



NATIONAL RURAL
HEALTH
ALLIANCE INC.

Position Paper

Principles for maternity services in rural and remote Australia

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This Paper reflects the agreed views of the National Rural Health Alliance, but not necessarily the full or particular views of all of its Member Bodies.

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The Commonwealth Department of Health and Ageing provides the Alliance with core operational support.

Principles for maternity services in rural and remote Australia

Purpose of the paper

This paper:

- presents the views jointly agreed by the 25 Member Bodies of the NRHA;
- will help secure a higher place on the national policy agenda for rural and remote maternity services;
- supports greater public understanding of the facts surrounding the issue;
- strengthens the case for new policies and programs in maternity services that will have beneficial impact on child and maternal health outcomes in rural and remote areas; and
- provides a resource for administrators, planners and policy makers to use in their efforts to improve access to maternity services for people in rural and remote areas.

The paper is aimed at consumers, public servants, politicians, health professionals, researchers, peak bodies and the media.

Executive summary

It is estimated that up to 130 rural maternity services have closed in the last decade. This amounts to about one closure per month. Over the years a great many families in rural and remote areas have relied on small maternity services for safe local birth outcomes. It is generally these smaller services that have closed, despite evidence that, for normal births, they are as safe as larger metropolitan units.

There is a longstanding shortage of appropriately qualified health professionals in rural and remote areas. However there is little evidence that maternity service closures are entirely a result of the workforce shortages. Nor have changes in birth rates justified the loss of so many services.

The closure of local maternity services has shifted significant risk to families and away from health services: there is an increased chance of birth occurring outside the appropriate care setting, a higher risk of associated complications, and greater costs (in time and money) to be borne by the mother and her family. The costs are incurred through increased travel and accommodation away from home (with concomitant family dislocation). Funds saved by closures have presumably been

reallocated by state health authorities to other services. The effects of these changes, both short and longer term, constitute a significant elevation and transfer of risk and diminution of the equity of access for rural and remote people.

Child and maternal health outcomes are influenced by experiences in the journey from pre-conception through antenatal care to birth and postnatal care. In particular, child and maternal health outcomes for Aboriginal and Torres Strait Islander peoples remain poor. Furthermore, rural and remote people have very limited options in terms of their choice of service provider and models of care.

The Alliance sees reinvestment in maternity services in the bush as a very high priority. In the interests of equity and safety there needs to be robust and transparent planning for future maternity services. Broadly, the reinvestment will address:

- better data collection and research evidence (e.g. on place of residence, place of birth) to inform the planning of service locations and models of care;
- the provision of diagnostic and treatment equipment commensurate with accessibility and remoteness factors of the service, and workforce expertise;
- undergraduate and postgraduate workforce education and training for adequate numbers and skills mix of relevant professionals;
- recruitment and retention strategies, including attention to remuneration and financing factors;
- improved cultural security for Aboriginal and Torres Strait Islander peoples; and
- risk management, including indemnity cover and other reforms to improve maternity care pathways for pregnant women (including clinician admitting privileges and primary care provider roles).

The expectations of health professionals are changing with, for example, part-time work increasing and average weekly work hours decreasing. There is some suggestion that procedural credentials, in particular obstetrics credentials, are more widely held by older general practitioners who will be leaving the workforce in the next few years. Many rural and remote communities also lack access to midwifery care. Health priorities are also changing with growing demand for workforce in chronic disease management, mental health and aged care. In combination, these will continue to create still further challenges in the maternity services area.

Although there is already some evidence that smaller maternity services are safe, further research on throughput and outcomes is required to strengthen the findings on this.

Improvements in the availability of maternity service personnel will be necessary to protect and re-open maternity services in rural and remote areas. The Alliance calls for:

- the development and adoption of consistent professional competencies in disciplines related to maternity services;
- recognition of professional skills and competencies both at the State/Territory and national levels and interprofessionally;
- substantial administrative and funding support for maintaining and enhancing clinicians' skills (including procedural skills and credentialing where required) and facilitated access to continuing professional development;
- recognition of the need for more peer support and mentoring, in particular for isolated practitioners;
- improved access to and utilisation of information and communications technologies to address in part the preceding two factors; and
- further research on rural and remote maternity outcomes.

In addition, equitable access to appropriate maternity services requires:

- improved cultural security in maternity services for Aboriginal and Torres Strait Islander people; and
- more comprehensive family support from patient travel and accommodation schemes when mothers are obliged to travel significant distances to give birth.

Scope of the paper

For the purposes of the paper 'maternity services' are an integrated sequence of services, including those relating to antenatal care, childbirth, parenting skills, postnatal services and specialised services needed by very young babies.

Maternity service options for women and their families in rural and remote communities have been diminishing for some time. The Rural Doctors' Association of Australia estimates that some 130 rural birthing services have been closed in the last decade.¹ The situation therefore continues to worsen for rural mothers. It is time for action on several fronts from Commonwealth, State and Territory governments.

A comprehensive plan for improved maternity services would play a key part in addressing the deficits in health, access and services experienced in aggregate by people in rural and remote areas. To be successful, such a plan will direct attention to providing sufficient professionals in the relevant disciplines; and to their distribution, remuneration and financing arrangements, professional relationships and incentives for them to work as a team.

Access to education and skills development is an integral component of workforce recruitment and retention. Adequate infrastructure and equipment is required for the working environment to be safe and appropriate for a particular maternity

service. In combination, attention to these matters will provide the basis for effective institutional risk management, necessary to bring clarity to the indemnity conditions under which clinicians provide maternity services.

The indemnity framework itself needs review to ensure arrangements are comprehensive for the various maternity services in place. There is a range of care models endorsed by State jurisdictions. Currently, care is delivered by institutional maternity services providers and by recognised individual private providers. Indemnity arrangements should support choice of provider by the mother and promote continuity of care through the antenatal and postnatal periods and for the birth itself.

It should also be recognised that in some remote and very remote locations where the number of deliveries in a maternity service may be at the lower end of the scale, retaining such units provides optimal obstetric outcome and risk management, because excessive travel distances in the event of closure create unacceptable risk.

Obstetric risks must be identified and managed with respect to timeliness of care and in an appropriate setting, and not transferred. The closure of maternity services has resulted in risk transfer as a result of births and complications in labour becoming more likely to occur in inappropriate settings or circumstances. These complications, such as unplanned home births, roadside births and births supported by the ambulance service, are more likely to arise because widespread maternity service closures have contributed to significant increased travel distances for many women. These circumstances have led to unacceptable risk transfer from organised health services to the community.

Expectant mothers must have good antenatal screening in terms of timing and frequency; reliability, precision and accuracy of diagnostic equipment; and the competence of the operator. Such guidelines are already available and well developed. Expectant mothers must also have good access to birthing services. Increased and excessive travel times for screening services may create barriers and disincentives for mothers to access appropriate antenatal care and screening. This may result in failure to identify and quantify obstetric risk. With respect to labour and birth, delays and excessive travel time will increase the risk of birth in an unplanned setting and/or with other sub-optimal outcomes.

There are already a number of innovative solutions to the challenge of maternity services in rural and remote areas and the Alliance has a strong interest in their continued success and operation. Beyond that, the Alliance is keen to promote the adoption of services that will work well in areas currently without service.

Principles

Principle One Services planning (infrastructure, workforce and community)

There needs to be a strategic approach to planning, including about the location of maternity services.

To have a sufficient maternity services workforce overall requires consideration of the numbers of undergraduate places and location of learning centres, course curriculums, interprofessional relationships, remuneration and financing, professional development and management of indemnity issues among other things. To have a sufficient workforce for maternity services in rural and remote areas involves additional elements, such as rural placements, access to special incentives for remote practice, data management and information and communications technology support, cultural training for rural areas and Indigenous populations, and locum support. Only with special consideration of the particular circumstances of non-metropolitan areas will it be possible to ensure that an adequate maternity services workforce is appropriately distributed.

The importance of all members of the team—procedural general practitioners, midwives, other medical specialists, and other health practitioners—must be acknowledged in policies and regulations; and by consumers and the various professionals involved.

To sustain maternity services in rural and remote areas, and to have the opportunity to provide them in areas where they have been lost, will require investment in relevant diagnostic and monitoring equipment (both its supply and maintenance), and in the preservation of staff competencies for maternity care.

In rural and remote areas it is particularly important to provide support for staff involved in an adverse event, for instance through debriefing, counselling and formal peer support. The need to provide professional and emotional support is even greater where staff experience such events in a close and personal fashion, as is often the case in smaller rural and remote communities.

Consumer involvement and the needs of particular groups

Maternity services must be planned and operated in close consultation with local consumers, particularly the families who are their clients. The primary underpinning framework for this principle has been endorsed in *Healthy Horizons: Outlook 2003–2007*.²

The needs of special groups must also be met, particularly Indigenous families and those in remote and very remote areas. The potential for isolation and dislocation experienced by birthing mothers in these groups can contribute significantly to maternal, family, social and economic distress which may be enduring. Access, and safety and quality, are two further principles articulated in *Healthy Horizons*,

which are highlighted here with regard to rural and remote people generally, and Aboriginal and Torres Strait Islander people in particular.²

For women from Indigenous communities, the cultural appropriateness and safety of the service provided is particularly important. For this group, there must be greater recognition and facilitation of family and kinship roles and support for traditional customs. Appropriate involvement of Aboriginal and Torres Strait Islander Health Workers in antenatal care and childbirth also needs development. Aboriginal women are not involved in delivering babies as much as they were previously and this means there may not be sufficient continuous practice to ensure safety—even though the expectations remain. Like all health professionals, Aboriginal and Torres Strait Islander Health Workers need to be continually upskilled. There needs to be further consideration of the concept of ‘Birthing on Country’ and for Aboriginal women to have the opportunity for assistance from someone known to and chosen by them.

It is also necessary to increase the cultural safety of birthing facilities in larger centres for Indigenous women and their families. Health services and their regional managers should be required to provide culturally appropriate services and to provide cultural education for their staff.

Special consideration for families and providers in remote and very remote areas will encompass issues such as assistance to overcome the difficulty of transport in some places and at some times, state-of-the-art telecommunications technology to enable telemedicine support, and improved financial assistance for patients requiring travel and accommodation. If women have to leave their area to have their baby, they need access to support for transport and accommodation for themselves and their carer(s) and/or immediate family.

One of the objectives of this paper is to improve birthing choices for rural woman. However the Alliance recognises that increased travel distances, emergency transit times and lack of immediacy of specialist input in adverse developments during labour and birth will prohibit the universal expansion of models and options for birthing that are available to many urban women. The immediate priority is the necessary attention to infrastructure and workforce factors to facilitate the opening of maternity services where the number of births is sufficient to preserve obstetric safety for the number of practising clinicians. As is implied in this paper, the benefits from improved measures of access to maternity services for people in rural Australia are almost certainly linked to rural community vitality, cohesion and vibrancy.

The reasons for the declining access to maternity services are complex and have contributed to a significant reorientation of health resourcing away from these services. Gross birth rate figures, which have shown a small decline over past years and increases in the last two years, do not justify this contraction of services. Among a range of deleterious impacts, a significant end result is disadvantage and dislocation for rural people starting or increasing their families. Thus there is a decline in equity of access, a shifting of costs onto rural families, and reduced community safety.

Through this position paper and associated effort the Alliance seeks progress toward the following vision for the future in relation to maternity services planning.

Vision for the future

1. Clear and active planning processes ensure that safe rural and remote maternity services are prospectively planned and adequately resourced so that the financial, social and emotional imposts of childbirth for a greater proportion of rural and remote people are comparable to those for people in urban areas. 'Safe' here connotes due attention to cultural, organisational and clinical risk control. Community engagement will be an integral element of such prospective planning.
2. At the local level, there is ownership of and investment in cultural security and awareness, in particular within maternity services that see higher numbers of Aboriginal and Torres Strait Islander people. Respect for traditional rituals and kinship roles can contribute to improved child and maternal health indicators and outcomes for Aboriginal and Torres Strait Islander people.

Recommendations

1. Frameworks and strategies to promote rural and remote general practitioner and midwife practice through undergraduate and training places and funding support are required at a national level.
2. Financing arrangements that attract and retain relevant clinicians to rural practice, and that enable better integration of maternity care within mixed employment, service delivery and remuneration arrangements, are required to improve the tenure of interested clinicians. There needs to be attention to the cover and rebate levels under the Medical Benefits Scheme, review and reform of incentives such as the rural retention payments, reasonable sessional and on-call payments but including workload control mechanisms; and subsidies or other offsets for the individual's burden of indemnity insurance.
3. Regional health authorities and health service boards need to improve frameworks for community involvement generally and in particular with respect to maternity service arrangements.
4. There should be significant investment at the institutional and clinical levels to improve the cultural security of maternity services for Aboriginal and Torres Strait Islander peoples, including:
 - an environment that improves two-directional learning between the service provider and the mother;
 - recognition and respect for traditional and extended family roles at the time of confinement and childbirth; and

- enhancement of services to recognise, embrace and invite as far as reasonably achievable, traditional rituals, practices and customs associated with childbirth.
5. Evidence of annual birth rates in health service catchment areas, balanced with reasonable preservation of obstetric safety based on evidence and outcomes, should be the basis of any future maternity services closures and the planning and (re-)opening of services. This evidence can be determined from data collected in the ‘Admitted Patient Care National Minimum Data Set’, which could be used to collate and map the distribution of birthing women by their residence and existing birthing services, to identify areas where demand justifies the addition of a maternity service.
 6. For planned or proposed maternity service closures, it should be a requirement that full and public impact statements are produced. These statements should include reference to evidence and timeframes. Financial, consumer, social, workforce and community impacts, including risk to the relevant communities and to health service sustainability, should be addressed.
 7. Assisted patient travel schemes should reasonably and equitably meet the additional financial imposts incurred by rural and remote people in accessing distant maternity services. Attention should be paid to fair and reasonable compensation for:
 - travel costs where distances are considerable;
 - accommodation costs, including where expectant mothers are required to spend the last weeks of confinement away from home and in close proximity to the birthing centre;
 - family costs where family disruption may occur and additional family care is required; and
 - loss of income or financial burden where business interruption occurs.

Principle Two Service capacity: a capability framework

The second agreed principle concerns operational safety issues. It is couched in terms of guidelines for services and practice, and for maintaining competencies and infrastructure within a ‘capability framework’ relating to institutional and clinical risk. The development and maintenance of these guidelines will be informed by national and international evidence.

Consistent maternity guidelines

Giving birth is a natural event and not an illness. However, it can entail major health risks for both mother and baby. Because of these risks, and especially in a climate of increasing litigation, health service practitioners who provide maternity services find themselves under greater legal and professional pressures than in earlier times. Bad birthing experiences impose costs for life on the mother, the

health professional and, most significantly, on the child. Unexpected events happen all too frequently and babies then need expert care from a wide range of professionals.

National Antenatal Guidelines (National Evidence Based Guideline for Antenatal Care) should be finalised and implemented to promote consistent protocols and standards for all maternity services, regardless of their size or location. Generally, at the state level there is a range of readily available resources detailing rural midwifery and obstetric guidelines (e.g. WA Health³), homebirth policy (e.g. WA Health⁴ and recognised by NSW Health⁵) and primary care for pregnancy and childbirth (Queensland Health⁶).⁷ However, documented evidence of progress or outcomes in these areas, other than the loss of maternity services, appears scant.

Uniform or national guidelines should include a framework to screen women, identifying those who are likely to require antenatal transfer to a higher level of care than available locally. They will also provide the indicators to be used for decisions to transfer women during the birthing event. As guidelines they will support and inform clinical decision making at the local level made by appropriate clinical experts that inform individual parent/family (consumer) preference. These guidelines, informing clinical decision making, will not be predeterminants for funding support or cost allocation functions. Presenting and pre-existing obstetric risk factors and local knowledge of workforce availability, including clinical expertise, resource and facility availability, referral pathways and timelines required to institute action plans, will also inform clinical decision making and consent of the parent(s).

The women and their partners and/or family⁸ should be involved in discussions about what the outcomes of this screening process mean in regard to their options and the safety of mother and baby. Where a woman's decision regarding child birth arrangements introduce higher risk than the managing clinician's decisions, informed consent is essential.

A further matter for federal attention or at least better national uniformity is the financing framework. The Australian Health Workforce Advisory Committee noted that:

... the fragmented nature of funding arrangements for maternity services was seen to have adverse consequences for the quality of care as existing funding arrangements break care into episodes centred around the groups which provide it and the settings in which it is organised, rather than the woman (p 27).⁹

Reform of financing arrangements to improve the continuum of maternity services care from pre-conception through to the postnatal period would improve satisfaction for both the consumer and the provider, as well as quality and risk management. This would entail a review of access to, and level of reimbursement from, the Medicare Benefits Schedule for private providers, the admitting and visiting privileges of these providers in State (and private) financed facilities, and clarity of indemnity arrangements for relevant practitioners covering both the primary maternity care role and within the institutional setting as a visiting clinician. Managed indemnity premium frameworks, including subsidies for

eligible practitioners, should receive particular attention for rural and remote practice. Appropriate reforms would almost certainly improve access measures as noted in Principle Three of this paper.¹⁰

Workforce

Quantifying the workforce shortages is problematic and, in any case, the closure of services is not due entirely to the workforce issues. Nevertheless the workforce shortage does have an effect on the viability of maternity services in some rural and remote areas, where the midwifery and medical workforce shortages have been impacting on access to care for some time.

The Australian Medical Workforce Advisory Committee's review of the medical workforce published in 2002 notes that in 1994 rural and remote areas had an undersupply of over 500 general practitioners or 445 full-time equivalents.² More recently, the Australian Medical Association in its submission to the Productivity Commission's research report on Australia's Health Workforce suggested a national shortage of 2000 full-time equivalent general practitioners.¹¹ In its review of general practice workforce needs to 2013, the Australian Medical Workforce Advisory Committee's data and methods suggest a shortage in the order of 1130–1360 general practitioners by 2012 in rural and remote Australia.¹²

In its 2002 investigation into the supply and requirements of the midwifery workforce, the Australian Health Workforce Advisory Committee found evidence of a shortage of nearly 1850 midwives across Australia.² Further, it found that the midwifery workforce has an average age of 40.7 years and was 99 per cent female. Although concern about the ageing midwifery workforce was repeatedly raised with the AHWAC, it could not confirm this directly. However the nursing workforce overall is ageing:

At the 1986 census, 23.3% of nurses were aged under 25 and 17.5% were aged over 45 years or more. At the 1996 census, the proportion of nurses aged less than 25 had fallen to 7.7% while the proportion of nurses aged 45 years or more had increased to 30.3%. The average age increased from 39.1 years in 1994 to 40.4 years in 1997.¹³

The report also notes

As with most health professionals, there are difficulties in the recruitment and retention of midwives to rural and remote areas. The Working Party noted that maldistribution of the midwifery workforce was of major concern in most jurisdictions. A significant issue is that of ensuring staff have access to continuing education and professional development. This is primarily due to the lack of available staff to backfill core staff. Initiatives—both local and national—have been implemented in recognition of this challenge (p 53).²

The Productivity Commission report *Australia's Health Workforce* acknowledges the workforce shortages and mal-distribution but does not attempt quantification.

Though precise quantification is difficult, there are evident shortages in workforce supply—particularly in general practice, various medical specialty areas, dentistry, nursing and some key allied health areas. These shortages persist despite the fact that the workforce has been growing at nearly double

the rate of the population—though reductions in average hours worked in response to such factors as workforce ageing and greater feminisation of some professions, have partly offset this increase in numbers. Medical shortages also remain despite an increasing reliance on overseas trained doctors, who now make up 25 per cent of that workforce compared with 19 per cent a decade ago. A significant number of trained health workers do not work in the sector. There are major workforce distribution issues. Shortages are often more significant in outer metropolitan, rural and remote areas and especially in Indigenous communities (p XVI).¹⁴

The Commission further notes that with an ageing population, demands in some areas will grow, including in areas such as mental health, aged care and disability services. Without intervention, such pressures are likely to make it even harder for maternity services to successfully compete for staff.

These figures, in conjunction with the loss of maternity services, suggest that a strategic and national approach to the allocation of maternity services is required to ensure the competing demands of volume (safe minimum number of maternity services births) and accessibility by the community of interest are balanced (distance, means and conditions of travel). Any decisions made by State, Territory or regional health authorities in relation to maternity services should be based on evidence, including that from community consultation; and consideration of imposts, risks and benefits of the alternative proposals.

On top of all of this are the changing demography and expectations of (for example) the general practitioner workforce. Evidence suggests that female general practitioners, who work on average 13.6 fewer weekly hours than their male colleagues, constitute a growing proportion of the general practitioner workforce. General practitioners are also seeking a ‘better’ work–life balance. Owning a general practice is now less desired than in the past, while newer and incoming general practitioners see having a ‘mobile career’ as important. These changes occur in an environment where hours worked per week for general practitioners increases from 40 hours per week in the urban setting to 49.2 hours per week in very remote settings.¹² It has also been reported that procedural credentials and work are largely done by older male general practitioners who will be approaching retirement and that this presents a further concern for planning for rural and remote services.¹²

Adequate workforce supply is essential for service capability at both the planning (for future need) and operational levels. Health and education planners must consider the current and future workforce needs to ensure sufficient supply for rural maternity services. Health administrations at both State and local levels, including policy makers, must ensure that suitable recruitment and retention strategies provide incentives to bring skilled maternity services professionals to rural and remote services. Integral to this is a responsive financing framework to balance the role and place of private and salaried practitioners in public, private and community birthing services.

Attention to continuing professional development (CPD) to preserve and enhance the skills of rural and remote maternity services clinicians will include measures to address isolated practice and peer support. Continuing professional development

here also refers to the preservation and enhancement of procedural, diagnostic and other advanced skills required by clinicians. Where possible some CPD (for example, the Advanced Life Support in Obstetrics [ALSO] or Advanced Paediatric Life Support [APLS] accredited courses) should be delivered in the local setting and, through multi-disciplinary participation, promote teamwork at the local level. Where procedural upskilling in a referral or tertiary centre is the preferred approach, or required for credentialing, adequate resourcing to support the clinician and provide locum relief for the absence is required. Access to dedicated discipline-specific CPD must also be supported and funding support for workforce replacement as well as direct costs of access to CPD must be embraced to ensure equity of access for rural and remote clinicians. The importance of staffing and/or locums to backfill workforce to cover CPD has been identified as an important factor in recruitment and retention of rural and remote workforce.

These and other team-building initiatives are required to address the concern raised by the AHWAC² about the polarisation of views on childbirth that emerged during the course of its inquiry; it noted that this polarisation existed between women in the general community and the professionals who care for them. It identified the need for greater co-operation among professionals involved in women's birth experiences.

Information and communications technologies provide a means for extending access to CPD, telemedicine and peer support. Largely this infrastructure is in place, but it is generally under-utilised. More effective utilisation could see this infrastructure extend family support, peer and professional support and professional development.

Informing practice

There appears to be limited information available about the relationship between various maternity service models, on the one hand, and child and maternal health outcomes on the other; and about the contribution made to different outcomes by the main variables. University Departments of Rural Health and possibly Rural Clinical Schools are now well-placed to investigate these factors. Investment at this level could also address, in the longer term, other capacity and workforce factors noted in this paper.

Vision for the future

1. Wherever evidence supports the need for the local provision of maternity services, the service environment will be developed in a timely manner and be conducive to the recruitment and retention of an appropriately skilled multi-disciplinary workforce to operate the maternity services safely.
2. Relevant data collection and analysis underpins workforce planning to address current shortages (or redistribution) and future needs. Forging frameworks for collaboration between State and Territory and Commonwealth governments, possibly under CoAG, leads to improved linkages between departments of health and education (tertiary and vocational training and continuing professional development, including procedural skills and credentialing), and

across government (Commonwealth, State, Territory and local) promoting responsive and responsible maternity services planning and development.

Recommendations

1. Attention must be directed to improving workforce conditions for rural and remote maternity services providers including:
 - planning for appropriate supply of workforce;
 - flexible funding and remuneration models to ensure workforce availability;
 - other specific incentive and retention strategies for rural and remote workforce;
 - brokerage of and innovation in education and support frameworks to foster skills and knowledge of a level and quality suitable for the relevant setting;
 - peer support and teambuilding strategies; and
 - risk management and attention to address uncertainty in indemnity for relevant clinicians working in a range of settings.
2. There should be increased investment in targeted data collection and research to inform future maternity services models and practice appropriate for rural and remote settings.

Principle Three Service access: a range of appropriate and safe options

The third agreed principle is that women living in rural and remote Australia should have access to high-quality, safe maternity services as close to home as possible. These services should be available for the whole continuum of care; that is from pre-conception, through pregnancy, at the time of birth and during the postnatal care period.

This will be improved by making available a range of services, determined on the basis of local need for the service and the local and regional availability of maternity services professionals. All the service options must be culturally appropriate, of high quality and take into account the risks to mothers and babies.

There is evidence that smaller birthing units can provide birthing services with better outcomes¹⁰, and this is an important finding in advocating for increasing the number of available maternity services in rural areas. This study also reiterates the finding that a lack of antenatal screening in remote and regional areas reflects the widening and persistent disparities in health according to socio-economic status reported in most resource-rich nations, including Australia.

The risks associated with birthing should be kept as low as reasonably achievable and not merely transferred from one institutional setting to another or transferred

out of the institutional domain—as when births occur outside appropriately credentialed birthing services.

The development of local service options must be undertaken through a partnership between community and health service management, involving collaboration, commitment and consultation on all sides. Planners and managers should “take the communities with them” on these decisions.

A set of agreed evidence-based principles should be used to determine the viability and safety of each individual maternity services facility. Decisions about the most appropriate maternity service should be made for each service and service district based on the available evidence as to what is locally sustainable. Evidence about the availability of staff with competency of practice and the annual birth rate in the community of interest must inform these principles. Management must be committed to birthing services and have an ethical governance structure for them.

Regional maternity services should be able to respond to the needs of the surrounding smaller communities and this will involve the commitment of regional funds. Consideration could be given to establishing clinical support systems within Area or District Health Services to co-ordinate planning and provide clinical support for their smaller maternity services.

State and Territory Health Departments should require their Area/District Health Services to consult with the local community when determining current and future need for small hospitals with birthing services. Every public health service in more remote areas where it is the only such service available must have front-line staff who can deal with the occasional emergency birthing situation, for such emergencies will continue to end up there in an unplanned fashion from time to time. This will mean ensuring that adequate skills are held by relevant clinicians, including ambulance officers, general practitioners and nurses. Clear protocols for accessing urgent specialist advice are also required. State or Territory health services must support emergency transport arrangements to cover remote or isolated health services in order to assist during such unexpected obstetric emergencies. Wherever the maternity facility is located, attention must be paid to cultural security, in particular for Aboriginal and Torres Strait Islander people.

The Alliance supports a range of service models, with referral and access determined in accordance with maternal risk factors, consumer choice and the local availability of the mix of skills required for maternity services, and the proximity to and access protocols for specialist and tertiary services.

Where local maternity services cannot be provided, transport and accommodation assistance must be available to those who need it to enable women and their carers to have access to the nearest regional service.

Vision for the future

1. Sound evidence-based planning ensures that maternity services are well planned and distributed so that child and maternal health outcomes for women in rural and remote areas are equivalent to those of metropolitan residents.

2. Improved support mechanisms ensure that the social, emotional and financial impost of maternal care and childbirth are as low as reasonably achievable for families from rural and remote areas.
3. Additional investments in and commitment to cultural security and other service enhancements improve the antenatal, birthing and early years' experiences and health outcomes for Aboriginal and Torres Strait Islander peoples.
4. People needing maternity services in rural and remote Australia have improved choice.

Recommendations

1. State health authorities should develop a plan to improve access to the full range of maternity services in rural and remote areas.
2. There should be significant investment at the institutional and clinical levels to improve cultural security (see Principle One, recommendation 2, above).

Notes

- 1 Rural Doctors Association of Australia 2006. *Maternity Services for Rural Australia*, February, <www.rdaa.com.au/uploaded_documents?ACF7D9A.pdf>, accessed June 2006.
- 2 Australian Health Ministers Advisory Committee & NRHA 2002. *Healthy Horizons: Outlook 2003–2007. A framework for improving the health of rural, regional and remote Australians*.
- 3 Western Australian Department of Health 2000. *Rural Obstetric and Midwifery Guidelines*, <www.health.wa.gov.au/publications/documents/robstetrics.pdf>, accessed June 2006.
- 4 Western Australian Department of Health, Principal Nursing Advisor's Office 2001. *Homebirth Policy and Guidelines for Management of Risk Factors*, <www.ocno.health.wa.gov.au/publications/docs/homebirth_policy_2001.pdf>, accessed June 2006.
- 5 New South Wales Department of Health 2000. *The New South Wales Framework for Maternity Services, 2000*, <www.health.nsw.gov.au/pubs/f/pdf/msreport148.pdf>, accessed June 2006.
- 6 Queensland Health 2003. *Primary Clinical Care Manual*, 3rd edn, <www.health.qld.gov.au/clinical/pccm/protocols.asp>, accessed June 2006.
- 7 This list is intended as indicative only and not an exhaustive list.
- 8 For Indigenous women and women of some other cultural groups it may not be the partner who is the most important birthing support.
- 9 Australian Health Workforce Advisory Committee 2002. *The Midwifery Workforce in Australia*, AHWAC Report 2002.2, Sydney.
- 10 See also Tracy S, Sullivan E, Dahlen H, Black D, Wang Y, Tracy M 2006. Does size matter? A population-based study of birth in lower volume maternity hospitals for low risk women. *BJOG*; 113:86–96.
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