

Australian Nursing And Midwifery Federation

**AUSTRALIAN HEALTH MINISTERS'
ADVISORY COUNCIL CONSULTATION
ON A NATIONAL STRATEGIC
APPROACH TO MATERNITY SERVICES
JUNE 2018**



Australian
Nursing &
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INTRODUCTION

The ANMF is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 268,500 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

Currently, the ANMF represents the largest number of midwives in the country, with over 20,000 members registered as midwives. This is more than two thirds of all registered midwives employed in Australia, according to the total number of 26,766 shown in the Australian Government Department of Health *Midwives National Health Workforce Data Set 2016 Fact Sheet*.¹

With a strong midwifery membership, we welcome the opportunity to participate in the national consultation workshops and provide written response to this public consultation on the development of a National Strategic Approach to Maternity Services.

¹ NHWDS Data Tool and Resources: <http://data.hwa.gov.au>



APPENDIX B: CONSULTATION INPUT TEMPLATE

Consultation questions

1. Can you in one or a few brief sentences provide what you think would be an overarching key outcome statement for the NSAMS?

National consistency, equity and leadership to provide best practice, evidence based care that achieves the health and wellbeing goals of all women, their babies and families, regardless of the personal, cultural or geographic context of care².

A national commitment to primary care principles for maternity policies and incentivised funding for implementation.³

Maternity care that is safe:

- Women should feel safe and patient reported outcomes measured;
- Perinatal morbidity and mortality indicators should be measured;
- Long term public health impacts, such as breastfeeding and normal birth rates, should be measured;
- Midwives only provide midwifery care; and
- Midwives and doctors providing maternity care should feel professionally and psychologically safe. This requires safe midwifery staffing ratios, including one to one midwife to woman ratio in labour and recognising, post birth, that the newborn baby is counted as an additional person under the midwives care.

2. Do you think there should be a set of values that underpin the NSAMS? If so, could you list the top four values you would like to see included?

Health care should be values driven. Maternity services must be equitable, efficient, woman-centred and evidence-based.

Equity

There must be equity of access to maternity services for women and their families with care provided on needs basis to ensure more equitable health and wellbeing outcomes across the community⁴. Women who are unable to access services locally and are required to travel to receive care must be supported to travel to services.

Maternity advisory groups established by the Australian Government through the Commonwealth Department of Health should have equal representation of midwifery, medical and consumer groups. The historical power imbalance and overt bias is worsened by overrepresentation of medical organisation's and underrepresentation of consumers, who have the most invested in maternity care systems, and midwives as the largest maternity care workforce. This must be addressed⁵.

There must be equity of funding arrangements for primary maternity services. Current structural bias to doctor-centered funding confines midwifery practice and suppresses innovation around new models of care. Current medical activity based funding of hospitals, as well as medico-centric primary services funding, restricts access to midwifery care and makes the input and value of midwifery invisible.

² APHCRI, 2009; Caroline S E Homer, 2014; Mary J Renfrew, 2014; Wim Van Lerberghe, 2014; Rowan, Hogg, & Huston, 2007; Council, 2008; McIntyre, 2014

³ APHCRI, 2009; Amy R. Monka, 2013; Council, 2008; Rowan, Hogg, & Huston, 2007

⁴ Miller, et al., 2016

⁵ Amy R. Monka, 2013



Efficiency

The community requires a sustainable health system which delivers the best outcomes for least cost. The ideal approach is a social model of healthcare which supports wellness, with a first principle to “do no harm”. This requires a shift in our current expensive maternity model which may in fact drive disease through incentivising medical activity⁶.

The current medicalised risk discourse that disempowers the individual woman must shift to recognise the social, emotional, economic, psychological and spiritual needs of maternity care, if we are to improve the health and wellbeing of women, babies and the community⁷.

Evidenced-based service design and decision making

There must be evidence-based policy and guidelines for maternity services that focus on wellness and prevention rather than intervention and associated risk. Service design, including capability frameworks, must take account of best practice evidence and shared multidisciplinary decision making. This must include, at all levels of maternity care provision, recognition of the newborn baby as an individual requiring care.

Evidence-based care, such as one to one midwifery care in labour, must be prioritised as essential to safe service provision at all levels.

Funding of services should be based on evidence of models of care that deliver improved health outcomes for women and babies and an understanding that safety stems from more than medical risk frameworks and ‘fee for service’ interventions. A linked data system which measures perinatal care outcomes, including patient reported indicators, and allows comparison of models of care is necessary to drive responsive design of services.

Woman-centred maternity care with respect and dignity

Power in decision making should rest with the woman. There should be a partnership relationship with women at every level of maternity service, from point of care to policy setting and evaluation. Maternity services founded on a collegial approach to interdisciplinary relationships would support woman-centred care.

3. Can you outline three or four positive aspects of maternity services in Australia?

Universal health care.

Gross perinatal mortality outcomes are comparable to other OECD countries.

Legislative change to enable access to Medicare for midwifery services.

Advances in access to midwifery continuity of carer models (public and private), although evolution is slow.

The strong body of evidence available to support midwifery care provision as a key component to improving women’s and babies’ health and wellbeing and decreasing interventions regardless of the woman’s risk status.

Public sector homebirth models of care, available in some states.

⁶ Shaw, et al., 2016; Miller, et al., 2016

⁷ Wim Van Lerberghe, 2014; McLachlan, et al., 2011; Caroline S E Homer, 2014; Amy R. Monka, 2013; Mary J Renfrew, 2014



4. What do you think are the three or four key gaps or issues for maternity services in Australia? Of these which is most important to you?

Inequity of access and outcomes for particular vulnerable groups of the population including Aboriginal and Torres Strait Islander women and women who live in rural and remote areas⁸.

Midwifery workforce issues which include:

- a lack of planning to ensure a sustainable midwifery workforce;
- the low participation rate of midwives in the workforce⁹;
- non-midwives (nurses) providing midwifery care because of workforce shortages. It is essential that midwifery care is provided by midwives;
- poor midwifery workforce retention related to hostile work environments and the loss of new graduate and experienced midwives, occurring simultaneously¹⁰;
- a practice environment, which is psychologically unsafe for midwives, exposes the women they provide care for, to risk¹¹;
- structural disempowerment of midwives¹²; and
- increasing numbers of midwives leaving the workforce or suffering from serious stress, and even PTSD, due to workloads and unsafe practice environments¹³.

Recognition, monitoring and development of strategies to address women's trauma related to childbirth.

Structural bias which disadvantages the midwifery profession and reinforces the dominant medical paradigm. Funding models are medico-centric and incentivise intervention. The power and control of the medical profession, at all levels of decision making, override the evidence-base and the voices of women and midwives. Current models of care and decision making do not place the woman at the centre of care nor the evidence as the dominant driver of care. There is a lack of opportunity for midwives to achieve seniority within the public and private hospital sectors.

5. What four to six key improvements would you like to see in maternity services in Australia? Please consider these from a national perspective.

All women have access to care by known midwife/midwives. Evidence overwhelmingly supports this as cost effective, women are more satisfied with their care, and have less interventions and better outcomes. This sustains the midwifery workforce and provides for seamless transition for women into higher levels of care when needed¹⁴.

A holistic model of healthcare approach to drive wellness rather than incentivising medical intervention.

⁸ Haines, Baker, & Marshall, 2015; Ireland, Belton, & Saggars, 2015; Ireland, Narjic, Belton, & Kildea, 2011; Chamberlain, Marriot, & Campbell, 2016; Browne, 2008; Brown, Varcoe, & Calam, 2011

⁹ Nurses and Midwives NHWDS 2016 Fact Sheet, 2017

¹⁰ Beck, LoGiudice, & Gable, 2015; Heath, 2014; Gould, 2004; Catling, Reid, & Hunter, 2017; McKenna & Boyle, 2016; Creedy & Gamble, 2016; Sheen, Spiby, & Slade, 2015

¹¹ Cacciabue & Oddone, 2016; Santomauro, Kalkman, & Dekker, 2014; Dekker, 2009; Gao & Dekker, 2017; Dekker & Leveson, 2014

¹² Renfrew 2017

¹³ Leinweber & Rowe, 2010; Cohen, Leykin, Golan-Hadari, & Lahad, 2017; Beck, LoGiudice, & Gable, 2015; White, 2007; Yoshida & Sandall, 2013; Fenwick, Lubomski, Creedy, & Sidebotham, 2018; Mollart, Skinner, Newing, & Foureur, 2013; Skinner, 2009; Newton, McLachlan, Willis, & Forster, 2014; Fenwick, Sidebotham, Gamble, & Creedy, 2017; Jordan, Fenwick, Slavin, Sidebotham, & Gamble, 2013; Hildingsson & Fenwick, 2015; Mahunguro, 2017; Schrøder, et al., 2016

¹⁴ Mary J Renfrew, 2014; McLachlan, et al., 2011; Bowers, Cheyne, Mould, & Page, 2015; Kildea, et al., 2017; Tracy, Hartz, Nicholl, McCann, & Latta, 2005; Homer, Leap, Edwards, & Sandall, 2017; Haines, Baker, & Marshall, 2015; Cummins, 2016



Incentivising development of best practice models of care (continuity of carer, primary midwifery services) through adjustments to funding mechanisms, for example increase access to primary midwifery services through COAG 19(2) arrangement and bundling of maternity service funding.

A valued and effectively utilised midwifery workforce that can work to its full scope of practice within a collegial network and have a voice which is heard in the system in whatever context or model of care they work. The work environment must support safe practice development at every stage from beginning practice to expert level, but is essential for the transition to practice of new midwifery graduates. Mentoring, clinical supervision, and other peer support and reflective practices (including interdisciplinary) must be embedded as normal and an essential part of the practice environment. There should be external, independent, resourced clinical supervision for all midwives from their midwifery provider of choice.

Strategic investment in better workforce planning, especially for vulnerable populations such as Aboriginal and Torres Strait Islander, refugee and rural communities, where supported “grow our own” midwifery education programs would be effective. Women must be able to access midwifery models of care and midwives need to be available to provide care.

In the best interests of women and babies, a more collegial approach to interdisciplinary relations would be supported by:

- investment in multidisciplinary education to improve the capacity of teams to work effectively together;
- embedded interdisciplinary reflective practice; and
- collaborative clinical governance processes.

Improve data collection and linking systems to support evidence based service design (outcomes linked to model of care).

Improve access to perinatal mental health support for women through:

- midwives working closely with qualified mental health nurses in maternity services to value add and capacity build the midwifery workforce;
- investment in perinatal mental health formal qualifications for midwives and medical practitioners; and
- enabling midwives access to Medicare items 2700 and 2701 (GP Mental Health Treatment Items) to enhance timely referral and access to appropriate mental health care services.

6. Are there specific strategies that you could suggest for rural and remote services and/or, Aboriginal and Torres Strait Islander women and/or, women from culturally and linguistically diverse backgrounds?

Flexible outreach programs tailored to the needs of the woman.

Increase relationship based models of care such as midwifery continuity models.

Increase telehealth funding for midwives to improve connection between maternity service providers.

Develop career pathways which are visible and accessible for individuals in these communities as part of a “grow our own” midwifery workforce strategy.

Enable and incentivise midwives as key primary care providers for women in all communities to improve access and outcomes as well as supporting a “grow our own” workforce development plan.



Develop models for midwives and general practitioners to provide local care to women with clear and supported pathways to engage in higher level support, telehealth, educational and developmental opportunities.

Ensure general practitioners who provide antenatal or postnatal services are required to undertake a minimum number of specific maternity continuing professional development hours to maintain currency and competence.

Change models of care so that services are built around the woman's needs rather than traditional fragmented models of care that do not have the level of flexibility or individualised relationship care provision that improves women's and babies' health and wellbeing outcomes.

Support and enable the option for birth on country¹⁵.

7. How will success be measured or how will we know if strategies are being successful?

Measures of success need to be quantifiable. Link key performance indicators to recommendations.

Standards of safe staffing will include one to one midwife to woman ratio in labour and newborn babies will be recognised as a separate individual for maternity service funding and midwifery workload allocation purposes.

Workforce participation, wellbeing and distribution should be monitored and demonstrate increased midwife participation rates, satisfaction, retention and geographical distribution.

Service design should be driven by the data. Patient reported data and clinical outcomes data should be compared by model of care and geographical location.

Disparity in outcomes for identified vulnerable groups should be reduced by improved access for women to evidence-based model of care. Access to primary midwifery services could be incentivised and monitored through improved funding mechanisms.

Reduction in women with mental health disorders, such as PTSD, due to childbirth experiences.

An increase in mental health services for all women. Evidence that women are able to access timely and appropriate mental health services. Increased number of midwives with mental health qualifications.

Improved safety culture which includes psychologically safe practice environments demonstrated by improved workforce retention, and a decrease in the numbers of midwives reporting stress, PTSD and high burnout scores.

¹⁵ CATSINaM, 2016



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