
# Respectful Maternity Care

**Submission to the National Maternity Services Framework Consultation**

**Safe Motherhood for All Inc.**

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# Contents

# 1 Executive Summary

This submission draws attention to Australia's maternity care system and was written to inform the National Framework for Maternity Services currently under public consultation by Australian Health Ministers' Advisory Council. The National Framework for Maternity Services replaces the National Maternity Services Plan which expired in June 2016.

> "When women thrive, all society benefits, and succeeding generations are given a better start in life" Kofi Annan

In Australia, there are missed opportunities to provide better maternity care and use public resources more wisely. The current system intervenes too often in pregnancy and childbirth in ways that interfere with, instead of promoting, supporting and protecting, innate biological processes that result in healthier outcomes for women and newborns. Australia needs to make pregnancy care safe both psychologically and physically for women. Much more attention needs to be focussed on the emotional, psychological and spiritual wellbeing of the childbearing woman. Childbearing is a biological process for the woman, it is also a social process where a woman becomes a mother on birthing her child and finally it is a cultural process where the norms and rules of the society can affect the outcome of pregnancy and influence the mother in her decision making during childbirth.

Each year in Australia, about 308,500 women birth and about 312,000 babies are born. Overall, just over half of women who gave birth in 2014 (51% or 157,820) had a spontaneous labour, more than one-quarter an induced labour (28% or 87,412) and 1 in 5 had no labour onset (20% or 62,562). Once labour starts, it may be necessary to intervene to speed up or augment the labour. Labour was augmented for 16% of mothers in 2014, which was equivalent to 31% of mothers with spontaneous onset of labour. In 2014, 205,927 of women (67%) had a vaginal birth and 101,896 (33%) had a caesarean section. (AIHW, 2016)

For international comparisons, the World Health Organisation (WHO) states - In normal birth there should be a valid reason to interfere with the natural process; 85% of births do not require interventions. As caesarean section rates rise towards 10% across a population, the number of maternal and newborn deaths decreases. When the rate goes above 10%, there is no evidence that mortality rates improve, (WHO, 2015).

> 'Spontaneous labour in a normal woman is an event marked by a number of processes so complicated and so perfectly attuned to each other that any interference will only detract from the optimal character. The only thing required from the bystanders is that they show respect for this awe-inspiring process by complying with the first rule of medicine – nil nocere [do no harm].' Kloosterman, 1982.

Furthermore the paper explores the focus on science, technology and profit and its impact on the childbirth process. The current focus on physical disease and bio-medicine is unbalanced. The medicalisation of childbirth has reached a stage in the Western world where the increasing reliance on technology is having a negative effect. Moreover, the power struggles within relationships that ensue, such as professional knowledge versus personal autonomy, affects the woman. If the women resists, her behaviour is considered abnormal and risky (Coxon, 2013). Childbirth should be part of a respectful relationship whereby women are respected to create a final outcome that empowers the woman, ensures a safe delivery for the woman and safe birth for her baby with the help of the health professional *only when indicated*. It is acknowledged that there will always be some poor outcomes of maternity care – the human condition. However the main causes of poor outcomes are well understood and the effective interventions are known.

The submission concludes that maternity and childbearing are women's issues and the unfinished business of feminism. Childbearing is an important rite of passage, with deep personal and cultural significance for a women and her family. All health professionals have a role in ensuring that they provide evidence-based respectful care and that the women they care for are empowered to be equal partners in this process.

The National Maternity Services Framework needs to ensure responsive, sensitive maternity care systems that cater for the individual woman and respect her human rights. The Respectful Maternity Care Charter: the Universal Rights of Childbearing Women provides the platform for this. Adopting it for all Australian women would be a good starting point to ensuring safety and dignity in maternity care, with improved health outcomes for our community while reducing whole of life health care costs.

Our recommendations are tabled below.

## 2 Recommendations

**Informing principles:**

- Reflect the World Health Organisation's framework for quality of care for pregnant women and newborns.
- Honour the Australian Charter of Healthcare Rights.
- Endorse The Respectful Maternity Care Charter - The Universal Rights of Childbearing Women (RMC) as the minimum standard of health professional practice.
- Be informed by the National Safety and Quality Health Care Standard – Partnering with Consumers - that requires respect for patient rights and engagement in their care.
- Develop the National Maternity Services Framework informed by the evaluation of the National Maternity Services Plan.
- Adopt and use the term *maternity care*. Maternity care places the woman at the centre of the care whereas obstetric care and midwifery care place the focus on the professional.

**Protect Human Rights**

- Ensure a woman's human rights are respected at all times during maternity care.
- Enforce the rights of women to dignified, respectful health care throughout pregnancy and childbirth through the adoption of *The Respectful Maternity Care - The Universal Rights of Childbearing Women.*
- Endorse, legislate and implement the *Respectful Maternity Care* Charter.
- Develop policy that reflects the *Respectful Maternity Care* Charter.
- Include reporting against the *Respectful Maternity Care* Charter in accreditation processes.
- The Framework to be guided by *The International Federation of Gynaecology and Obstetrics Mother-Baby Friendly Birthing Facilities Guidelines*.
- Provide guidance on the consent process and the health professional's legal accountability.
- Include the allocation of resources nationally, to educate women to understand their options and their rights in childbirth.
- Strengthen mothers' rights to respectful maternity care.
- Incorporate principles for developing and implementing a birth plan to inform consent in maternity care so as to minimise systemic abuse and disrespect in childbirth.

**Models of Care**

- Define the way maternity services are delivered and outline the best practice care and services for a woman as she progresses through the stages of a pregnancy, birth and transitioning to mothering.
- Develop models of care based on salutogenic and primary health care principles promoting factors that support human health and well-being, rather than on factors that cause disease.
- Develop models of care based on meaningful engagement with maternity consumer representatives/mothers.
- Include Transition to Parenting Education in pre-birth and post birth education.
- Mandate that all newly pregnant women are advised by their GP of their maternity care options.
- Consider mandating that all newly pregnant women are to be referred to a midwife for assessment and education, prior to referral to an obstetrician.
- Communicate directly to Australian women and the broader community the high value maternity service options available.

- Assist Australian women in being better able to make decisions about their maternity care by accessing comprehensive reliable accurate information including but not limited to: care and options, internet resources and the establishment of a single integrated pregnancy-related telephone support line.
- Include pregnancy and birth education in school wellness programs.
- Include a strategy to *get the first birth right*. One option is to promote the First Baby Campaign to enhance a woman's understanding of childbirth.
- Develop in consultation with the consumers, professions, state and territory governments develop national multidisciplinary guidelines for maternity care to promote consistent standards of practice.

**Continuity of Known Carer**

- Facilitate effective health services through addressing reproductive and maternal health along a life continuum.
- Increase women's access to continuity of midwifery carer services across the continuum of maternity from preconception to the postnatal period.
- Enshrine postnatal support for all breastfeeding women to a minimum of 14 days and preferably up to 12 months to support transitioning to parenting. This care to be provided by midwives.

**Violence Against Women**

- Address the horizontal and structural violence within the health care system, guided by the White Ribbon Campaign to End Violence against Women.
- Document methods to reduce the rate of instrumentalisation and / or interventions on women in the birthing process.
- Implement strategies that prevent the systemic mistreatment of pregnant women, mothers and their advocates within the maternity services system.

**Future Health of Mothers and Children**

- Require government to report breastfeeding rates at six weeks postpartum by clinician.
- Require government to collect and report longitudinal data on the impact of preventable chronic disease for the woman and her child.
- Require government to collect and report longitudinal data on the impact of shorter hospital stays for the woman and her child.
- Require government to collect and report longitudinal data on the impact of shorter hospital stays on breastfeeding.

**Health Professional Education and Competence.**

- Include *working in partnership training* in all health professional curricula.
- Enshrine Human Rights Education in health professional curricula.
- Educate all staff on the Respectful Maternity Care Charter
- Include normal pregnancy, labour and birth competency with a focus on both the mother and the baby in obstetric education.
- Provide a mechanism to train and ensure competence all health professionals in the normal transition of pregnancy and natural normal birth.
- As part of the registration process incorporate a process for annual declaration of competency for normal transition of pregnancy and natural normal birth.

**Professional Practice**

- Clearly define the role of an obstetrician and the scope of practice for an obstetrician.
- Recommend and provide guidance on a review of Medicare item numbers and reimbursements to reflect payment to the professional providing the service.

**Professional Practice continued**

- Embed the Respectful Maternity Care Charter into maternity care
  - Provide a mechanism to ensure all health professionals attending to a childbearing woman are competent in supporting the natural progress of pregnancy, birth and post-natal transition to parenting.
  - All professionals who care for birthing women to undertake an Annual Competency Assessment on normal pregnancy and birth.
- Introduce concise and clear indicators for caesarean sections in order to reach the WHO recommended rates and
- Ensure that penalties are incurred for unnecessary interventions.
- Define the breastfeeding education required for midwives and obstetrician and include in core competencies for practice.

**Mechanism for Professional Accountability**

- Develop an audit process to evaluate compliance rates with informed consent.
- Ensure that penalties are incurred for obstetrical violence and unnecessary interventions.
- Develop a Maternity Clinical Audit Process and report Audit Data by Clinician
- Review APHRA arrangements for investigation of health professional to ensure consistency across the professionals and equitable treatment of all health professionals.
- Develop Key performance indicators.
- Hold Australian Health Services accountable for implementing these commitments.

**Mechanism for System Accountability**

- Develop a consistent and standardised minimum dataset that could provide an evidence-based platform upon which a national benchmarking program for maternity services could be built.
- Immediately mandate and implement arrangements for consistent, comprehensive data collection, monitoring and review, for maternal and perinatal mortality and *morbidity.*
- As an initial focus, report all data by parity. Aggregated trended data can be deceptive and therefore not useful.
- Provide the structure to report a core suite of data by clinician and place of birth, both public and private.
- Require the Australian Commission for Safety and Quality in Healthcare, to develop a consumer feedback tool and process that elicits the spectrum of a woman's maternity experience – physical, social, cultural, emotional, psychological and spiritual safety.
- Given the documented benefits of care by a known midwife, adopt performance targets for care by a known midwife. The New Zealand benchmark is 80% of NZ women have a known midwife. This would be a suitable target for Australia.
- Adopt the WHO target of 85% of births not requiring interventions and work toward a 15% intervention rate for birth.
- Develop a template for and undertake a study to identify the whole of life costs and the loss to productivity associated with birth outcomes so as to better understand the economic and societal burden of birth outcomes; through estimating the economic impact of birth by quantifying the direct and indirect costs and describing the intangible costs of birth.
- Review financial and insurance systems to ensure best practice and minimise over-servicing.
- Adopt the Robson Classification System for assessing, monitoring and comparing caesarean section rates within healthcare facilities over time, and between facilities.

## 3 Glossary

- **Accreditation**: Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards.
- **Autonomy:** a person's ability to make decisions, or speak and act on their own behalf, without interference from another party. The right of persons to make decisions about their health care provider trying to influence the decision.
- **Childbearing**: the process of conceiving, being pregnant, and giving birth.
- **Consent:** An individual's moral right to make decisions about themselves and their health care**.**
- **Dignity:** A legal principle enshrined in human law and defined as the state or quality of being worthy of honour or respect.
- **Feminism:** To define, establish, and achieve political, economic, personal, and social rights for all women.
- **Human Rights:** The inherent value of each person, regardless of background, where we live, what we look like, what we think or what we believe. They are based on principles of dignity, equality and mutual respect, which are shared across cultures, religions and philosophies. They are about being treated fairly, treating others fairly and having the ability to make genuine choices in our daily lives. https://www.humanrights.gov.au/human-rights-explained-fact-sheet-1-defining-human-rights
- **Maternity:** the antenatal, intrapartum, and postnatal period for women and babies.
- **Maternity Care: -** Maternity Care in Australia includes antenatal, intrapartum and postnatal care for women and babies up to six weeks after birth. (http://www.health.gov.au/internet/publications/publishing.nsf/Content/pacd-maternityservicesplan-toc~pacd-maternityservicesplan-chapter3).
- **Midwifery Care:** encompasses care of women during pregnancy, labour, and the postpartum period, as well as care of the newborn. It includes measures aimed at preventing health problems in pregnancy, the detection of abnormal conditions, the procurement of medical assistance when necessary, and the execution of emergency measures in the absence of medical help. http://www.who.int/topics/midwifery/en/
- **Midwife: -** A person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery. http://internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/ & http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/Context-of-practice-for-registered-nurses-and-midwives.aspx
- **Obstetrician: –** For the purpose of this document an obstetrician is a doctor who is trained to intervene when pregnancy does not progress as expected and who has who has successfully completed an education programme that is duly recognized in the country where it is located who has acquired the requisite qualifications to be registered and/or legally licensed to practice obstetrics; and who demonstrates competency in the practice of obstetrics. No formal definition of an obstetrician could be located on the Australian Health Practitioner Regulation Agency website or the Royal Australian and New Zealand College of Obstetricians and Gynaecologists website https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Who-is-your-Doctor

- **Respect:** A due regard for the feelings, wishes, or rights of others.
- **Respectful Maternity Care Charter:** A Charter which demonstrates the legitimate place of maternal health rights in the broader context of human rights. It is an approach focusing on factors that support human health and well-being: Care that does no harm and Care that is culturally sensitive, valued by the woman and her community. http://whiteribbonalliance.org/campaigns2/respectful-maternity-care/.
- **Robson classification:** is a system that classifies women into 10 groups based on their obstetric characteristics (parity, previous CS, gestational age, onset of labour, foetal presentation and the number of foetuses).
- **Salutogenesis:** The term describes an approach focusing on factors that support human health and well-being, rather than on factors that cause disease (pathogenesis).

## 4 Purpose

To provide input into National Framework for Maternity Services (NFMS) currently under development by Australian Health Ministers' Advisory Council (AHMAC) through the Community Care, Population Health Principal Committee (CCPHPC) on behalf of the Council of Australian Governments Health Council (COAG).

## 5 Background

In November 2010, the Federal, State and Territory Governments committed to implementing the five year National Maternity Services Plan (NMSP) with its Five Year Vision being:

> "Maternity care will be woman-centred, reflecting the needs of each woman within a safe and sustainable quality system. All Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live. Provision of such maternity care will contribute to closing the gap between the health outcomes of Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Appropriately trained and qualified maternity health professionals will be available to provide continuous care to all women" (Commonwealth of Australia, 2011, p. iii).

All jurisdictions committed to increasing women's access to high quality, woman-centred and cost effective maternity services. If the NMSP key priorities were fully implemented childbearing women would be treated with dignity and respect, receiving best practice maternity care. While there have been some gains in improving the quality of maternity care service options for some women implementation of the key NMSP commitments has been piecemeal and women's access to respectful high quality and women centred maternity services remains limited. (Donnellan-Fernandez, Newman, Reiger, & Tracy, 2013).

The NMSP expired in June 2016. In April 2016, COAG agreed to task AHMAC through CCPHPC to develop an enduring national maternity policy position that includes neonatal and child health services, antenatal health risk factors and screening for family violence. The National Maternity Services Framework (NMSF) will provide a vision and principles for the delivery of maternity services in Australia. However in developing the NMSF, that there is no evaluation of the NMSP success or failure is of serious concern and should be addressed.

Childbearing is an important rite of passage, with deep personal and cultural significance for a woman and her family. A women's experience of maternity care has the potential to empower and comfort or to inflict lasting physical, psychological and emotional trauma. The events surrounding pregnancy and birth will influence a woman's mothering career, her future health and her future child bearing.

The concept of "safe motherhood" is usually restricted to physical safety at birth. Safe Motherhood is more than the prevention of death and disability. It is also respect for every woman's basic human rights: autonomy, dignity, feelings, choices, and preferences. Cultural, emotional, social, psychological and spiritual safety, rarely appear in the discussions. Yet, not only do these factors dominate women's thinking, research indicates ignoring its importance is potentially deadly." (Lock, 2014) & (Dahlen 2015).

On 28 October 2016, Safe Motherhood for All Inc. (SMFA) convened a Summit on *Respectful Maternity Care - Contemporary Approaches*. The Summit explored the challenges and opportunities of achieving respectful maternity care so as to inform a National Maternity Services Framework. The Summit determined that the NFMS needs to:

- Reflect the World Health Organisation's framework for quality of care for pregnant women and newborns published in May 2015. The framework breaks quality of care into two equal parts that influence each other:
    - the provider's provision of care (evidence-based practices, actionable information systems, and functional referral systems); and
    - the patient's experience of care (effective communication, respect and dignity, and emotional support), (WHO, 2015)
- Honour the National Safety and Quality Health Care Standards that require respect for patient rights and engagement in their care, https://www.safetyandquality.gov.au/publications/national-safety-and-quality-health-service-standards/; and
- Be informed by The Respectful Maternity Care - The Universal Rights of Childbearing Women, developed by the White Ribbon Alliance for Safe Motherhood and endorsed by the World Health Organisation.

## 6 Underlying Issues

Pregnancy and birth is a *normal physiological life* event not an illness to be treated. Australia needs to make pregnancy care safe both psychologically and physically for women. Childbearing women need:

- A health system where the woman is central to that system;
- Care that does *no harm;*
- Care that is culturally sensitive, *valued by the woman* and her community;
- Care that focuses on the factors that support her health and well-being rather than on factors that cause disease; and
- To obtain the best health outcomes she can for the resources invested in health care.

> Birth is not only about making babies. Birth is about making mothers .... strong, competent, capable mothers who trust themselves and know their inner strength. (Barbara Katz Rothman)

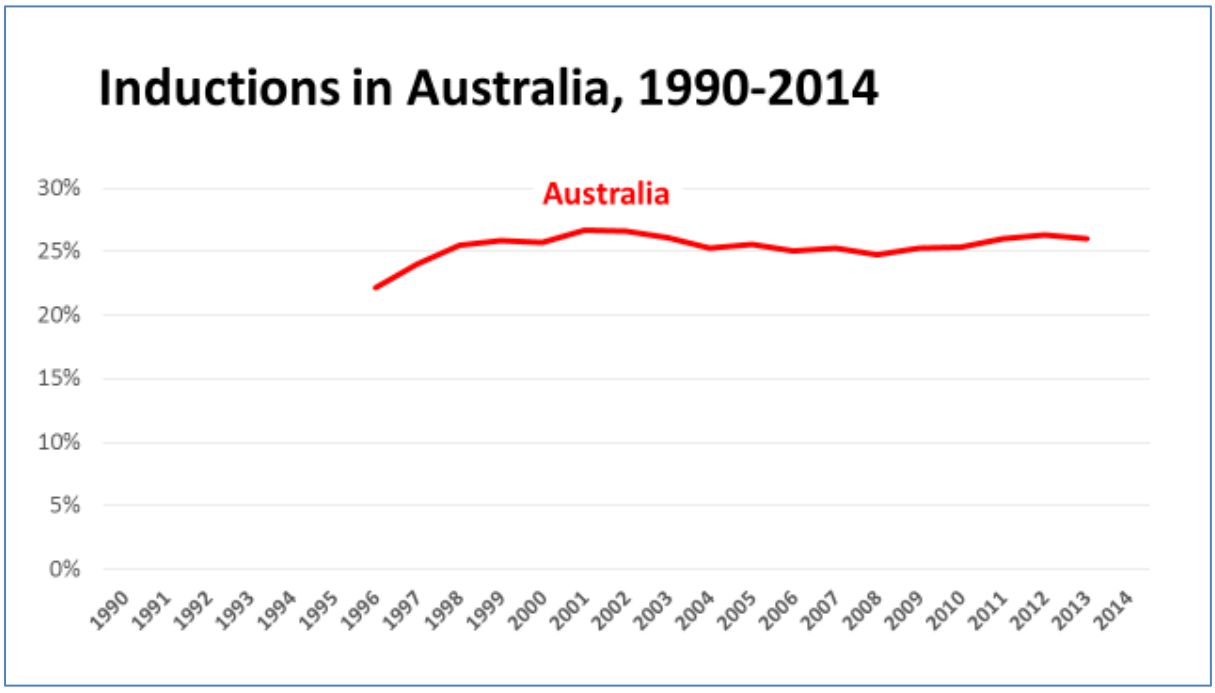
### *6.1 Australian contemporary health care context and the childbearing woman*

Australia faces the challenges of supporting good quality, woman-centred care. The 20th century has seen significant improvements in the safety of birthing and aftercare for example the prevention of infections and the development of community health services for infants and children, which offered care and support to parents. Australia made significant progress in improving the safety of pregnancy and childbirth. By 1980, the maternal, mortality rate has dropped to below 10 per 100,000 live births; (AIHW 2015) and has stayed in this range. However, the data shows there has been no major improvement in maternal mortality over the past 20 years even given the high level of interventions during pregnancy and birth and the subsequent cost to the community. Most mothers have more than one ultrasound, the Caesarean Section rate has risen from under 20% a decade ago; today the number of births ending in major surgery has reached 32% in 2015.

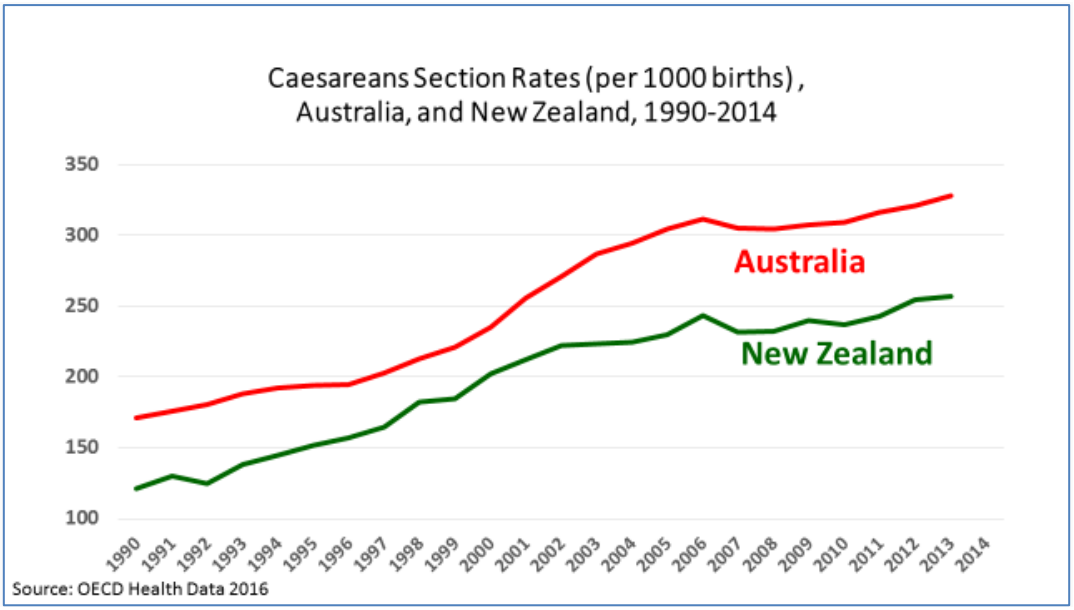
In a recent AIHW report we are told country people have fewer interventions in birth because the services are not available. They have a caesarean section rate of 19% yet city women have a rate of greater than 30%. We need to ask what is the impact? Surely if country women are having a 19% caesarean section rate with no adverse outcomes then we need to reflect this care for city women. If however country women have poorer outcomes then we need to ensure this is addressed (AIHW, 2016).

Intervention in childbirth seems to have reached a stage where the increasing reliance on technology & interventions may be having a negative effect at a time when the majority of Australian are experiencing better physical, emotional and social health advantages. There has never been a safer time for a woman yet Maternal Mortality appears to now be rising and suicide is becoming a leading cause of death, (Walker, KF; et al, 2014). The High level of intervention has unintended negative consequences - 30 per cent of women report that their birth was traumatic; that they feared for their life, or their baby's life; of these women about 6 per cent go on to develop post-traumatic stress disorder, (Gamble,J, 2011). Caesarean sections are marketed as a safer option yet despite a fivefold increase in caesarean section over recent decades, the incidence of cerebral palsy remains steady at 1:500 births*, (McLeannan et al. 2005) & (Cerebral Palsy Organisation 2013).*

Australia has no true understanding of the real impact of pregnancy and birth and the consequence for our community? Damaged mother child relationships are known to impact on child development and future quality of life. The health status following childbirth has productivity implications of lost work performance due to ongoing ill health. In denying a woman her basic human rights in childbirth does this impact on her experience of future abuse in her life? For the child, the consequence of birth injury often only becomes evident when the child experiences learning difficulties at school, creating an impact for school funding and possible supported care in later life. The financial costs associated with poor birth outcomes cannot be sustained especially when we know that women who have had a vaginal birth (rather than an operative one) recover from the experience, are independent much sooner and enjoy a better quality of life (Mousavi, Mortazavi et al, 2013).

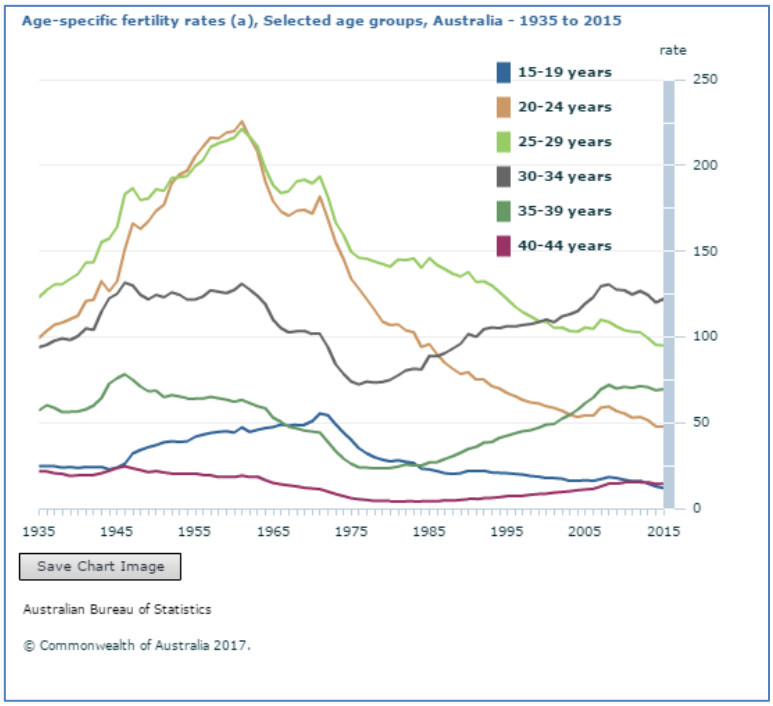



Australian Mothers and Babies 2013.



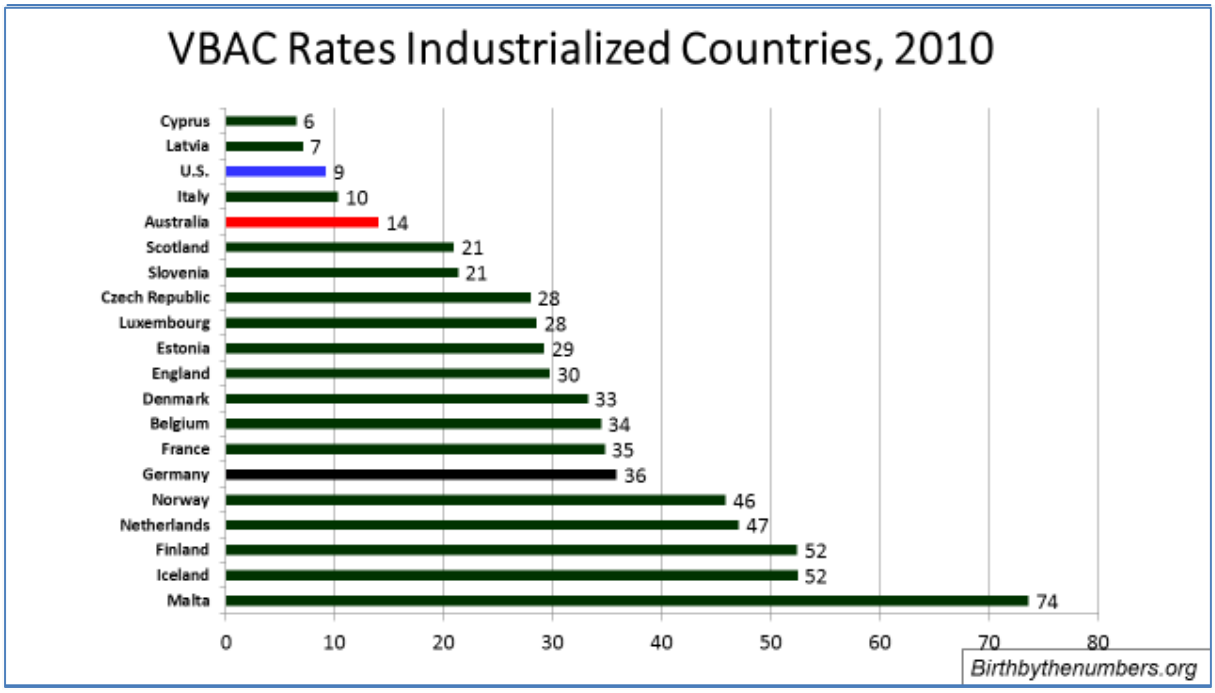

There is no consensus on what is contributing to the rising rates of caesarean section. Possible explanations are:

- The increasing risks associated with 'older' mothers;
- The increasing use of assisted reproduction to assist conception;
- Decreasing procedural skills amongst clinicians;
- Defensive medical practice amongst clinicians;
- Increasing rates of obstetrician preferring to perform a caesarean section when it is not medically required; or
- Increasing rates of women electing to give birth by caesarean section when it is not medically required.




Maternal age is often cited as the reason for increasing interventions in childbirth, however this argument could be considered flawed. Maternal mortality started to dip in the 1970s as

birth control became more used and women stop having large numbers of babies. However older women in real terms are still fewer in numbers than prior to 1965. There were older mothers prior to 1975, when the Caesarian section rate was below 10%. Caesarean rates are associated with several nonclinical factors, and the nonclinical parameters with statistical significance for primary caesarean were delivery during evening hours, a male provider, public insurance, and non-white race, (Haberman et al 2014). One explanation may be that the current practicing obstetricians have no recent experience of older women birthing naturally.




## *6.2 International contemporary health care context and the childbearing woman*

The World Health Organization (WHO) states - In normal birth there should be a valid reason to interfere with the natural process; 85% births do not require interventions. Caesarean section rates continuing to rise, particularly in high- and middle-income countries; w*hen caesarean section rates rise towards 10% across a population, the number of maternal and newborn deaths decreases. But when the rate goes above 10%, there is no evidence that mortality rates improve,*(WHO, 2015).

Australia has a responsibility to ensure the maternity services provided are best practice for our women and also when we export our practices to the women of developing and low income countries in our region.

> "The most striking thing about health in the twenty-first century is that the whole world is now so interconnected and so interdependent." (Crisp, 2010)

This interdependence creates an opportunity for shared learning and mutual improvement. Western medicine with its technological advances can definitely make an impact on the health of populations in poorer countries, and innovations and lessons from poorer countries can inform and improve Australia's delivery of care, especially in times of runaway costs and resource constraints.

### *6.3 The Childbearing Womans' Paradigm.*

Women are designed to birth children and they have intimate knowledge of their body. For women, pregnancy and birth is a normal physiological life event and not just a physical act, it is an emotional, social and psychological act. Birth is uncertain but not dangerous for the majority of women, (Safe Motherhood for All, 2016).

The choices a woman makes will influence the outcomes of her birth, the success of her *mothering career*, and the *long-term wellness* of herself and her child. A childbearing woman requires *compassionate and competent professionals* to support her to make safe maternity and birth choices. When a woman engages a maternity care provider, she wants that person to be skilled and *to use that skill when clinical indicated*, not for their own convenience.

### *6.4 Prevention of chronic disease.*

#### *6.4.1 Chronic Disease*

The impact of the burden of disease in Australia is rising. Australia's Health 2014 found that chronic diseases were the leading cause of illness, disability and death in Australia, accounting for 90 per cent of all deaths in 2011. (AIHW 2014) & (Dutton, 2014). These diseases include cardiovascular disease, diabetes, cancer and mental health issues.

In health, it's obvious that well-chosen preventive health measures will yield big payoffs to taxpayers down the track.

Preventing chronic disease starts at birth.

One area that can contribute significantly to the prevention of chronic disease is a focus on maternity care and infant health. A healthy, strong and confident mother gives a baby the best start at birth, influencing the long-term wellness of her child. Diabetes, obesity, mental health and auto immune diseases often have linkages / causes that research shows relate back to maternity care and the early years of life.

There is no real comprehensive understanding of the long term impact on health and well-being for parents suffering from iatrogenic harm, disability, grief, anxiety and depression for long periods of time following a traumatic birth.

Postnatal depression (PND) total costs to government for attributable to maternal and paternal PND were estimated at $40.52 million in 2012. Private costs were estimated at $38.13 million, including $22.69 million to private health insurance funds and $15.44 million to individuals. Total costs for maternal and paternal PND (governments and private) were estimated at $78.66 million. (Deloitte Access Economics, 2012)

#### *6.4.2 Breastfeeding*

Australia's Health 2012 reports breastfeeding initiation rates in Australia at 96% in 2010 with only 39% of babies exclusively breastfed to around 4 months; and only 15% were breastfed to the recommended 6 months. This falls well short of the global targets of 50% of babies exclusively breastfeeding at 6 months set by WHO, (WHO/NMH/NHD, 2014).

Whether a woman breastfeeds her baby—or not—can affect the lifelong health of both. Breastfeeding is the normal biological extension of pregnancy and childbirth. Breast feeding

is protective of many chronic diseases and of maternal neglect. The State of the World's Mothers Report (2015) asserts that "Immediate breastfeeding is one of the most effective interventions for newborn survival. Breastfeeding provides the baby with good immune system protection, gut protection, protection against obesity and short- and long-term disease protection. Breastfeeding also benefits the mother: her uterus returns to normal size more quickly after birth if she breastfeeds; she is less likely to experience postpartum depression; she is less likely to have brittle bones later in life. Every six months of breastfeeding cuts down a woman's breast cancer risk.

One of the key success factors for breastfeeding is early initiation of breastfeeding after birth. One of the most common reasons for not establishing breastfeeding is the delay of the first breastfeed as a consequence of birth interventions. Often mother and baby are separated, which means a delay in getting baby to breast. The baby is fed formula and imprints a teat rather than a nipple. The mother has to cope with pain, fatigue, possibly stress and the trauma of separation from her infant. All of which impact on successful breastfeeding, (Strathearn 2009). Therefore it follows that achieving a normal birth will increase the rates of successful breastfeeding.

Shorter stays for mothers reduce hospital costs but whether they represent genuine efficiency improvements depends on a number of factors. Shorter stays can, for example, have an adverse effect on the health of some mothers and result in additional costs for in-home care and potential readmissions.

The median length of stay after birth was 3.0 days. There has been a trend toward shorter postnatal stays—in 2013, 20% of mothers were discharged less than 2 days after giving birth and 65% between 2 and 4 days, compared with 11% and 61% in 2003. Regardless of place of birth, almost all babies were live born (more than 99%).

The impact of shorter stays on breastfeeding is unexamined. With the increasing trend to shorter stays in hospital after birth, there is a need for more extensive professional postnatal support, specifically in the 6 weeks postnatally, in initiating and establishing breastfeeding, including greater access to support from midwives, including those trained as lactation consultants.

Women wear the emotional burden when they do not breast feed, yet often it is the birth interventions that impact on breast feeding rates. Given the fact that breastfeeding contributes both to the physical and economic health and welfare of women and their infants and society at large, not focussing on the impact of birth intervention on breastfeeding is at a least misguided and at worst negligent.

**Recommendations**

- Define the breastfeeding education required for midwives and obstetrician and include in core competencies for practice
- Provide professional postnatal support - a minimum of 14 days
- Report breastfeeding rates at six weeks postpartum by clinician
- Report breastfeeding rates at six weeks postpartum by birth outcome
- Collect and report longitudinal data on the impact of chronic disease for the woman and her child.
- Collect and report longitudinal data on the impact of shorter hospital stays for the woman and her child.
- Collect and report longitudinal data on the impact of shorter hospital stays on breastfeeding.

**Recommendations** Continued

- Effective health services should address reproductive and maternal health along a continuum and maternity care should be expanded to 12 months to include transitioning to parenting.

### *6.5 Cultural View of Maternity*.

Childbirth stands between the two paradigms of nature and nurture. (Ann Oakley; 1980). It is a biological process whereby the woman's body goes through childbirth. The cultural aspects of childbirth are the norms and rules of the society that can affect the outcome of pregnancy and influence the mother in her decision making during childbirth. By being portrayed as an illness, pregnancy can be considered dangerous. Pregnant women are warned of dangers if they do not do what they are told and so the docile and passive pregnant body become objectified by the care givers. This undermines women's sense of power and control over their bodies. Most women submit to this, because of the normality of medicalisation of childbirth, (Oddný Vala Jónsdóttir; 2012).

This cultural view of pregnancy and birth stems from a patriarchal attitude that women must be submissive, passive, and let the experts who know better do the work. The paternalistic model of treatment decision-making, characterised by a care provider taking the active role in treatment decision-making and a passive and acquiescent patient, has been challenged in recent years in favour of alternative doctor-patient partnership models (Thompson & Miller, 2014)

Considerable evidence indicates that respecting choice and partnering with consumers in their own care is associated with a better care experience. A better care experience is associated with better clinical outcomes, enhanced consumer safety and less use of health care (http://www.safetyandquality.gov.au/). Whereas disrespectful care, care that diminishes a woman's involvement in the birth of her child, leads to birth trauma, post-natal depression and poor maternal attachment. Maternity care must be part of a respectful relationship whereby both views are respected to create a final outcome that empowers the woman, ensures a safe birth of her baby assisted by the help of the health professional when indicated.

**Recommendations**

- That the term maternity care be adopted by Australia. Maternity Care places the woman at the centre of the care whereas obstetric care and midwifery care place the focus on the professional; (Medieval Latin *māternitās,* equivalent to Latin *mātern).*
- The NMSF to be informed by the National Safety and Quality Health Care Standard – Partnering with Consumers - that requires respect for patient rights and engagement in their care.
- Include working in partnership training in health professional education.

### *6.6 Childbirth, Fear and Risk*

Safer care must focus on services that does no harm to those who use them, rather than just focusing on the potential risk.

> 'All life involves risk. …..But just as wise parents resist the temptation to keep their children metaphorically wrapped up in cotton wool, so too we must avoid the temptation always to put the physical health and safety of the vulnerable before everything else' (Munby, 2013)

Hygiene, better overall health, and antibiotics were responsible for the dramatic drop in maternal morbidity and mortality in the 20th century (Rooks, 1997). In the last 50 years, advances in medicine made birth safer for high-risk women and for women with pre-existing medical conditions or serious complications in their current pregnancy. These advances in medical science and technology having significantly reduced the risk of serious complications and death during pregnancy and birth should help to reassure pregnant women making them more confident and relaxed than the generations before them. However perceptions of pregnancy risk have escalated and so have rates of stress as women are constantly warned about things that can go wrong during pregnancy. (Robinson, 2012). How is it that in spite of technology and medical science advances to manage complex health problems, current maternity care has increased risks for healthy women and their babies?

> While the focus of caregivers appears to be on trying to eliminate fear: of pain, of losing control, of a bad outcomes, loss of financial security, loss of reputation, fear has become an inevitable part of the birthing experience. When birth is insensitively managed, clock-watched and interventionist, it can exacerbate existing trauma and may be perceived as violence. (Kitzinger, 2012).

How did this happen? "It is very easy, even profitable, to scare pregnant women. But it is not nice, so we shouldn't do it, (Gaskin 2008) and we know the "The fear each woman has as she enters childbirth will have a direct relationship to the progress of labour." (Sundin, 2008) Women afraid of labour are more likely to have an emergency caesarean (10.9 percent, compared to 6.8 percent of the other mums). They were also more likely to have an assisted/instrumental delivery (17 percent versus 10.6 percent). (Adams 2012).

> But whose fear is it really? Are women simply reflecting our fear? Is our fear impacting on our care? Is our care causing fear? Where relationships of trust are developed between women and midwives and models of care enable women to feel safe and powerful, fear can be reduced (Dahlen et al., 2010).

> When health professionals decide to secure their own financial security and manage their own risk, ethics and morality are an inconvenience. . Health cannot bloom in such a narrow focus. Risk must always be a carefully monitored and a balance of safety and informed choice, (Commonwealth of Australia, 2009).

When health professionals, and in particular obstetricians, talk about safety in relation to birth, they usually are referring to perinatal mortality and women are frightened into complying with the will of their doctors. It is acknowledged that safety and quality of care is the overarching goal, it would be remiss to always use it as an excuse not to change practice. The real problem with fear is not the women, but rather the ability of practitioners to switch from low to high risk management. In maternity services, where most pregnancies follow a normal pattern, we must ensure, first, that practice is based on evidence and,

second, that we are not allowing our safety and quality concerns to prevent us acting on evidence that supports changes to practice, (Commonwealth of Australia, 2009).

> What we fear comes to pass more rapidly than what we hope – mainly because we make it so, (Grayling, 2002).

Knowing what we know now, why do we continue to disadvantage our women's and children's health by interfering with the normal under the guise of safety so as to mitigate perceived personal risk by using technological interventions that can be lifesaving in some situations but also interfere with healthy, natural processes and increase risk when used inappropriately.

### *6.7 Human Rights and Legislation*

Governments are obliged under international human rights law to promote, protect, and fulfil the right to health; this includes maternal and prenatal health. Human rights are universal - 'All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.' (Article 1, Universal Declaration of Human Rights).

A human rights based approach is about empowering women to claim their rights and participate in decision making, and it covers the interrelated determinants of health and wellbeing, including the rights to life, bodily integrity, autonomy, information, and privacy. Applying a human rights based approach to maternal health requires attention to the fundamental human rights principle of dignity as well as its related principles autonomy, equality and safety. There are three dimensions of dignity; dignity in person, dignity in relation and dignity in institutions. The personal dimension of dignity is associated with one's perception of worthiness as an individual and autonomous human being (). Relationship dignity is the individual and collective behaviour towards a person in terms of respect and worth While dignity in institutions is the context, the environment and institutional structures that influence dignity in care, (Van Gennipj 2013; Jaconson, 2009, Miltenburg, 2016).

The WHO Global Strategy for Women's and Children's Health (2010), emphasises for childbearing women a participatory decision making processes, non-discrimination, and accountability, affirmed the importance of human rights. A woman is not assigned to a special 'class' when she becomes pregnant. Like all human beings, she possesses basic human rights such as:

- Right to highest attainable level of health;
- Right to dignity and equal treatment;
- Right to autonomy;
- Right to family life;
- Right to privacy; and
- Right to spiritual/ cultural freedom.

Maternity care can either protect *or* violate the fundamental human rights of women. While it is likely that disrespect and abuse are often multi-factorial and may be perceived differently and sometimes normalized depending on the specific setting, many stakeholders and maternal health experts agree that disrespect and abuse in facility based childbirth is:

- a global problem affecting low, med and high income countries;
- sometimes seen as normal and acceptable;
- an important barrier to skilled care utilization; and
- a violation of women's human rights; but also

- may have direct adverse consequences for mother and baby (White Ribbon Alliance) & (Hazard; 2013)

Caring and respectful relationships with healthcare professionals can make the difference between a positive and a negative birth experience, but the basic principles of respectful treatment are sometimes neglected in large-scale healthcare facilities, investigations into failing health services have repeatedly shown. The 7.30 Report on Bacchus Marsh Hospital revealed a profound lack of respect for patient rights that has gone hand in hand with clinical and systemic failings, which compromised patient safety, (Reynolds, 2016). The Mid-Staffordshire public inquiry revealed the impact of failure to respect basic dignity had on patients. The labour ward at Stafford Hospital was implicated in the scandal. Human rights claims brought under Article 3 on behalf of over 100 patients of the Mid-Staffordshire have succeeded, (Francis, 2013). This is a salient reminder that the NMSF must be based on respect for human rights.

> *"There has been an increasing understanding …..that reducing maternal mortality and morbidity is a matter of human rights." (*United Nations, 2010)

and

> A women's non-discriminatory enjoyment of the right to health must be autonomous, effective and affordable and the *State* has the primary responsibility to respect, protect and fulfil women's right to health in law and in practice, including where health services are provided by private actors. (United Nations Human Rights Council, 2016).

and

> The WHO defines "health" as both mental, physical and spiritual health which is determined by reference to the human being affected by the healthcare systems, and not their "care provider" and the Council is unequivocal about whose responsibility that lies with – it lies with our government bodies, including where that service is being provided by our private actors. Therefore States should be working to: **"**Emphasize the rights of women to dignified, respectful health care throughout pregnancy and childbirth" (WHO Statement, 2016).

The World Health Organisation's vision of quality of care for pregnant women and newborns was published in May 2015. The framework breaks quality of care into two equal parts that influence each other:

- the provider's provision of care (evidence-based practices, actionable information systems, and functional referral systems); and
- the patient's experience of care (effective communication, respect and dignity, and emotional support).

This linking of quality of care with the human rights approach to health is the intent of The Respectful Maternity Care Charter. The charter purposely focuses specifically on the patient's experience of care - on the interpersonal aspects of care received by women seeking maternity services. The Respectful Maternity Care Charter provides a platform for change. A focus on maternity care and infant health linked with the Respectful Maternity Care Charter would be an innovative approach to reform maternity care and has the potential to reduce health care costs.

**Recommendations**

- The NMSF Emphasize the rights of women to dignified, respectful health care throughout pregnancy and childbirth
- Include Human Rights Education in Health Professional Curricula.
- Endorse the Respectful Maternity Care Charter as a model for maternity care.

### *6.8 Gender Equity and the Elimination of Violence against Women*

Many factors impede women's ability to achieve the best possible reproductive and maternal health. The environment in which women live determine their life chances. The laws and policies on gender equality that determine women's access to education and livelihood opportunities contribute to women's health, power and influence in society.

> *The evidence is sound; when we invest in girls and women, society as a whole benefits, Princess Mary of Denmark, Women Deliver Conference*

As motherhood is specific to women; issues of gender equity and gender violence are at the core of maternity care. The United Nations Declaration on the Elimination of Violence against Women states:

> "*the term 'violence against women' means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation whether in public or in private life*." www.un.org/documents/ga/res/48/a48r104.htm

Disrespectful maternity care represents a dimension of violence against women (Jewkes & Penn-Kekana, 2015) and it is imperative that the Australian community acknowledges, minimises and addresses the violence experienced by pregnant women. Without knowing the incidence of obstetric violence; the violence cannot be addressed. Women are slow to make a complaint as making a complaint is hard and may be re-traumatising as the woman has to complain to the very system that abused her.

The violation of women's human rights within maternity services has largely evaded the attention of the Australian community (Freedman & Kruk, 2014). This oversight may be partly explained because some women's exposure to disrespectful, non-consented and non-dignified maternity care is *overshadowed* by Australian women's heightened risk of experiencing disrespect, discrimination and/or abuse in relation to their paid work and personal relationships during pregnancy, (Australian Human Rights Commission, 2014; Fair Work Ombudsman, 2013; Gartland, Hemphill, Hegarty, & Brown, 2011).

It needs to be noted that in acknowledging that obstetric violence happens it is *not* to imply that *all* intervention is violent or unnecessary, nor is it a suggestion that health professionals are not quality care providers.

**Recommendation**
In conjunction with the Australian Commission for Safety and Quality in Healthcare, develop a consumer feedback tool and process that elicits the spectrum of a woman's maternity experience – physical, social, cultural, emotional, psychological and spiritual safety.

### *6.9 Abuse and Disrespect*

> "Not all disrespect towards women results in violence. But all violence against women starts with disrespectful behaviour". https://www.respect.gov.au/

There are two dimensions of abuse:

- Intentional use of interpersonal violence - -physical abuse, verbal abuse, discrimination, humiliation, negligent withholding of care (e.g. denial of food/water, denial of pain relief, refusing to answer questions); and
- Structural Violence - a form of violence where some social structures or social institutions may harm people by preventing them from meeting their basic needs. In maternity it is the use of infrastructure, staffing, and equipment availability to:
    - limit or deny care,
    - inflict unnecessary interventions to suit the organization or staff,
    - failure to obtain consent, and
    - breaching of a person's privacy, (Violence Prevention Alliance; www.who.int/violenceprevention/approach/definition/en/ )

Structural violence creates conditions where interpersonal violence can occur, shaping gendered forms of violence that place women in vulnerable positions. The Lancet's 2014 Midwifery Series notes that discrimination and abuse is linked to, and reinforced by, systemic conditions, such as degrading, disrespectful working conditions and multiple demands, and can be seen as a signal of a "health system in crisis". It is also tied to power dynamics and the vulnerability of women and their babies during pregnancy and birth. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60701-2/fulltext?rss=yes

There are massive power imbalances between maternity consumers, their advocates and a maternity services system that provides fragmented care to most Australian women. As a result, many pregnant women/mothers and their advocates are mistreated, bullied and abused within Australia's maternity services system. 20 to 30% of women who birth; experience traumatic, disrespectful and fragmented care. http://pattch.org/resource-guide/traumatic-births-and-ptsd-definition-and-statistics/ & http://www.abc.net.au/news/2010-09-14/study-finds-mums-suffering-from-ptsd/225990.

Women in Australian studies have reported women feeling judged, coerced and discriminated against by maternity services staff (McKinnon et al., 2014; Yelland et al., 2012), subjected to varying degrees of intimidation and bullying and treated "like a piece of meat" by hospital staff (Keedle et al., 2015, p. 5). Further, there is large variability in the level of women's informed decision-making and consent to a range of hospital procedures (Prosser et al., 2013). For example, 26% of women experiencing an episiotomy reported that they were neither informed nor consulted about the procedure, while13% of women receiving vaginal examinations were neither informed nor consulted, indicating concerning levels of non-consented care (Thompson & Miller, 2014). As Freedman and Kruk (2014) observe "health systems often reflect the deeper dynamics of power and inequity that shape the broader societies in which they are embedded".

> With all the doubts, fears and concerns a woman faces during pregnancy it's easy to scare a pregnant woman. Pregnant women are especially at risk of emotional abuse from caregivers. Just suggest that she doesn't care about her baby. This form of abuse is VERY prevalent, (http://matterhatter.com.au/obstetric-violence-stop-burying-your-head-in-the-sand/#sthash.jFlG6V8Z.dpuf ).

**Recommendations**

- That the NMSF enforce the rights of women to dignified, respectful health care throughout pregnancy and childbirth through the adoption of *The Respectful Maternity Care - The Universal Rights of Childbearing Women.*
- *Embed the Respectful Maternity Care Charter into maternity care*
- Endorse, legislate and implement the RMC Charter
- Develop policy that reflects the RMC Charter
- Educate all staff on the RMC Charter
- Include reporting against the RMC Charter in accreditation processes
- That these strategies to be guided by *The International Federation of Gynaecology and Obstetrics Mother-Baby Friendly Birthing Facilities Guidelines* which aim to improve quality of care and reduce abuse, neglect, and extortion of childbearing women in facilities. *(*http://whiteribbonalliance.org/wp-content/uploads/2015/03/MBFBF-guidelines.pdf and the Global White Ribbon Alliance for Safe Motherhood guidelines.)
- Address the horizontal and structural violence within the system, guided by the White Ribbon Campaign to End Violence Against Women https://www.whiteribbon.org.au/understand-domestic-violence/
- Reduce the rate of instrumentalisation and / or interventions on women in the birthing process many of which are performed without medical necessity by training or retraining medical personnel on natural birth and introduce strict control of medical indications for caesarean sections in order to reach the WHO recognized rates; and
- Ensure that penalties are incurred for obstetrical violence and unnecessary interventions.
- Implements strategies that prevent the systemic mistreatment of pregnant women, mothers and their advocates within the maternity services system:
- Strengthen mothers' rights to respectful maternity care
- Hold Australian Health Services accountable for implementing these commitments.

### *6.10 Consent*

> "Our laws protect a woman's right to choose where and in what circumstances she has her baby. We know how important these laws are. Women are carers. When we enhance the autonomy and freedom of a woman, we raise the living standards of her community and her children. With so much resting on her shoulders, it is vital she is given the information she needs to make an informed choice or to provide informed consent to a procedure that could affect her wellbeing or her ability to care for her family and children. Anything else is an assault on her and on her family." (Hazard; 2012)

In Australia all legally competent adults can consent to or refuse medical treatment. Under the law of trespass, patients have a right not be subjected to an invasive procedure without consent and if consent is not established, there may be legal consequences for health professionals. Therefore when a woman declines advice, or chooses not to follow recommendations of maternity care professionals, all collaborating clinicians need to respect the woman's decision and provide care for her, even if they disagree with her choice (NHMRC, 2010)

Unfortunately, there is a growing body of evidence demonstrating that disrespectful and non-consented treatment of childbearing women within the health system is a widespread occurrence, (Bohren et al., 2015; Bowser & Hill, 2010). A significant number of pregnant women are not consulted in decision-making about the medical procedures they undergo, or informed of their risks and benefits. (Thompson, R et al; 2014). Some health professional

may go as far the to not give the pregnant woman all of the information they require to make an informed decision, so that they conform to the norms of the treating clinician, (Gastaldo, 2002).

> This can lead to trauma and feelings of disempowerment about the birth for the woman. It may also impact how mothers connect with their newborn baby. Some women are so traumatised; they become depressed and even develop post-traumatic stress disorder. In some cases, women choose to birth at home next time with or without a midwife in attendance (Dahlen & Tracy, 2014)

However, maternity care professionals demonstrate a poor understanding of their own legal accountability, and the rights of the woman and her foetus. Midwives and doctors believed the final decision should rest with the woman; however, each also believed that the needs of the woman may be overridden for the safety of the foetus. Doctors believed themselves to be ultimately legally accountable for outcomes experienced in pregnancy and birth, despite the legal position that all health care professionals are responsible only for adverse outcomes caused by their own negligent actions.' (Kruske et al, 2013)

> "The default position of many health professionals is that in labour a women is in no fit state to give consent. However, consent for labour and birth should start at the first visit to a maternity care provider. During antenatal care a birth plan can be developed. A birth plan is the closest expression of informed consent that a woman can offer her caregiver prior to commencing labour. Reports received by Human Rights in Childbirth indicate that care provider pushback and hostility towards birth plans occurs most in facilities with fragmented care or where policies are elevated over women's individual needs. Mothers report their birth plans are criticised or outright rejected on the basis that birth is "unpredictable". There is no logic in this. If anything, greater planning would facilitate smoother outcomes in the event of unanticipated eventualities. In truth, it is not the case that these care providers don't have a birth plan. There *is* a birth plan – one driven purely by care providers and hospital protocols without discussion with the woman. This offends the legal and human rights of the woman concerned and has been identified as a systemic form of abuse and disrespect in childbirth, and as a subset of violence against women". (Dahlen & Kumar, 2016).

The medicalised definition of risk informed by the insurer's perspective of economic risk, does not factor in the most important issue in childbirth: women's subjective experience of bodily autonomy. It is for this reason that human rights must always come before expert-led discourses of risk and safety. The latter are a precondition of informed consent, *not* its replacement. (Bueskens, 2016). Not involving a woman fully in decision making, results in her discomfort and disempowerment and equals disrespectful care, (White Ribbon Alliance, 2015)

It is of concern that in *Obstetricians and Childbirth: Responsibilities* consent is not a responsibility of an obstetrician, rather they are to treat the pregnant woman with consideration and respect, seeking her *cooperation* and her *full understanding* of medical issues, taking account of particular social, linguistic and cultural needs --- Provides an accessible and appropriate level of information and Provides the pregnant woman with the opportunity to participate in making decisions about her own care, and that of her baby before and after delivery (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2013).

Consent data.

- 10 % - uninformed about the risks of emergency caesareans and epidurals,
- 25% - not consulted before having an episiotomy.
- 60% - not adequately informed about vaginal examinations and
- 22% - not consulted or informed before having an ultrasound.

(Prosser et al., 2013); (Thompson & Miller, 2014).

**Recommendations**

- That the NMSF provide guidance on the consent process and the care provider's legal accountability.
- That the NMSF incorporate principles for developing and implementing a birth plan to inform consent in maternity care so as to minimise systemic abuse and disrespect in childbirth.
- That the NMSF develop an audit process to evaluate compliance rates with informed consent.

### *6.11 Ethics*

*Routine unnecessary intervention in birth is an ethical issue, (Byrom, 2015)*

*and*

In applying and advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account. Individuals and groups with special vulnerability should be protected and the personal integrity of such individuals respected. Universal Declaration on Bioethics and Human Rights. Adopted by the UNESCO General Conference at Paris, 19 October 2005.

Maternity care above all, must do no harm – non-maleficence and above all, do good – beneficence. During maternity women are most vulnerable. Having a baby is one of the most vulnerable, if not the most vulnerable periods, of any woman's life.

## 7 Professional Roles, Functions and Accountability

While midwifery care is based upon viewing pregnancy and birth as normal physiological life events, obstetric medicine is based upon treating pregnancy and birth as a medical procedure. Obstetricians are surgeons, and surgeons excel at performing surgery. While midwives are paid to wait for labour to unfold and to act if and when necessary, obstetricians are paid to act. So is it any wonder that when healthy pregnant women are predominantly managed by surgeons – as they are in Australia – rates of surgery are high! (Lock K; 2015).

Women should be able to choose an obstetrician; these medical specialists provide an indispensable service in for high risk women. But based on the evidence of better outcomes and lower cost, women should have the option of calling the midwife. (The Conversation, 2014)

### *7.1 Midwifery Paradigm:*

As defined by the International Confederation if Midwives, midwives works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period. The midwife practice in a wellness model, understanding that most pregnancies and births are normal biological processes. The midwife is responsible for

identifying problems early on and referring to the medical officer. (www.internationalmidwives.org & www.midwives.org.au).

Midwives are experts in normal, healthy pregnancy and birth. They are also skilled at recognising any problems and at involving doctors and other health professionals in a woman's care if the need arises. Countries with low caesarean section rates and excellent maternal and perinatal outcomes are consistently rated as the best places in the world to be a mother and in all of these places *midwives* are the main providers of care, (WHO, 2015). .

Given this knowledge it follows that the care of well pregnant woman is best provided by a midwife. As already noted WHO states 85% births do not require interventions. The World Health Organisation has identified midwives as "the most appropriate and cost effective type of health care provider to be assigned to the care of women in normal pregnancy and birth, including the risk assessment and the recognition of complications" (World Health Organisation, 1999).

Midwifery care is associated with longer prenatal visits, more education on pregnancy and breastfeeding; prenatal counselling, fewer hospital admissions and a more positive birthing experiences for women, easing a woman's transitioning to parenting and in meeting the demands of a new baby. (Leslie & Storton, 2007). A Cochrane Systematic Review based on a systematic review of 13 trials involving 16,242 women, concluded that most women, unless they have significant risk factors, should have the option of midwife-led continuity of care. Midwife-led continuity of care – in which a pregnant woman sees the same midwife during pregnancy and labour – is associated with a higher level of spontaneous vaginal birth; the women were less likely to experience interventions such as episiotomies or use of forceps; more likely to be satisfied with their care; had a lower risk of foetal loss before 24 weeks' gestation and at least comparable adverse outcomes for women or their infants than women who received other models of care. Midwifery care has also been found to result in fewer women suffering from debilitating post-natal problems such as illness or injury associated with some interventions (particularly operative deliveries) and postnatal depression, (Sandall et al, 2016).

Women can engage a private midwife to care for her in pregnancy, however the moment the woman requires admission to hospital the midwife must in all states other than Queensland handover care to a doctor and the midwife must remain silent, having no input into the care of the woman who engaged her services. Though midwives can practice independently, most midwives in Australia are employees of an organisation, bound by the rules of the organisation, often caring for women who have a private obstetrician. This gives rise to significant role conflict and role ambiguity they have to reconcile Midwifery Professional Practice Standards, with organisational policy and procedure while being directed by an independent practicing clinician?

### *7.2 Medical Paradigm.*

The role and scope of practice of an obstetrician is not clearly defined in Australia. For the purpose of this paper an obstetrician is a doctor / surgeons who has undertaken training to care for high risk pregnancies and to intervene as required when pregnancy does not progress as expected. Obstetricians play an important role in preserving lives when there are complications of pregnancy. This expertise is vital for women and babies with complications. The WHO states 85% of births do not require interventions. The corollary is that 15% of births will require interventions. This is the work of an obstetrician.

In developed countries, obstetrician involvement and medical interventions have become routine in normal childbirth, without evidence of effectiveness. The evidence suggests that higher rates of normal births are linked to provider beliefs about birth. As obstetric training

does not focus on developing skills to support the natural progression of an uncomplicated labour and birth it is to be expected that this view will influence the care provided. (Johanson, 2002).

> "Care providers who relied on surveillance, interventions, and plotting courses that emphasized risk were more likely to exert their control and feel strong through minimizing women's power and control and, ultimately, their integrity." (Hall, et al 2012)

The practice of some professionals tends towards risk amplification by selectively emphasising potential risk in some areas of childbirth but not others (e.g. vaginal births). Many obstetricians believe that you need specialist medical care and sophisticated technology in order to ensure that the mother and baby will be safe in what they perceive is a high-risk event. As a consequence when obstetricians care for a normal pregnancy medical preference and expediency appears to be taking a priority over best outcomes, with obstetricians often operating according to their own timetable rather than the less predictable schedule of mothers and babies. Is this justified, especially in light of the constraints it places (almost exclusively) on women's choices regarding childbirth and her future health. (NICE Guidelines,2011).

### *7.3 Restrictive Trade Practices in Maternity Care*

> Medical Practitioners have been very well protected, whilst consumer rights have diminished and the continuation of a totally anti-competitive maternity health system has resulted in a reduction of services and arguably quality and safety for women and babies in rural and metropolitan Australia, (Caines, 2010).

In order for women to be able to make informed decisions about their maternity care, it is important that the availability of quality maternity care options is communicated to them. Research demonstrates that many women are not provided with adequate information to make informed decisions about their model of maternity care (Prosser et al., 2013; Stevens, Thompson, Kruske, Watson, & Miller, 2014). This is in part due to referral practices of general practitioners. Women often consult with their general practitioner when pregnant and general practitioners refer women to obstetricians often without a frank discussion of the options available hence limiting the informed decision process about their preferred model of maternity care. Regardless of personal beliefs, general practitioners need to be mindful of the Australian Medical Association's position statement regarding the key role that general practitioners play in supporting pregnant women's informed decision making (Australian Medical Association, 2013).

Currently a Commonwealth subsidised scheme supports obstetrician professional indemnity insurance premiums. However midwives are only provided the Commonwealth subsidised scheme for pregnancy and postnatal care in any setting, and labour and birth care in a hospital or birth unit. Midwives, who provide intrapartum care at home, will not be insured.

Restrictive practices are also evident in the handing of claims for compensation for women damaged in pregnancy and birth. The common law concept of professional negligence developed by courts and set-out in the decision of Rogers v Whitaker, have now been changed to a statutory definition in QLD, SA, NSW, VIC, TAS. A person practising in a profession ("a professional") does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice. However, peer professional opinion cannot be

relied on for the purposes of this section if the court considers that the opinion is irrational. This is of concern as:

- It would be rare to identify instances of treatment that is both irrational and in accordance with an opinion widely held by a significant number of respected practitioners in the field; and
- The majority of obstetricians engage in practices that are not based on evidence. As an example is the anal sphincter damage created from an extended episiotomy. The evidence regarding episiotomy effectiveness would assist a consumer in mounting a claim. Under the 'Modified Bolam Test', however, if the subject practitioner gathered other specialists who agreed they would also perform an episiotomy, the injured woman could be unsuccessful, (Caines; 2010).

**Recommendation**

- Clearly define an obstetrician and the scope of practice for an obstetrician.
- Include normal pregnancy, labour and birth competency with a focus on both the mother and the baby in obstetric education.
- All professionals who care for birthing women to undertake an Annual Competency review on normal birth.
- Mandate that all newly pregnant women are advised by their GP of their maternity care options.
- Mandate that all newly pregnant women are to be referred to a midwife for assessment, prior to referral to an obstetrician.
- Adopt performance targets for care by a known midwife. The New Zealand benchmark is 80% of NZ women have a known midwife. This would be a suitable target for Australia.
- Allocate resources nationally, to educate women to understand their options and their rights in childbirth.
- Communicate directly to Australian women and the broader community the high value maternity service options available.
- Assist Australian women in being better able to make decisions about their maternity care by accessing comprehensive reliable information: consideration of better access to a range of information on antenatal, birthing and postnatal care and options, including internet resources and the establishment of a single integrated pregnancy-related telephone support line.
- Include pregnancy and birth education in school wellness programs.

### *7.4 Regulation of Obstetric and Midwifery professions*

Australian Health Practitioner Regulation Agency's (AHPRA) operations are governed by the Health Practitioner Regulation National Law, which means that the14 regulated health professions are regulated by nationally consistent legislation under the National Registration and Accreditation Scheme. AHPRA supports the health Practitioner boards responsible for regulating the health professions. The primary role of the National Boards is to protect the public and they set standards and policies that all registered health practitioners must meet.

The Medical Board of Australia (MBA) and The Nursing and Midwifery Board of Australia (NMBA) undertakes functions as set by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). The NMBA regulates the practice of nursing and midwifery in Australia while the MBA regulates the practice of medicine Australia, and as stated above one of their key roles is to protect the public.

The NMBA protects the public by developing registration standards, professional codes, guidelines and standards for practice which together establish the requirements for the professional and safe practice of nurses and midwives in Australia.

The Medical Board of Australia protects the public:

- registers medical practitioners and medical students
- develops standards, codes and guidelines for the medical profession
- investigates notifications and complaints about medical practitioners
- where necessary, conducts panel hearings and refers serious matters to Tribunal hearings
- assesses international medical graduates who wish to practise in Australia, and
- approves accreditation standards and accredited courses of study.

When a practitioner is reported to the relevant Board, a National Board must within 60 days conduct a preliminary assessment of the notification and decide whether the notification relates to a matter that is grounds for notification. The Board is also required to notify the relevant health complaints entity in the jurisdiction in which the practitioner practises if the Board reasonably believes that a registered practitioner or student has, or may have, a health impairment or may have practiced in the profession may exercise a range of actions dependent on the seriousness of the evidence. These include; to take immediate action to suspend a practitioner's registration until further investigation occurs, place conditions on a practitioner's registration, or establish a performance and professional standards panel or a health panel. A health panel comprises of at least three members selected from a list of people approved by the National Board, including:

- at least one member who is a registered practitioner in the relevant health profession
- at least one member who is a medical practitioner with expertise relevant to the matter subject to the hearing, and
- at least one member who is not, and has never been, a registered health practitioner.

While this process is designed to protect the public it fails on many counts:

- Those employed by a hospital will have their cases reviewed by peers against the reasonable practitioner standard and if found to be reasonable, they will not be referred to the relevant board. There is no openness in this review.
- Those employed as independent practitioner are referred to the relevant board. In this situation the concept of the common law presumption of innocence is negated due to the imposition of pre-determination conditions on registrations, while waiting until their case goes to the board. There is no equity in this process.
- There is a disproportionate impact of the conditions commonly imposed (particularly on midwives' registrations) as their practice is curtailed until investigations have been completed, leaving them without income and unable to fulfil their duty of care that they have to their clients and their families,
- The public scrutiny of a board investigation is unfair to women and the health professionals involved.
- There is no public understanding of the individuals practice, no public learnings from an investigation and little public understanding of the role of professional boards, the complaints process, or the opportunity for feedback to the complainant either during or at the conclusion of the matter.

**Recommendation**

Review arrangements for investigation of health professional by AHPRA to ensure consistency across the professionals.

## 8 Cost to Society, Allocation of Resources and Return on Investment

The ever-increasing cost of health care to the economy, is reflective of poor maternity care impacting on the quality of life for women and the lifetime impact for their children.

> *Spontaneous labour is safest for woman and infant, with benefits that improve safety and promote short- and long-term maternal and infant health. The hormonally-mediated processes of successful lactation and maternal-infant attachment are intertwined and continuous with the biologic processes of parturition." (Sarah Buckley 2016)*

Maternity services are a combination of Commonwealth, State and Territory Government services and privately funded and delivered services. Maternity services are provided in multiple settings by a range of different providers. For Australian women and their babies, this often means a range of different health care providers are involved across the course of their pregnancy. From the woman's perspective, maternity services often appear fragmented. They often have different care givers involved in different stages. For example, in many instances a woman will be in labour in hospital attended by a midwife (or more than one midwife if shifts change), whom she has never met before. This is despite international and national studies which have consistently demonstrated that continuity of care/r improves satisfaction for both women and health professionals, boosts health outcomes, and reduces intervention rates. (National Maternity Services Plan)

It is cheaper to promote optimal health and care for a woman during pregnancy and to invest in that pregnancy, than to provide whole of life finance for damage incurred.

### *8.1 Models of care*

A woman require a safe place and skilled, compassionate health professionals to support her to a safe birth. A woman and her supports feel safe when they are respected and partners in the process.

The National Maternity Service Plan (NMSP) defines '*Continuity of Care'* as: *"the practice of ensuring that a woman knows her maternity care provider(s) and receives care from the same provider, or small group of providers, throughout pregnancy, labour, birth and the postpartum period" (Commonwealth of Australia, 2011, p. 121).*

A key NMSP commitment was to increase women's access to continuity of care models, particularly continuity of midwifery care, as it is a high value service, being both high quality and more cost effective than standard, fragmented maternity service options (Tracy et al., 2013). Continuity of care with a known care giver has been shown to achieve best outcomes for birthing women.

The M@NGO Study, found lower rates of intervention, lower costs and equivalent outcomes for women and babies randomised to continuity of midwifery vs usual care. (Tracy, et al, 2011) Continuity of midwifery care can no longer be overlooked because it is perceived to be too expensive. With nearly 300,000 births a year in this country, caseload midwifery could potentially save around A$4.5 million dollars per year by reducing medical intervention and reducing hospital stays, (Hannah & Tracy; 2014).

However, when a woman engages an obstetrician for their maternity care, they see the obstetrician usually in their private rooms. Antenatally, the obstetrician monitors the

progress of the pregnancy. The woman independently has to seek education on labour, birth, breastfeeding and parenting. When the woman presents to the hospital in labour, the midwife employed by the hospital provides care to the woman. If the labour progresses without complications, the obstetrician only appears when the baby is about to be born and the midwife steps aside. If the birth is without complications, the obstetrician departs and the midwife provides the post-delivery care and supports the woman to commence breastfeeding. Where is the continuity of care? How is this value for money? Why does the healthcare system pay twice? Why are women deprived of comprehensive continuity of care? Regrettably most women in Australia continue not to receive continuity of care. There has been an increase in access to continuity of midwifery care for women using public health services though it is relatively modest, increasing from approximately 2-5% in 2010 to approximately 8% in 2015 (Butt, 2015).

> *"... it ought to be remembered that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. Because the innovator has for enemies all those who have done well under the old conditions, and lukewarm defenders in those who may do well under the new."* - Nicolo Machiavelli, *The Prince*, 1515

Recommendations:

- Develop models of care based on salutogenic principles and primary health care promoting factors that support human health and well-being, rather than on factors that cause disease.
- Include Transition to Parenting Education in pre-birth and post birth education.
- Develop models of care based on meaningful engagement with maternity consumer representatives/mothers.
- Increase women's access to continuity of midwifery carer services across the continuum of maternity form preconception to postnatal care.
- Consider a "Get the first birth right - First Baby Campaign" to minimize interventions in childbirth.

### *8.2 Place of Birth*

Almost all births in Australia occur in hospitals, in conventional labour-ward settings. In 2013, 97% (296,611) of women gave birth in hospitals, while much smaller proportions gave birth in birth centres (2.0% or 6,085), at home (0.3% or 958) or in other settings including births occurring before arrival at hospital (0.3% or 984 women). Regardless of place of birth, almost all babies were live born (more than 99%), (The Australian Institute of Health and Welfare's Australia's Mothers and Babies 2014 Report).

In Australia, most women give birth in a hospital setting. Some hospitals offer midwifery programs, but the places are limited. Women giving birth in hospital are likely to be supported by midwives, but will come up against hospital policies that increase the risk of interventions during labour. These might include induction for being 'overdue', and time limits on labour. In private hospitals, where obstetricians manage care, the C-section rate can be double the rate of the public hospital system. In 2011, 43% of women in private hospitals gave birth by C-section, compared with 30% in public hospitals, (AIHW, 2014). Obstetric medicine specialises in dealing with health problems in pregnancy. Healthy, low-risk women are at increased risk of interventions and C-section when cared for by an obstetrician, (Johanson, 2002). There is no scientific evidence to support that moving birth to the hospital or primary maternity care provided by obstetricians has made birth safer for healthy women with no pre-existing medical conditions (Enkin et al., 2000).

The intervention rates by place of birth are:

Spontaneous Vaginal Birth

- All Hospital 67%
- Public Hospital 52%
- Private hospital 15%
- Birth Centre 86%
- Home 97.4%

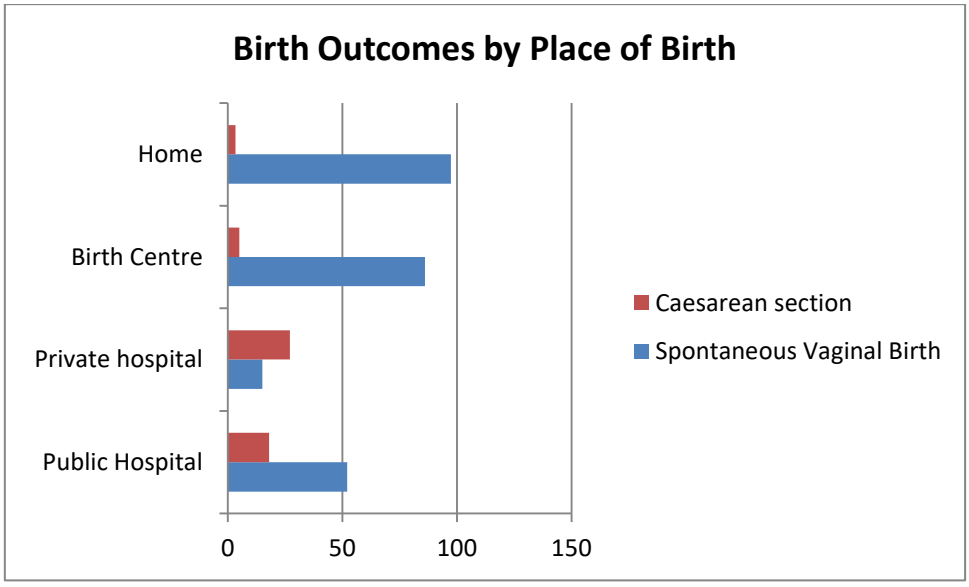
Caesarean section

- Public hospital 18%
- Private Hospital 27%
- Birth Centre 4.8%
- Home 3.3%

Epidural or spinal

- Hospital 29.1%
- Birth Centre 16%
- Home 8.15%

(AIHW 2012 & 2014)




The birthweight of live born babies in hospital (3,350 grams) was on average lower than for those born in birth centres (3,540 grams) and at home (3,641 grams). The average gestational age was also slightly lower for babies born in hospital (38.7 weeks) compared with those born in birth centres (39.5) or at home (39.7). This may be due to the fact that babies who are expected to require a higher level of care are more likely to be delivered in hospital than in other settings, and are more likely to be of lower birthweight and pre-term.

Factors associated with increased intervention in childbirth seem to include private practice, medico-legal pressures, and not involving women fully in decision making. (Homer, C et al., 2014). and (The Australian Institute of Health and Welfare's Australia's Mothers and Babies 2012 Report).

*The Birth Place Matters.*

### *8.3 Use of technology*

The technology that is available for use in childbirth by health professionals ranges from forceps and suction cup to consistent use of induction drugs or manual techniques, anaesthetics, to electronic foetal monitoring to caesareans. These were all created so as to help in childbirth to make the process more manageable for the mother and to be able to save both mother and baby during complications of childbirth. In many cases they do certainly help save babies but they can also create even further complications as they interfere with personalized care (Brodsky, 2008). When the technology is in use, it takes attention away from the birthing mother which in itself can create problems as it makes childbirth impersonal and technical.

Increasing evidence shows that the routine use of technology during labour and birth and the use of other routine interventions without a clear medical indication have contributed to the dramatic rise in the caesarean rate and other maternal and newborn complications, (Goer, Leslie, & Romano, 2007). This is of concern when increasingly the indications for use of technology are subjective and non-clinical. Each intervention interferes in often powerful ways with the process of labour and birth and increases risks for mother and baby. Of concern is the additional burden on the health system and pressure on scarce hospital resources such as operating theatres.

Data for 106,546 births found rate of cesarean delivery was positively associated with:

- Postpartum antibiotic treatment
- Severe maternal morbidity and mortality
- Increase in foetal mortality rates
- Increase in babies admitted to neonatal intensive care
- Rates of preterm delivery and neonatal mortality both rose at rates of CS between 10% and 20% (Haberman 2013; Shah 2009; Boyle 2012)

The use of Electronic Foetal Monitoring is associated with the following issues:

- Technology, maintenance and costs
- Training – how to use, how to interpret
- High inter- and intra-observer variability in interpretation of FHR tracing (ACOG 2009)
- Lack of proven benefit of continuous EFM over intermittent auscultation in low-risk pregnancy (Cochrane 2013, ACOG 2009) and
- May restrict ambulation and positions during labor

Women who assumed a non-supine position for birth had:

- fewer perineal injuries less vulvar oedema, and less blood loss (Shorten, 2002; Soong, 2005; Terry, 2006);
- shorter second stages, required less pain relief medication, and had fewer abnormal FHRs (Simkin 2002); and
- no reduction in neonatal death, cerebral palsy, other significant neonatal morbidity Cochrane 2013

The overuse of technology impacts on the separation of mothers and their newborns at birth, when separation is shown to be contraindicated for the mental health of the mother and baby, (American Academy of Nursing; 2016 & Choosing Wisely & NICE, 2016).

In Australia, More than one-fifth (22%) of live born babies required some form of active resuscitation immediately after birth in 2013 (excludes data from Western Australia) and 24% babies delivered at term were admitted to special care nursery, (The Australian Institute of Health and Welfare's Australia's Mothers and Babies 2013 Report).

**Recommendation**

- Develop national multidisciplinary guidelines for maternity care to promote consistent standards of practice, use of technology, quality and safety in collaborative team models, in consultation with the professions consumers and state and territory governments.

### *8.4 Productivity and Economic Impact*

> *Girls and women carry more than babies. ……..They carry families. They carry businesses. They carry potential. And when we invest in their health, rights and well-being, it creates a positive ripple effect that lifts up entire countries. (Iversen, Women Deliver Conference, 2016).*

It is difficult to fully understand and quantify the loss of productivity within the Australian community related to pregnancy and birth. The *Cost of Postnatal Depression in Australia* Report 2012 and *The Economic Impact of Stillbirth in Australia* Report are useful in understanding the impact.

The *Cost of Postnatal Depression in Australia* report shows that perinatal depression will affect nearly 100,000 new parents in 2012. This includes 1 in 7 new mothers and 1 in 20 new fathers. The report also outlines the $433.52M cost to the Australian economy. The report shows that in 2012:

- Lost productivity due to perinatal depression will cost Australian workplaces $310.34M, with costs substantially higher for men than for women.
- Government and private direct health care costs of $78.66M (including primary care, psychiatrist and allied health services, medications, hospital, and community mental health services).
- Costs to the wider community of $44.53M resulting from direct expenditure on health services for people with perinatal depression and forgone taxation revenue due to lost earnings.

The results from the economic impact of stillbirths in Australia Survey indicate that 9.7 per cent of parents did not return to work, resulting in lost productivity from exiting the labour force. The study also includes the cost of unemployment benefits for those who did not return to work. Stillbirth can have an impact on the extended family members. 52 per cent of respondents from the survey reported that family members took time off work to support parents and/or to deal with their own grief. This study estimates the cost of lost worker productivity through absences from work for the family as an indirect cost of stillbirth. Cost of stillbirth for the five-year period 2016-2020, in 2016 present value terms was estimates at $681.4m, (Price Waterhouse Cooper, 2016). The study attempts to quantify and monetise the loss of the future productivity of the stillborn child. For the five-year period 2016-2020, in 2016 present value terms the estimated health and well-being cost is $7.5 billion. This work could be used to quantify and monetise the loss of the future productivity of the child born with disability. We may then have a more realistic understanding of the impact of poor birth outcomes.

### *8.5 Whole of life costs*

One of the smartest investments a society can make is to foster the health of its mothers. Healthy mothers raise healthier children, which boosts the productivity and stability of communities and economies. We need to embrace the continuum of mother and child health to provide more effective care and use of resources so as to achieve health benefits to mothers, children and their families across their lifetimes.

Poor pregnancy and birth outcomes have a profound impact on parents. Many suffer from ongoing depression and anxiety exacerbated by having to manage chronic pain, have ongoing health care needs as a consequence of iatrogenic injury to the mother and child, the effects often lasting long periods of time. There is a heightened risk of stress and anxiety in subsequent pregnancies. Poor birth outcomes put considerable strain on marital or partner relationships which has flow-on effects for the other children, as poor early relationships in child hood lead to great vulnerability in life, (Fisher & Rowe, 2013).

Rates for Australian Women that:

- experience acute stress disorder - 2% - 6%
- develop Post Traumatic Stress Disorder (PTSD) following childbirth - 9% -.
- with PTSD have depression 11 months after birth - 65% of.
- suffer PND 15 –20 %. (Evans, Kathy; 2010)

Perinatal depression is estimated to cost the Australian economy $433.52 million in 2012, in financial costs only ($4,509 per person with perinatal depression). In addition to the financial costs, perinatal depression equates to a loss of 20,732 DALYs in 2012, which represents a significant disease burden. The majority of the economic costs attributable to perinatal depression result from lost productivity in the workplace. These findings are consistent with other studies of the cost of depression (e.g. Greenberg et al. 1993) & (Deloitte Access Economics 2012).

The Economic Impact of Still Birth in Australia provides insight into the impact of stillbirth. While not diminishing the impact of stillbirth on the parents of children who are born still born, some children survive, requiring significant financial and social input to live a dignified life. (Price Waterhouse Cooper, 2016). Extrapolating this study would be helpful in understanding the impact of poor birth outcomes for the mother, her live child, her family and her community. There are significant costs associated with pregnancy and childbirth that does progress normally. These include:

- direct costs such as hospital costs, follow-up health care and debriefing / counselling
- direct costs such as early childhood education, and disability pensions
- indirect costs such as absenteeism, government subsidies, divorce, and costs to the family, and
- intangible costs such as the impacts on mental well-being and relationships, and flow-on effects on family and friends.

However, these costs and the associated economic and social impact of birth in Australia are poorly documented, resulting in an under-estimation of the impact of birth. The Economic Impact of Still Birth in Australia identifies five components of intangible costs that may be analysed to develop the qualitative narrative. These include:

- impact on mental well-being,
- relationship with partner,
- relationship with other children,
- relationship with others (family and extended family), and
- the effect of financial loss.

**Recommendation**

Develop a template for and undertake a study to identify the whole of life costs and the loss to productivity associated with birth outcomes so as to better understand the economic and societal burden of birth outcomes; through estimating the economic impact of birth by quantifying the direct and indirect costs and describing the intangible costs of birth.

### *8.6 Funding maternity care*

Maternity care is a major industry, big enough that poor performance is significant at the macro-economic level. Current funding discourage efficiency and effectiveness and therefore we need to focus on ensuring systems are working in ways that have a good trade-off between fairness and efficiency and effectiveness.

The main driver of maternity health expenditure increasing is that health professionals are doing things differently. A pregnant woman today is getting treated very differently from a pregnant woman two decades ago, with no significant improvement in maternal mortality. Doctors are ordering more pathology tests than before, and they're doing more procedures than before. For example:

- Ultrasounds: Two ultrasounds are recommended for a normal pregnancy and ultrasound in the third trimester is of no benefit. Yet women are having an average of 5.2 ultrasounds per pregnancy, (NICE, 2017).
- Induction or augmentation of labour without a medical indication is also shown to increase the intervention rate. (WHO ,2014)
- Continuous electronic foetal heart rate monitoring during labour for women without risk factors has shown to increase the intervention and caesarean section rate. (Devane D, et al; 2017).

Current maternity care practices create a demand for health services that are not clinically indicated and reduce/limit access to clinical interventions for those who really need them. Maternity care – ante-natal, birth and post-natal care is an area of rising cost in Australia. Do we really get good value from the money spent on maternity care in terms of better health outcomes? The data suggests not. Australian research published today in the Lancet Medical Journal, has found that using more midwives could save the Australian medical system more than $500 per birth. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60701-2/fulltext?rss=yes.

The continual rise in obstetric intervention for low-risk women in Australia is concerning in terms of morbidity for women and cost to the public purse. The findings of one study suggest that a two-tier system exists in Australia without any obvious benefit for women and babies and a level of medical over servicing which is difficult to defend within a system that is bound by a finite health dollar. (Hannah, D et al, 2012). Using UK data, the relative 2009/10 cost of a Caesarean section verses vaginal birth was GBP,2,369 verses GBP 1665 (NICE 2011).

Women are disadvantaged and exploited by the health professionals. As a consequence many more women than men suffer financial hardship, sickness, disability and death as a direct result of medical treatment overuse.

In Norway Denmark, Finland and Sweden, where 70% of births have a midwife as the sole birth attendant, perinatal mortality rates are lower than those of any country in Europe, North America and Australia, (http://www.ethics.org.au/on-ethics/our-articles/april-2015-(1)/part-two-%E2%80%98but-your-child-might-die%E2%80%99-the-right-to-d#.VSYItpVVGog.twitter.)

**Recommendation**
Review financial and insurance systems to ensure best practice and minimise over-servicing.

### *8.6.1 Medicare*

By default all pregnant women in Australia link into the *medical* system as current Medicare arrangements only permit an eligible midwife to render a Medicare rebateable service when working in a collaborative arrangement with a medical practitioners. This very much limits access to midwifery services for the women, does not permit autonomy of practice and limits the scope of practice for the midwife.

Existing MBS items for obstetric services are medically focused and are primarily concerned with the provision of antenatal care and labour/ delivery services. We currently fund doctors under the MBS items for the Planning and Management of Pregnancy, yet in reality it is the midwives who perform most to of this service. It is the midwife who stay with the women in labour, they call the doctor when indicated and they support the woman to establish breastfeeding. Postnatal care in Australia is very limited die to funding constraints and shortened length of stays in hospitals. By diverting the funding to the provider of the service the will be a minimal increase in the net cost and improved access to postnatal care.

While women can now claim Medicare rebates for a range of midwifery services including birth care in hospital, currently Queensland is the only state to have midwives credentialed to admit their clients and provide inpatient services.

**Recommendations**

- Review Medicare item numbers and reimbursements to reflect payment to the professional providing the service.
- Fast-track the review of items on the Medical Benefits Schedule removing items that do not reflect best practice and define best practice limits.

## 9 Data

> *Data holds power: It demonstrates the size and nature of social or economic problems, and brings clarity around who is falling through the cracks,* (Gates, Women Deliver Conference, 2016)

Health care is a rising expense for Australians. Almost 70 per cent of total health spending in 2011-12 was funded by governments, with the Australian Government contributing the greatest share at 42.4 per cent. (AIHW 2014).

How do we know we are getting values for money in maternity services? We as the public do not have the information to scrutinise health services. There is a lack of information generally on the outcomes of maternity care in Australia, and limited information is collected on safety and quality, efficiency and cost-effectiveness. Without rigorous data on targeted variables in an established systematic fashion, we cannot answer relevant questions and evaluate outcomes. The aim is to collect quality evidence that translates into data analysis allowing the convincing and credible understanding of the issues. An improved national maternity data collection is required to inform future investments to maximise the return on investment, minimise wastage of limited financial resources, to promote accountability, to support a safety and quality framework for maternity and children and monitor the impact of changing models of care effectively.

### *9.1 Lack of transparency and accountability*

> *Accountability, is not a standalone initiative, but needs to be supported by sound evidence and strategic advocacy.*
> Kate Gilmore - the United Nations Deputy High Commissioner for Human, Women Deliver Conference, 2016)

Clinical audit is about measuring the quality of care provided against relevant standards. Clinical Audit identifies variances in practice and outcomes, helping to understand the factors that are contributing to the outcomes so priorities can be set and improvements made. Audit is required to identify the disparities in practice between different parts of the system and between individual institutions. Audit data relating to the number of services performed by particular services and services providers (public as well as private) is generally not publicly available, and so variations in the rates at which services are performed is not available. This is unacceptable given that the public purse funds 70 per cent of total health spending in 2011-12. How will the Australian public know they are getting value for money, without the publication of clinical audit data?

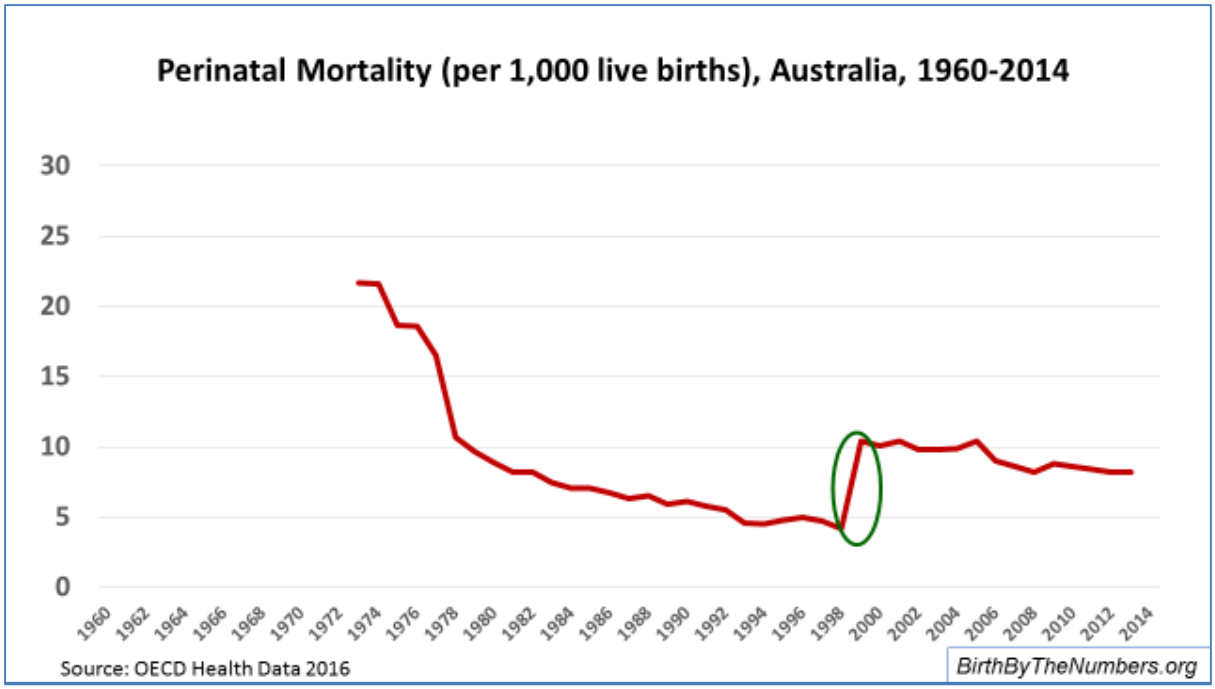
There is an urgent need for a nationally agreed, consistent and standardised minimum dataset that could provide an evidence-based platform upon which a national benchmarking program for maternity services could be built.

### *9.2 Focus on mortality*

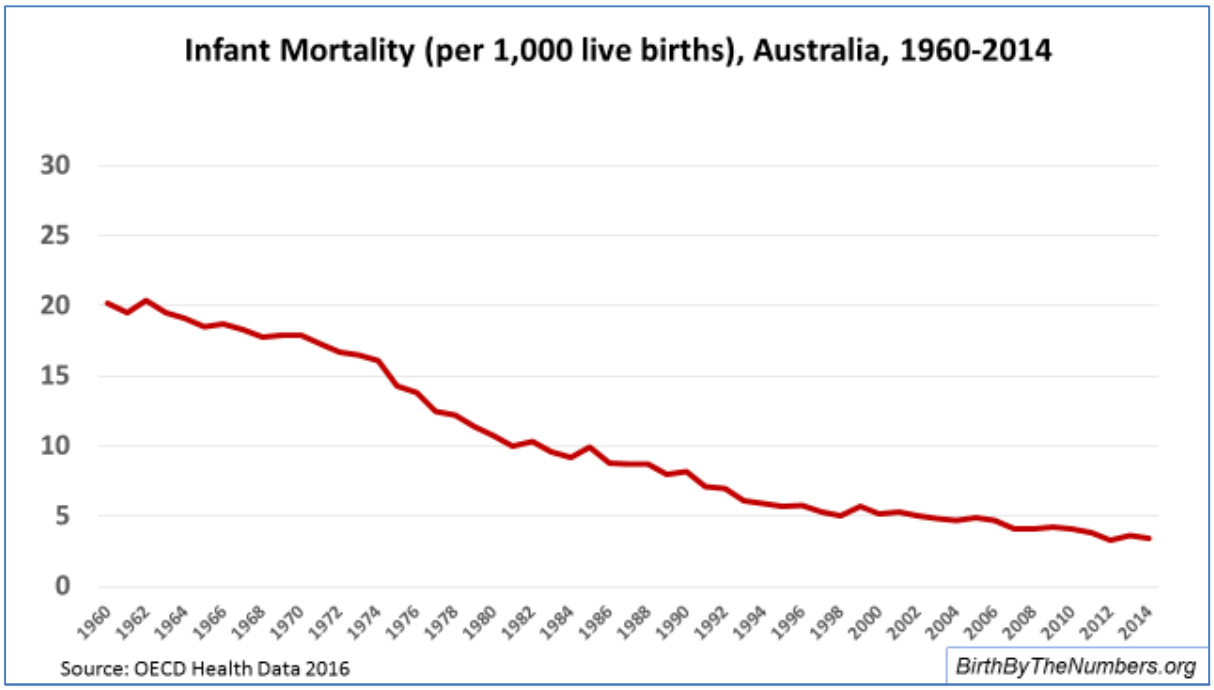
High quality, safe maternity care goes beyond measures of mortality and encompasses many parameters.

Yet, when health professionals, talk about safety in pregnancy and birth, they usually are referring to perinatal mortality. In Australia the maternal and infant mortality rates are thankfully low and have generally plateaued. Maternal and perinatal rates of mortality are not an adequate measure of the performance and outcomes of maternity services. Does the narrow focus on mortality provide a false and limited view of safety? Despite the fact that the maternal mortality ratio is considered one of the main indicators of Australia's maternal health status, the burden of maternal mortality is only a small fraction of the burden of maternal morbidity – the health problems borne by women during pregnancy and the postpartum period. Current practices can and do lead to poorer health outcomes – as evidenced by a falling normal birth rate, a rising birth injury rate; declining breastfeeding rates; rising postnatal depression rates; increasing reported birth trauma rates; and more recently with suicide during pregnancy and the postnatal period now one of the leading causes of maternal death in Australia. Severe maternal and perinatal morbidity is an important indicators of system performance. There is clearly a group of women, the numbers of whom are unknown, who continue to have short- or long-term sequelae from their pregnancy and delivery. For every woman who dies of pregnancy-related causes, 20 or 30 others experience acute or chronic morbidity, often with permanent sequelae that undermine their normal functioning, (Hardee, et al, 2012).

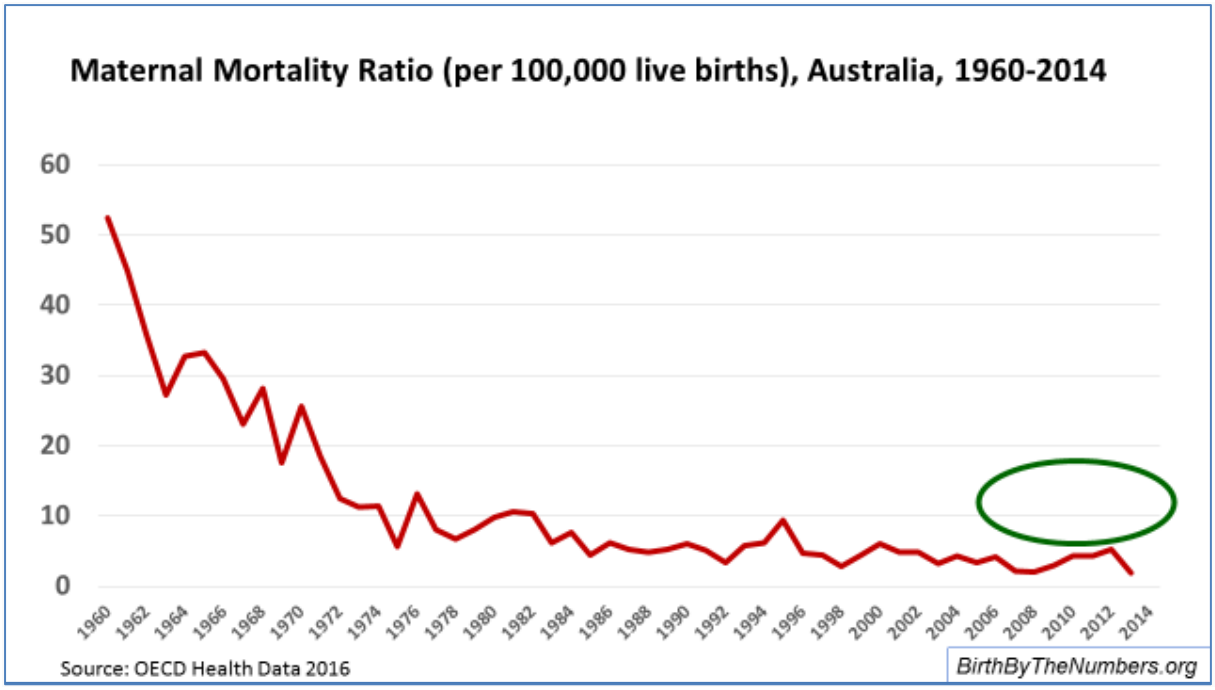
To continue to focus on mortality is doing society a disservice. We will not understand the true picture until we focus on long term morbidity.In Australia, there continues to be no agreement on what constitutes maternal morbidity, preventing in-depth analysis of the effects/impacts of current maternity practice. (Commonwealth of Australia, 2009).




**NB** The data for 1978-1998 live births exclude those under 1000g, which comprise about 0.4% of the total




The infant mortality rate in 2012 was 3.3 infant deaths per 1,000 live births, a decrease on the rate in 2011 (3.8 infant deaths per 1,000 live births). Ten years ago in 2002, the infant mortality rate was 5.0 deaths per 1,000 live births.




*No comprehensive morbidity data is available for the same periods.*

**Recommendations**

- Immediately mandate and implement arrangements for consistent, comprehensive data collection, monitoring and review, for maternal and perinatal mortality and morbidity
- Develop a consistent and standardised minimum dataset that could provide an evidence-based platform upon which a national benchmarking program for maternity services could be built...
- As proposed by WHO adopt the Robson classification system for assessing, monitoring and comparing caesarean section rates within healthcare facilities over time, and between facilities.
- Aggregated data can be deceptive and therefore not useful. As an initial focus, report all data by parity.
- Report a core suite of data by clinician and place of birth, both public and private.
- Develop the National Maternity Services Framework informed by the evaluation of the National Maternity Services Plan.

## 10 Conclusion – Securing the Future

Childbearing is an important rite of passage, with deep personal and cultural significance for a women and their family. The maternity care that women receive intersects with the rights to physical integrity, self-determination, privacy, family life, and spiritual freedom. Childbearing is now too often seen as an illness to be treated rather than a normal life event that requires skilled observation and support.

> "As more women survive childbirth, the global burden of poor maternal health is shifting markedly *from avoidable deaths to* an increasingly diverse array of *maternal morbidities*.
>
> For women using services, some receive excellent care but too many experience one of two extremes: too little, too late, where women receive care that is not timely or sufficient, and too much, too soon, marked by over-medicalisation and excessive use of unnecessary interventions.
>
> Both extremes represent maternal health care that is not grounded in evidence."
>
> (The Lancet Series, 2016)

and

> Intervening in childbirth is like throwing a pebble into a pond. The ripples keep on going and you don't know where they will end up - but you can bet that on some distant shore there will be an effect. It is only relatively recently that we have been looking beyond the throw of the stone to the distant shore. What we see is very, very scary, (Dahlen et al., 2014).

Australia faces a challenge in achieving high quality, woman-centred maternity care.

- Firstly, in providing maternity services that respect the childbearing woman right to respectful maternity care and the highest level of health.
- Secondly, in achieving effective, efficient and appropriate use of the funds available, while maximising the health outcomes for society. The financial costs associated with current maternity care practices create a demand for health services that are not clinically indicated and reduce/limit access to clinical interventions for those who really need them.
- Thirdly reducing the productivity implications of lost work performance due to ongoing ill health following maternity care.

Quality of care for pregnant women and their infants has two equal parts that influence each other: Firstly, the provider's provision of care (evidence-based practices, actionable information systems, and functional referral systems); and secondly the patient's experience of care (effective communication, respect and dignity, and emotional support). All health professionals have a role in ensuring that they provide evidence based respectful care and that the women they care for are empowered to be equal partners in this process.

A focus on maternity care and infant health linked to the Respectful Maternity Care Charter would be an innovative approach to reform maternity care. The Nataional Materntiy Services Framework needs to ensure responsive, sensitive maternity care systems that cater for the individual woman and respect for her human rights.

> "There are risks to action. But they are far less than the long-range risks of comfortable inaction." John F Kennedy

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