



Submission to the Consultation on the National Safety and Quality Health Service Standards (Third Edition)

Submitted to: Australian Commission on Safety and Quality in Health Care

Introduction

Thank you for the opportunity to provide feedback on the proposed National Safety and Quality Health Service (NSQHS) Standards (third edition).

Maternal Health Matters Inc strongly supports the Commission's work to strengthen Australia's national safety and quality framework. The proposed third edition represents an important evolution of the Standards, with greater emphasis on clinical governance, person-centred practice, safe clinical systems, outcomes, integration and continuous improvement. These principles are particularly important in acute, complex and high-risk healthcare. (1)

Maternal Health Matters Inc concern is not with the direction of the third edition, but with ensuring that its framework is genuinely fit for purpose across all areas of healthcare.

Maternity care is an important example, that requires a different lens. Maternity is not simply acute healthcare delivered in a different setting. It is a continuum that begins with health and normal physiology and must be capable of moving seamlessly to specialist and acute care when required.

Maternity is not simply acute healthcare delivered in a different setting. It is a continuum that begins with health and normal physiology and must be capable of moving seamlessly to specialist and acute care when required.

The third edition is intended to support safe, high-quality and person-centred care across the continuum of healthcare. (1) For maternity care, this requires recognition that pregnancy and birth are fundamentally different from the treatment of acute illness. Pregnancy and birth are normal physiological processes that can, sometimes, become complicated and require specialist intervention. This distinction matters to the design and application of national safety and quality standards.

For a woman experiencing an uncomplicated pregnancy, high-quality care may appropriately involve health promotion, support, assessment, monitoring, relationship care, information and informed decision-making as well as preparation for the postnatal period. When complications arise, the system must be capable of rapid assessment, consultation, referral and escalation.

A high-quality maternity system must therefore be capable of doing both: supporting normal physiology, while responding rapidly and effectively when clinical circumstances require specialist or acute care. This is consistent with the World Health Organization's approach to maternity care. WHO's antenatal care guidance places person-centred health and wellbeing, health promotion, prevention, screening, communication and support at the centre of routine maternity care. (2) WHO's intrapartum care guidance recognises childbirth as a physiological process and cautions that increasing medicalisation of normal childbirth can undermine women's capability and negatively affect their experience of birth. (3)

This is an important consideration for the third edition. The risk is that a framework developed principally around the management of illness and clinical risk may, if applied without sufficient maternity-specific context, position

intervention as the starting point rather than ensuring that intervention is appropriate to the woman's clinical circumstances.

The goal is the right care, at the right time; beginning with support for health and normal physiology and escalating when clinical circumstances require it.

The fundamental question for the third edition should therefore be: *Can the national safety and quality framework support both the woman who needs complex acute care and the healthy woman who needs high-quality primary maternity care?* For maternity services, the answer must be yes.

Maternity as Primary and Preventive Healthcare. Maternity care should also be understood as an important form of primary and preventive healthcare, rather than predominantly as an acute hospital service.

Pregnancy provides an important opportunity for health promotion, prevention, screening, education, psychosocial support and identification of health needs that may affect women and families beyond pregnancy. WHO's antenatal care guidance explicitly identifies antenatal care as a platform for health promotion, screening and diagnosis, disease prevention, communication and support, while prioritising person-centred health and wellbeing and a positive pregnancy experience. (2)

A maternity system should therefore be designed around keeping women well, supporting normal pregnancy and birth, strengthening women's capability and providing continuity throughout the maternity journey, rather than being designed primarily around what happens when pregnancy goes wrong.

Maternity Is a Test of Person-Centred Care. Maternity provides an important test of whether the principles of person-centred care can be applied across different forms of healthcare. Person-centred maternity care should include:

- respectful and culturally safe care;
- continuity of care in a relationship model;
- support for physiological pregnancy and birth;
- timely access to specialist care when required;
- informed decision-making and informed consent; and
- meaningful measurement of women's experiences and outcomes.

These are not optional additions to clinical safety. They are components of quality maternity care.

We propose there is a case for a Clinical Care Standard for Maternity Services. The Commission states that Clinical Care Standards are developed for priority areas for quality improvement, particularly where there is evidence of unwarranted variation in care. Each Standard contains quality statements and indicators to support improvement.

Maternity care is well suited to this approach because it encompasses:

- a defined clinical pathway;
- established evidence about models of care;
- measurable clinical outcomes;
- measurable experiences of care;
- significant variation in models of service delivery;
- multiple professional disciplines;
- interaction between primary, community and hospital services;
- substantial opportunities for prevention and early intervention; and
- important equity considerations.

The NSQHS Standards provide the overarching requirements for safe and high-quality health services. However, maternity care has clinical characteristics and requirements that are specific to pregnancy, birth and the postnatal period. These require more specific clinical expectations than can be provided through overarching safety and quality standards alone.

Maternal Health Matters Inc. recommends that the Commission develop a National Clinical Care Standard for Maternity Services. Such a Standard would translate the principles of the NSQHS Standards into clear, measurable and maternity-specific expectations for the delivery of safe, high-quality and woman-centred care. It should address:

- health promotion, prevention and early intervention;
- support for physiological pregnancy, birth and postnatal care;
- continuity of care and the development of therapeutic relationships;
- informed decision-making and informed consent;
- respectful, woman-centred and culturally safe care;
- access to midwifery continuity of care for women experiencing uncomplicated pregnancy;
- appropriate clinical assessment, monitoring and surveillance;
- timely recognition and management of complications;
- consultation, referral and escalation when clinically indicated;
- integration between maternity, primary, community and hospital healthcare services;
- maternal and neonatal outcomes;
- women's experiences and outcomes of care; and
- equity, access and the reduction of unwarranted variation in care.

A Clinical Care Standard for Maternity Services would provide a clear framework for ensuring that maternity care is available and provided according to clinical need, while also supporting health promotion, normal physiological processes, continuity of care and women's wellbeing.

Importantly, such a Standard would recognise that high-quality maternity care is not defined solely by the detection and management of complications. It also requires systems that support healthy pregnancy, physiological birth where appropriate, informed choice, continuity and respectful care, while ensuring that complications are recognised promptly and managed effectively when they arise.

A national maternity-specific Clinical Care Standard would therefore provide an important mechanism for translating the principles of safety, quality, equity and person-centred care into consistent clinical expectations across Australia's maternity services.

The Economic and System Context. Maternity is a major component of Australia's health system, and the way maternity care is organised has implications beyond the immediate birth episode.

Australian economic research demonstrates that maternity models of care can have measurable economic consequences. Callander et al. found that, among low-risk first-time mothers, caseload midwifery was the lowest-cost option among the strategies examined and was projected to produce **\$172.6 million in savings over three years** if implemented nationally for that population. (4)

This is not an argument for reducing clinically indicated intervention. Rather, it demonstrates that how maternity care is organised can influence both outcomes and health-system expenditure.

Australian research examining maternity and early-childhood healthcare costs over the first 1,000 days similarly demonstrates substantial expenditure across public and private funders. The study estimated that, under its modelled counterfactual, reducing caesarean births could result in savings of \$974 million to public hospital funders and \$216 million to private health insurers. (5)

These figures demonstrate the broader health-system consequences of variation in maternity care.

Australia cannot afford to design maternity care without considering the clinical, social and economic consequences of how care is organised.

The relationship between the NSQHS Standards and a maternity Clinical Care Standard should be complementary:

The NSQHS Standards provide the system architecture defining how *a safe and high-quality health service should operate*? While Clinical Care Standard for Maternity Services would provide the *clinical context and maternity-specific expectations*, and Quality indicators provide the evidence that the vision is being *delivered*?

Recommendations:

Maternal Health Matters recommends that the Commission:

1. Retain the strong system-wide safety and quality focus of the third edition.
2. Ensure the Standards explicitly recognise that not all healthcare is acute illness care and that maternity requires a different clinical lens.
3. Ensure the application of the Standards to maternity supports physiological pregnancy and birth and does not inadvertently position intervention as the default.
4. Develop a National Clinical Care Standard for Maternity Services to complement the NSQHS Standards.
5. Use maternal outcomes, neonatal outcomes, women's experiences, equity measures and appropriate measures of intervention and unwarranted variation to assess maternity quality.

Conclusion

Maternal Health Matters Inc strongly supports the Commission's work to strengthen Australia's national safety and quality framework.

The opportunity now is to ensure that the framework is sufficiently broad to work across the full continuum of healthcare.

Maternity is not an exception to safety and quality. It is a test of whether our definition of safety and quality is sufficiently broad.

Pregnancy and birth are normal physiological processes that sometimes require specialist or acute intervention.

The system should therefore be designed to support normal physiology **and** provide rapid, high-quality intervention when it is required.

A Clinical Care Standard for Maternity Services would provide the mechanism to translate this principle into consistent, measurable and accountable practice across Australia.

The goal is not less clinical care. It is the right care, at the right time, beginning with support for health and normal physiology and escalating when clinical circumstances require it.

At Attachment A we have provided a policy Brief.

Yours sincerely



Ms Ellen O'Keeffe

25 September 2026
President

References

1. Australian Commission on Safety and Quality in Health Care (ACSQHC) 2026, *NSQHS Standards (third edition): Third edition engagement hub*, Australian Government, Sydney, viewed 25 September 2026.
2. World Health Organization (WHO) 2016, *WHO recommendations on antenatal care for a positive pregnancy experience*, WHO, Geneva.
3. World Health Organization (WHO) 2018, *WHO recommendations: intrapartum care for a positive childbirth experience*, WHO, Geneva.
4. Callander, E.J., Creedy, D.K., Gamble, J., Fox, H., Toohill, J., Sneddon, A. & Ellwood, D. 2020, 'Reducing caesarean delivery: an economic evaluation of routine induction of labour at 39 weeks in low-risk nulliparous women', *Paediatric and Perinatal Epidemiology*, vol. 34, no. 1, pp. 3–11, doi:10.1111/ppe.12621.
5. Callander, E., Shand, A., Ellwood, D., Fox, H. & Nassar, N. 2021, 'Financing maternity and early childhood healthcare in the Australian healthcare system: costs to funders in private and public hospitals over the first 1000 days', *International Journal of Health Policy and Management*, vol. 10, no. 9, pp. 554–563, doi:10.34172/ijhpm.2020.68.

Attachment A — Policy Brief

Why Australia Needs a Clinical Care Standard for Maternity Services

Prepared for: Australian Commission on Safety and Quality in Health Care

Date: 25 September 2026

Purpose

To recommend that the Australian Commission on Safety and Quality in Health Care develop a National Clinical Care Standard for Maternity Services to complement the National Safety and Quality Health Service (NSQHS) Standards.

Background

Australia needs a national Clinical Care Standard for Maternity Services because maternity care is fundamentally a **health-promoting and physiological service**, with specialist and acute care available when clinically required.

The proposed third edition of the NSQHS Standards provides an important framework for clinical governance, person-centred practice, safe clinical systems and continuous improvement. The eight Standards in the second edition have been consolidated into three integrated Standards: Clinical Governance, Person-Centred Practice and Safe Clinical Systems. (1)

The opportunity is to ensure that these system-wide requirements are appropriately translated into maternity care.

Issues

Maternity Is Different

Pregnancy and birth are normal physiological processes. Most maternity care therefore begins with health promotion, prevention, support, monitoring and continuity, while maintaining robust systems for recognising complications and providing timely escalation.

WHO's antenatal care guidance places person-centred health and wellbeing at the centre of routine care and identifies antenatal care as an important platform for health promotion, screening, prevention, communication and support. (2)

WHO's intrapartum care guidance similarly recognises the physiological nature of childbirth and cautions against unnecessary medicalisation of normal childbirth. (3)

A maternity Clinical Care Standard would ensure that these principles are translated into national, measurable expectations.

Continuity of Care

Continuity of care is an important component of woman-centred maternity care. Evidence supports midwife continuity models for a range of maternal outcomes and women's experiences, particularly among women initially assessed as being at lower risk.

Australian economic modelling provides an additional health-system perspective. Callander et al. found that, among low-risk first-time mothers, caseload midwifery was the lowest-cost strategy of those examined and projected savings of \$172.6 million over three years if implemented nationally for this population. (4)

This finding should not be interpreted as evidence that one model is appropriate for every woman. Rather it demonstrates that the organisation of maternity care is itself a quality and health-system issue. A safe continuity model should provide relationship care, ongoing monitoring and assessment, collaboration, consultation, referral and escalation when clinical circumstances require it.

Continuity does not mean care without medical involvement. When the medical model is provided to women and their infants who need intervention, it is medicine at its best, it is beautiful medicine, it transforms lives, it saves lives. When applied to all women however, it has the potential to cause harm, due to the impact of too much too soon leading to a cascade of interventions.

Measurement and Unwarranted Variation

Australia already has national maternity data through the National Core Maternity Indicators, providing measures of maternity activity and outcomes. (6). These data demonstrate significant variation in maternity interventions. For example, among selected women giving birth for the first time, caesarean birth increased from 25% in 2004 to 36% in 2023. (7) These figures should not be interpreted as demonstrating that intervention is inherently inappropriate. Clinical circumstances and population characteristics influence intervention rates. They do, however, demonstrate the importance of a national framework capable of identifying and examining unwarranted variation. This is particularly important when considering adverse postnatal outcomes, which may be associated with fragmented or inappropriate maternity care and highlight the consequences of gaps in the quality, continuity and coordination of care.

A maternity Clinical Care Standard should therefore support measurement of:

- maternal outcomes;
- neonatal outcomes;
- women's experiences;
- access and equity;
- continuity of care;
- intervention rates; and
- variation between services and populations.

The Economic Case

Maternity care is a significant component of Australia's health system.

Australian research examining healthcare expenditure across the first 1,000 days following birth found substantial costs to public and private funders. The same study estimated that, under its modelled counterfactual, reducing caesarean births could result in savings of *\$974 million to public hospital funders and \$216 million to private health insurers*. (5) These figures should not be interpreted as a target for reducing caesarean birth. Caesarean birth is an essential intervention when clinically indicated. Rather, the evidence demonstrates that variation in maternity care and the organisation of services have economic consequences for the health system.

A further Australian economic evaluation found that caseload midwifery was the lowest-cost strategy of those examined for low-risk first-time mothers and projected national savings of \$172.6 million over three years for that population. (4)

The policy objective is therefore not simply to increase or reduce intervention. It is to provide: the right care, at the right time, for the right clinical circumstance.

- A national Maternity Clinical Care Standard should establish measurable expectations for health promotion and prevention;
- physiological pregnancy and birth;
- continuity of care;
- informed choice and shared decision-making;
- respectful and culturally safe care;
- appropriate assessment and monitoring;
- timely recognition of complications;

- consultation, referral and escalation;
- integrated maternity and primary healthcare;
- maternal and neonatal outcomes;
- women's experiences; and
- equity.

The relationship between the NSQHS Standards and a maternity Clinical Care Standard will be complementary. The NSQHS Standards provide the system architecture defining how *a safe and high-quality health service should operate*. While Clinical Care Standard for Maternity Services would provide the clinical context and maternity-specific expectations, and Quality indicators provide the evidence that the vision is being *delivered*? This is complementary, not duplicative.

Recommendation

The Australian Commission on Safety and Quality in Health Care:

Develop a National Clinical Care Standard for Maternity Services to complement the NSQHS Standards (third edition).

The Standard should recognise that maternity is fundamentally different from acute illness and establish a national framework supporting: health promotion and physiological care when appropriate + timely specialist and acute care when necessary. It should incorporate continuity, informed decision, respectful care, clinical escalation, maternal and neonatal outcomes, women's experiences, equity and economic sustainability.

Conclusion

Australia does not lack evidence about what constitutes high-quality maternity care.

The challenge is translating that evidence consistently into the systems, models of care, measures and accountability mechanisms that shape everyday practice.

The NSQHS Standards provide an important foundation for safety and quality.

A Clinical Care Standard for Maternity Services would ensure that this foundation is appropriately applied to pregnancy, birth and the postnatal period.

Maternity care is too significant a component of Australia's health system to be treated simply as another form of acute care.

A national Maternity Clinical Care Standard would provide the opportunity to support normal physiology, promote health and wellbeing, strengthen continuity, identify complications early, enable timely escalation and reduce unwarranted variation.

The goal is not less clinical care. It is the right care, at the right time, beginning with support for health and normal physiology and escalating when clinical circumstances require it.

References

1. Australian Commission on Safety and Quality in Health Care (ACSQHC) 2026, *NSQHS Standards (third edition): Third edition engagement hub*, Australian Government, Sydney, viewed 25 September 2026.
2. World Health Organization (WHO) 2016, *WHO recommendations on antenatal care for a positive pregnancy experience*, WHO, Geneva.
3. World Health Organization (WHO) 2018, *WHO recommendations: intrapartum care for a positive childbirth experience*, WHO, Geneva.

4. Callander, E.J., Creedy, D.K., Gamble, J., Fox, H., Toohill, J., Sneddon, A. & Ellwood, D. 2020, 'Reducing caesarean delivery: an economic evaluation of routine induction of labour at 39 weeks in low-risk nulliparous women', *Paediatric and Perinatal Epidemiology*, vol. 34, no. 1, pp. 3–11, doi:10.1111/ppe.12621.
5. Callander, E., Shand, A., Ellwood, D., Fox, H. & Nassar, N. 2021, 'Financing maternity and early childhood healthcare in the Australian healthcare system: costs to funders in private and public hospitals over the first 1000 days', *International Journal of Health Policy and Management*, vol. 10, no. 9, pp. 554–563, doi:10.34172/ijhpm.2020.68.
6. Australian Institute of Health and Welfare (AIHW) 2025, *National Core Maternity Indicators*, AIHW, Australian Government, Canberra, viewed 25 September 2026.
7. Australian Institute of Health and Welfare (AIHW) 2025, *National Core Maternity Indicators: Caesarean section*, AIHW, Australian Government, Canberra, viewed 25 September 2026.