequences of unwarranted interventions, including the effects of birth trauma on both the mother and the service providers, are of increasing concern in Australia, as was recently discussed in the Report of the Victorian Inquiry into Perinatal Services (2018) [21] and in submissions to the

Federal enquiry.

With research increasingly focused on examining the benefits and harms associated with different models of care, including the physiological and psychological harms of interventions, in both the long and short term, there is a need for research into the operation of different models of care and the outcomes they achieve within their specific operational contexts. This research needs to include a focus on client characteristics and demographics, attendant health professionals, interventions provided, outcomes for women and infants, and the service system contexts within which the model operates and outcomes are achieved. In the context of expanding existing models of care to incorporate midwife led models, policy must demand improvements in research that reflect attention to safety and quality rather than ideology (Kierse 2010 [22]).

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