

Implementing the National Maternity Action Plan In Western Australia

**A call for the introduction of caseload
midwifery care options within the WA public
health sector.**

**Prepared by: The WA Branch of the
Maternity Coalition Inc.**

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Denise Hynd RN, RM, BApSc (NsgEd), IBCLC,
Pete Malavisi RN, RM, BNsg, FCH,
Lois Wattis RN, CM, BNsg, PD-CNM, IPM ACMI,
Tracy Reibel PhD,
Sue Kildea RN, RM, BHScHons.

GLOSSARY

ABS; Alternative Birthing Services programme funding by the Commonwealth government.

Accredited Midwife; a midwife who submits documentary evidence of currency of reflective, autonomous, 1-to-1 professional midwifery practice for bi-annual assessment by an ACMI national committee.

ACMI; Australian College of Midwives Incorporated.

ACSQHC; Australian Council of Safety & Quality in Health Care.

AHCA; Australian Health Care Agreements is the means of federal funds allocation to state health services.

AHWAC; Australian Health Workforce Advisory Committee.

Caseload Midwife; A midwife who is responsible for, and provides most of the care continuously for up to 40 women per year (=1 full time equivalent) through the whole process of pregnancy, labour and birth, and up to 6 weeks after the baby is born.

CMWA; Community Midwifery Western Australia a not-for-profit organisation providing the Community Midwifery Program (**CMP**) and related services.

DoH WA; Department of Health Western Australia.

FBC; Family Birth Centre at King Edward Memorial Hospital.

GP; General Practitioner(s).

MIPP or **IMP**; Midwife In Private Practice or Independently Practicing Midwife.

KEMH; King Edward Memorial Hospital.

MBC; Mandurah Birth Centre.

MC; Maternity Coalition is an Australia wide umbrella advocacy organisation of maternity consumer individuals and groups.

MGP; Midwifery Group Practice.

NESB; Non-English Speaking Background (person).

NMAP; National Maternity Action Plan launched by Maternity Coalition in Sept; 2002.

NHMRC; National Health & Medical Research Council of Australia.

NZCOM; New Zealand College of Midwives.

OSQH; Office of Safety and Quality in Health Care in the Department of Health WA.

RANZCOG; Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

VBAC; Vaginal Birth After Caesarean section.

WCH; Women's and Children Hospital (Adelaide, South. Australia).

Executive Summary

This document sets out why and how the National Maternity Action Plan¹ (NMAP) can be introduced to provide Western Australian women with real choice of carer during childbearing. Therefore the NMAP document needs to be read in conjunction with this proposal.

NMAP calls on Federal and state/territory governments to implement universal access to one-to-one primary midwifery care in all locations. The rationale of NMAP is that midwives, as experts in normal pregnancy and childbirth, are able to provide primary care for women and refer to obstetric care if required. NMAP uses highly regarded research evidence to support the call for changes to maternity services in Australia that would enable women to choose a midwife as their lead maternity carer based on their individual need and preference. Such changes would bring Australian maternity services in line with World Health Organisation recommendations for maternal and neonatal care².

The proposal presented here, based on the principles set out in NMAP, is in two parts. The first section (Part A) explores many benefits of caseload midwifery to different groups in WA, additional to those presented in NMAP. This information justifies the overall recommendation of both documents for universal access of healthy women to the choice of primary or caseload midwifery care.

The second section (Part B) discusses feasible means and professional guidelines for the initial "*Implementing of NMAP in WA,*" which are summarised in an accompanying set of six recommendations.

As above the objective of this document, as with NMAP, is to call on the WA government to provide access for all women to the option of primary care from a known midwife. It is beyond the resources of consumer groups such as Maternity Coalition (MC), to present or investigate the particular logistical requirements for implementing models of care in set locations. However MC is confident that within WA maternity services the necessary skills exist to address these and other challenges so that WA can resume national leadership in provision of safe, cost effective, evidence-based and consumer responsive maternity services.

Access to WA caseload midwifery care opportunities, also referred to as primary care from a known midwife or one-to-one midwifery care, is required to meet principles of equity and informed choice in health services provision. As a consumer advocacy group, the Western Australian branch of MC proposes that all women should be able to access caseload midwifery within the public system, regardless of whether their midwife is community or hospital based, contracted or employed. This care should be offered in collaboration with obstetric care for women who have a pre-existing medical condition or obstetric risk, as these women and their babies have an increased need for continuity of carer and its potential to optimise the pregnancy experiences and outcomes.

MC has affiliations with many women's and maternity groups and is Australia's national maternity consumer advocacy organisation, representing individual members and birth support groups from all Australian states and territories. MC aims include ensuring that maternity care and services meet the needs of all women, babies, and families throughout the childbearing continuum. As with all health services, consumers and the public have an expectation that help, not harm, provided in a timely and effective manner will be a principle of maternity service provision. MC WA presents this paper on behalf of the women and families of this State, and advocates that the Government take a proactive stand to ensure maternity services meet individual needs of women and their families. This can only be achieved by providing access to a full range of maternity care options, including caseload or primary midwifery models .

¹ "National Maternity Action Plan" (2002), see www.marternitycaolition.org.au/nmap.

² Technical Working Group. "Care in Normal Birth: A practical guide." (1996) Safe Motherhood. WHO Department of Reproductive Health & Research. www.who.int/rht/documents/MSM96-24/msm9624.htm

Recommendations for WA Maternity Services.

Overall, as per the NMAP document, the Western Australian branch of the Maternity Coalition recommends that the WA government funds access for all WA women to the choice of primary midwifery care as part of state-wide public maternity services.

The WA Branch of Maternity Coalition recommends the following means for the initial Implementation of NMAP in WA;

- 1) The WA government provide immediate additional funding for Community Midwifery WA to accept all suitable applications to the Community Midwifery Program and to meet the full range of support services, such as community resource centres and prenatal education programs, for these families.
- 2) The WA government provide funding to replicate CMWA services in regional and rural WA, beginning in regions where there is demonstrated demand by consumers and midwives.
- 3) The WA government provide funding to re-configure small maternity units, particularly those listed for closure by the Obstetric Services Review and Health Reform Committee reports, into midwifery led units or units with caseload birth centres.
- 4) The WA government support development of a Professorial Chair of Midwifery, jointly appointed by the DoH WA and WA Schools of Nursing and Midwifery, to coordinate and oversee implementation of hospital based caseload midwifery care.
- 5) The establishment and management of all WA maternity service options include meaningful and representative consultation with local consumer groups.
- 6) All WA midwifery options are established according to Australian College of Midwifery Inc. Standards of practice and referral.

Part A: Relevance of NMAP to the WA Community & Maternity Services.

1) Benefits to WA Women and their Communities of Caseload Midwifery

- a) Integrated maternity care for antenatal, labour and postnatal follow-through providing continuity of care, where possible in women's own homes, is of particular concern and benefit to multiparous women, Muslim women and those who have experienced this option of care in other countries (for example New Zealand, Netherlands, UK and Canada).
- b) Provision of a maternity service within a woman's local area, including educational resources and other supports, facilitates informed decision making throughout her parenting years.
- c) Provision of community based services that are family centred foster the development of relevant community support networks.
- d) Continuity of care by a known midwife supports and strengthens each women's networks and development of problem solving skills and resources.
- e) The CMP is a proven example of a "community based solution" which supports individuals and families taking personal responsibility for health and effective parenting³, as outlined in NMAP. Politicians, media and many other authoritative figures are currently offering these concepts as a means of addressing many social problems. For example, Professor Fiona Stanley has recently stated that *"It is now very, very obvious from all the research that if you don't nurture a child properly, respond to it's crying in a certain way, comfort it in certain ways, even from the very first year of that child's existence, then patterns of responses are laid down. The circuits in the brain are developed that actually lead to... psychological problems, behavioural problems. The hormones do not get turned on at the right time, the brain connections are not made. And so in fact it's very, very important. Perhaps we knew about this intuitively before and we've somehow forgotten it now in modern society. Children have fallen off the agenda. But this incredibly rich time for brain development starts in utero, when you're pregnant with a baby, and it goes on for the first 8, 10 years with incredible development still occurring through the teenage years."*⁴ In South Australia, recognition of the importance of community based care has been demonstrated with funding approved for a Community Midwifery Program in Port August and Whyalla⁵ in addition to the Northern Women's project based in Elizabeth.
- f) Experiences overseas, particularly in New Zealand⁶ and Canada, as well as some interstate, show that primary care by midwives can safely meet the maternity care needs of WA rural women. Due to withdrawal of services by specialist and GP obstetricians, such as in the South West, women are currently being forced to leave their families and communities to birth, with negative to questionable consequences. For example, there is growing evidence that some healthy rural women currently giving birth at regional or metropolitan hospitals are returning home with uterine scars, unaware of the potential risks for subsequent pregnancies as the significance of these sequelae are under rated by their doctors⁷. Overseas studies demonstrate that at small (rural) hospitals without on-site caesarean capability, a high proportion of women can safely give birth close to their homes or communities⁸. Such hospitals show a low level of perinatal risk consistent with national

³ Dodd, J. Reibel, T. "Birth transforms her; A report on birth choices, adjustment to parenting, breastfeeding and post-natal depression." (January 2000) Community Midwifery WA, Fremantle.

⁴ Prof. F Stanley on Enough Rope, 19 May 2003.

⁵ Alternative Birthing Services Program proposal (January 2004) Northern & Far Western Regional Health Service, South Australia.

⁶ New Zealand Health Information Service. "Report on Maternity 2000 & 2001". April 2003.
<http://www.moh.govt.nz/moh.nsf>

⁷ Rasdien, P, 2004 "The Caesarean Debate" West Australian Newspaper 14th February.

⁸ Leeman, L & R. 2002 "Do all hospitals need caesarean delivery capability? An outcomes study of maternity care in a rural hospital without on-site caesarean capability." Journal of Family Practice Feb.

norms when functioning as part of an integrated system which offer services with appropriate ante-partum and labour screening.

- g) Senior Aboriginal Health Worker, Molly Wardaguga and Ex-Kimberley midwife, doctoral student Sue Kildea argue that the call by Aboriginal women to regain the right and means to birth in their own country can be safely and positively met by midwifery led services. The recently screened (8th July 2004 on SBS) documentary "Birthrites" demonstrated how this can be achieved. It is time to listen to the voices of Aboriginal women and trust their ability to judge what is right for themselves, their families and their communities^{9,10}. Increasing numbers of communities across Northern Canada are showing extra-ordinary improvements in maternal and neonatal birthing statistics, where Inuit run maternity services are provided in very remote settings^{11,12,13,14,15}. The Inuit experience showing increased empowerment leading to decreased domestic violence suggests that community based midwifery services are a viable answer to current difficulties of maternity service provision in remote Australia, as well as a means to address other problems of remote Aboriginal communities¹⁶. In Australia, despite reliance on expensive, 'high tech' obstetric services, the Indigenous maternal and perinatal mortality and morbidity rates remain 2 to 3 times higher than for non-Indigenous families^{17,18}. Kildea and Inuit midwives contend that this reliance actually exacerbates the difficulties of Indigenous women and their communities to achieve positive birth and health outcomes¹⁹. MC WA believes that WA's indigenous run community based health and education services, such as Marr Moodijt, would be appropriate hosts for midwifery services to address local Aboriginal needs.
- h) WA, interstate and international experiences show that a majority of families would quickly subscribe to any new WA midwifery services given equity of access and information of these services. For example demand for CMP service has continually exceeded the number of funded places, despite token promotion.²⁰ Also WA women, like their overseas counterparts²¹, report their highest levels of satisfaction with midwifery care and to be treated most often with "*respect, dignity and consideration of privacy and special needs*", and to have treatments explained in understandable terms by midwives compared to medical practitioners^{22,23}.

⁹ Kildea S, (1999) "And the women said." Report on birthing services for Aboriginal women from remote Top End Communities. Darwin NT Health Service

¹⁰ Waraguga M, & Kildea S, (2004) "You mob just don't listen." Keynote Address Perinatal Society for Australia & New Zealand 8th Annual Conference, 'Integrating Science & Perinatal Practice; Controversies & Dilemmas, Sydney NSW.

¹¹ Chamberlain, M. (1997) "Power in action; Empowerment of Indigenous communities; A midwifery run birthing centre in the Canadian Artic." In The Truth, Virtue & Beauty of Midwifery Australian College of Midwives Inc. Melbourne Victoria.

¹² Tookalak, N.(1998) "Birthing in Povurnituq in remote Artic Canada." Birthplace Magazine Summer 2000-1 Edition.

¹³ Morewood-Northorp M (2000) "Community birthing project." in The New Midwifery Page L, & Percival P, Churchill Livingstone, Edinburgh, Scotland.

¹⁴ Rawlings L (2000) "Birthing in Povungnituk" Childbirth in Isolation conference Kalgoorlie WA.

¹⁵ Van Wagner V. (2003) Personal Communication S. Kildea email.

¹⁶ Rawlings L. (2002) Gheradi "Birthrites" JAG Films, Margaret River, WA.

<http://www.sbs.com.au/whatson/index.php3?id=724>

¹⁷ NH&MRC & Australian Institute of Health & Welfare (2001) "Report on Maternal Deaths in Australia 1994- 1996." NHMRC & AIHW. Canberra, ACT.

¹⁸ Trewin D & Madden R. "The health & welfare of Australia's Aboriginal & Torres Strait Islander peoples." 4704.0 AIHW Australian Bureau of Statistics Canberra ACT.

¹⁹ Kildea S, "Risk & childbirth in rural & remote Australia." 7th National Rural Health Conference (2003)

<http://www.dwd.com.au/crana/sue/suefiles/1053390514.pdf>

²⁰ Thorogood C, Thiele B, Hyde K. Centre for Research for Women. "Community Midwifery Program (WA) Evaluation November 1997 – December 2001" Community Midwifery Program (WA) 2003

<http://www.communitymidwifery.iinet.net.au/Eval97-01.PDF>

²¹ Hodnett ED "Caregiver support for women during childbirth" (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software.

²² Thorogood C, Thiele, B. Centre for Research for Women (1996) "Evaluation of the Mandurah Murray Birth Centre: Alternative Birthing Services Program Phase Two".

²³ Rasdien, P, "Stillbirth devastates couple." West Australian Newspaper 6th January 2004.

2) Benefits to the WA Health Budget of Caseload Midwifery

Implementing NMAP in WA can begin to address the following current health budget concerns;

- a) As stewards of the public purse, governments are obliged to consider all safe potential means to reduce expenditure. With approximately 25,000 WA births per annum, the costs of maternity care account for a significant portion of total health service budgets, with the largest proportion of hospital bed days across the state and Australia wide. Unlike in Australia, the Welsh Assembly publicly commends and supports health regions and midwives to increase their rates of homebirth in recognition of this option as a safe and cost effective beginning for the healthy majority of its population²⁴.
- b) The August 2003 Australian Health Care Agreements created a new need for cost savings in the delivery of health services. The NMAP document presented research and a costing model, which showed that the implementation of midwifery-led care options could reduce the high, rates of expensive medical procedures currently being experienced by healthy pregnant Australian women.
- c) Applying one Australian study²⁵, reviewing the costs of current medical based forms of maternity care and related outcomes compared to midwifery options, to WA suggests that universal adoption of midwifery options would bring large reductions in current costs. In the study amongst NSW women the relative cost of medicalised birth increased by up to 50% per birth for women having their first baby and 36% for women having a second or later baby once the cascade of obstetric interventions begins. Similarly the National Hospital Cost Data Collection Weights for WA shows the following Cost Estimates for Public Hospital Expenditures:
 - \$2,434 to \$3,791 for vaginal deliveries with increasing levels of complications,
 - \$4,419 to \$6,867 for Caesarean deliveries with increasing levels of complications.As in NSW, these costs are for labour, birth and an average number of post-natal care days. They do not include any antenatal care, ultra sounds or pathology charges. Also not included are any non-standard payments, such as those made to doctors such as fees for covering shared care programs as occurs at Woodside, Bentley, Armadale and Peel hospitals or \$3,400 a day for obstetric cover at Swan Districts Hospital²⁶. In the case of midwifery led units these latter costs would be minimal to nil depending on the rates of obstetric consultant referrals.
- d) The above WA costs are excessive when compared to those for the majority of CMP²⁷ women who birth at home (69%). The average CMP cost is \$2,300 per woman, which includes all antenatal, labour, birth and post-natal care up to 6 weeks. As with the aforementioned hospital based patients, visits to doctors and, or clinics (which average two per CMP woman), pathology and radiology expenses are not included in the CMP cost.
- e) Other public health savings can be achieved with community based midwifery-led care, as it requires minimal capital expenditure in the form of building and equipment outlays. These savings would be substantial compared to the upgrading or maintenance of large hospital based, capital-intensive maternity services, particularly if homebirth is offered as a universal option. Another potential area of savings relates to the safety of babies born at home, for example these babies do not need expensive electronic or biological security to safeguard them from abduction or other hospital-based risks such as exposure to foreign milks, chemicals or pathogens.

²⁴ "Welsh Assembly aims for 10% Homebirth rate" Practicing Midwife Volume 7 Number 6.

²⁵ Tracy S, Tracy M. "Costing the cascade: estimating the cost of increased obstetric intervention in childbirth using population data." BJOG Aug, 2003, Vol 110, pp. 717-724.

²⁶ Legislative Council Questions on Notice to the Minister for Health Tuesday 4th May 2004, WA Parliament

²⁷ Community Midwifery WA "Community Midwifery Program Statistics 1996 – 2003, April 2004

- f) Interstate hospital based caseload midwifery programs suggest this form of maternity care has other means of achieving substantial savings including:
- i. Altering the ratio of midwives to doctors in the provision of care for women with uncomplicated pregnancies.
 - ii. Providing a system of care that does not require 24 hour on site medical obstetric staff. Mobilising under utilised sections of the midwifery workforce to provide continuity of care, thus enhancing the service for women and midwives²⁸.
 - iii. Enhancing individual care increases rates of successful breastfeeding, and other factors, which increase long-term maternal and infant health outcomes. For studies have shown that *“the continuous presence of a support person reduced the likelihood of medication for pain relief, operative vaginal delivery, caesarean delivery, and a 5-minute Apgar score less than 7”*^{29, 30}.
- g) The 1994-1997 report of the AIHW National Perinatal Statistics Unit on Maternal Deaths in Australia suggested a 19% increase in direct maternal deaths resulting from obstetric complications with the escalation of Caesarean sections. The imminent next two-triennium reports for 1997-1999 and 2000-2002 will indicate whether these previous outcomes were a statistical aberration or a concerning new trend. Meanwhile Australia needs to act on growing evidence of the need for governments and health authorities to initiate national collaborative actions to reduce the rates of Caesarean section such as is happening in the UK^{31, 32}.
- h) State wide caseload midwifery options would address objectives of the DoH WA Office of Safety and Quality in Health (OSQH) such as *‘to promote consumer focused, safe, quality health care across the WA health system’*. The Clinical Governance Unit of this DoH division acknowledges that *“as more individuals from more groups look after a patient within a tighter time frame, maintaining a consistently high standard of care – even across a single health care episode becomes more challenging. The potential for error increases particularly whenever responsibility is handed from one agency to the next.”* This document refers to *“the Douglas Inquiry’s findings of poor policies and practices and inadequate systems that resulted in poor outcomes for patients and their families... as emblematic of system wide concerns.”*³³
- i) The OSQH unit’s review of legal precedents and system responses supports the British concept of Clinical Governance, which has resulted in resource savings, including reductions in clinical negligence premiums in the UK. As above, continuity of midwifery care for women can address concerns in WA about litigation risks and the price of PI insurance premiums. Both are cited as a factors contributing to Australia-wide reported withdrawal from practice of GP obstetricians and specialist obstetricians.
- j) The current closure of small maternity services due to withdrawal or lack of doctors could be addressed by providing community or hospital based primary midwifery care to women; particularly those already marginalised in regional and rural WA. Groups of midwives in both WA metropolitan and regional hospitals, some under threat of closure, have expressed their desire to undertake such opportunities to MC WA and others, including their area health service managements. MCWA feels certain that sufficient personnel and skills exist in WA

²⁸ Tracy S. “Proposal for a primary health care model of maternity services at Ryde Hospital; The introduction of Ryde Midwifery Group Practice.” Midwifery Research & Practice Development Unit Northern Sydney Health. December 2003.

²⁹ Hodnett ED “Caregiver support for women during childbirth.” in The Cochrane Library, Issue 2, 2003. Oxford: Update Software

³⁰ Rosser, J.(2003) *“How do the Albany midwives do it? Evaluation of the Albany Midwifery Practice.”* MIDRIS midwifery Digest vol 13 no 2, pp 251 -257

³¹ “All Wales clinical pathway for normal labour launched.” The Practising Midwife page 7 Volume 6 Number 4, April 2003.

³² The National Sentinel Caesarean Section Audit Report.” October 2001. RCOG Clinical Effectiveness Support Unit <http://www.rcm.org.uk/files/info/documents/261001121427-128-2.pdf>.

³³ Office of Safety & Quality in Health Care (2003) *“Consumer Information & Participation Program”* www.health.wa.gov.au/safetyandquality Department of Health Govt. of WA.

for these evidence base services and has asked the DoH to explore the level of current interest and skills levels available through a state-wide video linked conference regarding the issues raised in NMAP and this document. In SA, the loss of specialists at The Queen Elizabeth Hospital is to be addressed by creating a midwifery-led maternity unit for low risk women with specialist services back up from the Women's & Children's or Lyle McEwin hospitals by March 2005³⁴.

3) Benefits to WA Midwives of Caseload Midwifery.

- a) The AHWAC Report on the Midwifery Workforce showed that Australia has a national shortage of midwives. It shows that in most states and territories midwives are leaving the profession faster than new students are being trained, with more than 1,800 positions currently unable to be filled³⁵. However overseas and interstate experiences show with re-orientation of practice and increase in skills to work in partnership with women, their families and community that midwives employed in caseload practices experience high levels of job satisfaction. UK examples of these models of service do not report any recruitment or retention of staff problems³⁶.
- b) Also according to the above AHWAC report providing Australian midwives with primary care opportunities to practice in a community or hospital setting in collaboration with doctors and other health care professionals is a much needed positive move toward retaining both experienced and new midwives.
- c) Caseload options offer midwives development opportunities for all competencies and clinical applications as per the NHMRC, Australian Maternity Action Plan (AMAP)³⁷ and WA Enhanced Role of the Midwife Project, as well as more efficient utilisation of midwifery workforces by employers or contractors of midwives. For example a South Australian audit showed that in the current fragmented system each midwife working shifts provides care for the equivalent of 25 women, with each woman seeing between 15 – 25 midwives depending on risk factors in the pregnancy, type of labour and length of post-natal stay. However each full-time caseload midwife working in a sub-group of 3 (Adelaide's Midwifery Group Practice) will provide care for 40 women per year throughout each pregnancy episode³⁸.
- d) Introduction of caseload midwifery options addresses other midwifery workforce issues raised in "Nursing and Midwifery; New Vision, New Directions" and "Enhanced Role of the Midwife" as presented further on in this document (see pages 12 & 13).
- e) Concerns of some WA midwives about perceived difficulties with the different social and professional demands of caseload care which make them reluctant to consider such change to current work patterns lack substance for those who have worked both systems. CMP midwives and other caseload midwives interstate and overseas have found that the difficulties of these adjustments are manageable and compensated by the increased autonomy and job satisfaction³⁹. The CMP is regularly approached by aspiring community midwives from across Australia and overseas, seeking an opportunity to develop within their full practice scope, skills and meaningful partnerships with women. Funded opportunities for the re-skilling of midwives moving from fragmented to continuous care or from hospital to community based care is necessary, but a cost-effective investment as with all professional development programs.

³⁴ Communications from SA members and others, to MC National Management Committee members.

³⁵ Australian Health Workforce Advisory Committee (AHWAC) 2003 *The Midwifery Workforce in Australia 2002-2012*.

³⁶ Reibel T (2003) "To investigate management and integration of midwifery models of care in the UK and Netherlands." Winston Churchill Fellowship Trust of Australia.

³⁷ Barclay L Brodie P Lane K Leap N Reiger K Tracy S The Final Report of The Australian Midwifery Action Project, AMAP Centre for Family Health and Midwifery, UTS, Sydney 2003.

³⁸ Cornwall. C, 2004 "Midwifery Group Practice is born at WCH Adelaide." Australian Midwifery News Vol 4 No1, Feb.

³⁹ Reibel T (2003) "To investigate management and integration of midwifery models of care in the UK and Netherlands." Winston Churchill Fellowship Trust of Australia.

4) Benefits to WA Government/DoH of Implementing NMAP in WA.

- a) Introducing caseload midwifery options across the state is consistent with the government's commitment to provide public patients with "quality services on the basis of clinical need"⁴⁰. As the majority of WA women are healthy "the midwife appears to be the most appropriate effective type of health care provider to be assigned to the care of normal pregnancy and normal birth, including risk assessment and recognition of complications"⁴¹. This is consistent with a recommendation of the Douglas Inquiry to increase appropriate and accountable delegation of duties including supporting midwives to be responsible for the care of healthy women.
- b) Similarly replication of CMWA services including the Community Midwifery Program is consistent with the Reid Inquiry committee's stated intentions of "building on innovative home and community based or nurse-led initiatives in other medical specialities"⁴².
- c) "Implementing NMAP in WA" would put WA on par with the Victorian Labor government which has announced they will provide their midwives with opportunities to work within their full scope of practice in metropolitan, regional and rural Victorian locations. The goal in "Future directions for Victoria's Maternity Services"⁴³, unlike the actions proposed in WA by the Reid and Cohen reports "is to keep services as close as possible to where women live". Meanwhile hospital based caseload options of care are being implemented in NSW and South Australian settings, so WA midwives and women are denied safe, cost-effective options supported interstate.
- d) "Implementing NMAP in WA" would also negate the need of the government to prepare to resist the anticipated backlash, foreshadowed in the Cohen Report⁴⁴ when advocating the rationalisation of small WA maternity units, now part of the agenda of the Health Reform Final Report⁴⁵.
- e) Replication of CMWA services across the state would return WA to the paramount position as an innovative supporter of healthy women's family friendly options. For the NSW Health Department has announced that is to fund "a radical program of publicly funded homebirth for healthy women in NSW"⁴⁶. In this front-page announcement the Chief Nurse & Midwife Prof M Chiarella, foreshadowed that NSW homebirth midwives may be employed or contracted through hospitals, local area health services or centrally. NHMRC member Professor Lesley Barclay was reported as saying, "a hospital was still the safest place to give birth when there was a known risk of a medical problem. But for healthy mothers, the risks of having their baby in hospital might outweigh the benefits". At least one large Sydney teaching hospital and its area health service is formerly involving all stakeholders, including consumers on a planning committee regarding provision of a homebirth service⁴⁷.
- f) Replication of CMWA services across the state is consistent with various DoH policy documents^{48, 49} which acknowledge the right of women to choose a midwife as their primary maternity carer, as well as their right to choose to birth at home. Integrated provision of

⁴⁰ Department of Health Government of WA (2004) "The WA Public Patients Hospital Charter." Perth WA.

⁴¹ Technical Working Group. "Care in Normal Birth: A practical guide." (1996) Safe Motherhood. WHO Department of Reproductive Health & Research. www.who.int/rht/documents/MSM96-24/msm9624.htm

⁴² Health Consumers' Council WA (Inc) "Discussion papers and agenda; Community Consultation Health Reform Committee." November 2003 www.health.wa.gov.au/hrc.

⁴³ Department of Human Services Victoria, "Future directions for Victoria's Maternity Services" www.health.vic.gov.au/maternitycare/pubs.htm

⁴⁴ Western Australian Statewide Obstetrics Services Review, Report of the Project Working Group, 'An integrated maternity service; a new way forward' Discussion Paper April 2003 Department of Health WA.

⁴⁵ Health Reform Committee Final Report. "A Healthy Future for Western Australians." Department of Health Government of WA. www.health.wa.gov.au/hrc/finalreport/index.cfm.s

⁴⁶ Robotham, J. (2004) "Publicly funded home births for healthy women on agenda." Sydney Morning Herald March 1.

⁴⁷ Personal communications from MC NSW members to MC National Management Committee July 2004.

⁴⁸ Health Department of WA (1992) "Operational instructions; Policy on Homebirth in WA." Perth HDWA.

⁴⁹ Department of Health WA (2001) "Homebirth Policy and Guidelines for Management of Risk Factors"

these services with-in the public health system as occurs overseas⁵⁰, would ensure access to suitably qualified and equipped midwife practitioners, supported by a statewide obstetric infrastructure.

5) WA Government Reviews, Statement Policies Consistent with NMAP

State wide introduction of primary midwifery options is consistent with the themes and directions of many past and current WA Government policy directions, statements of concern and reviews of maternity services as per the following examples;

Legislative Assembly Select Committee on Intervention in Childbirth (1995)

This extensive public review of WA maternity services⁵¹, chaired by Dr Hilda Turnbull supported the opening of shared care options of maternity services such as the Swan Districts and Mandurah birth centres, which have since been closed. A previous obstetric led review⁵² had responded to consumer demand by supporting the establishment of the Family Birth Centre (FBC) at KEMH. This review raised concerns about the high rate of transfer of women out of the FBC (then 50%) due to the level of medical influence on practices within this unit, and supported "*midwives as the lead professional at the centre*". Still in 2004, unlike in interstate and overseas birth centres, midwifery options such as waterbirth and care for women seeking VBAC continue to be prohibited by KEMH management.

New Visions, Healthy Communities and Sustainability in WA

The government's aim in the first document⁵³ is to develop WA health services with an emphasis on promoting both healthy individuals and healthy communities. The document advocates activities that include "*using effective, preventive strategies; community development; proactive partnerships with communities and service providers and a focus on the determinants of health.*" Extensive evidence for caseload midwifery as an effective, preventative health strategy is set out in NMAP. Positive childbirth is inextricably linked to "Healthy Communities" as well as subtly linked to health and sustainable communities as discussed in the second document⁵⁴. Additionally the relevance of sustainability, in relation to health services provided by the WA Government, is recognised as significant by senior WA consultant obstetricians.⁵⁵

Douglas Report (November 2001)

This extensive inquiry⁵⁶ involved 18 months of data gathering and analysis summarised in 5 volumes of findings. The investigation followed another by Child and Glover (1999) into a string of adverse outcome cases found to be due to poor clinical practices and non-accountability, which necessitated distressed patients and midwives making extra-ordinary efforts to gain some redress of their concerns. Two themes of the report's findings are: (1) the need to increase appropriate and accountable delegation of maternity service duties including midwives should be responsible for the care of healthy women, (2) need for institutional support for informed consent by maternity patients. As previously mentioned the newly created Office of Safety And Quality in Health Care of the DoH WA, refers to the Douglas Inquiry's findings as an indication of the need for auditing and reviews of WA services involving cultural changes including recognition of "Consumer value" in service planning and provision⁵⁷. However recent

⁵⁰ Kings College University London & National Childbirth Trust Conference 27th November 2003 "*Making normal birth a reality: Sharing good practice & strategies that work.*" in MIDRIS Midwifery Digest vol 14 Supplement 1, Mar 2004

⁵¹ WA Legislative Assembly *Select Committee on Intervention in Childbirth Report* 1995.

⁵² Department of Health Western Australia (1990). "*Ministerial task force to review obstetric, gynaecological and neonatal services in Western Australia*". Perth.

⁵³ Marshall, J. and Craft, K. (2000). *New Vision for Community Health Services for the Future* report. Perth, Western Australia: Health Department of Western Australia.

⁵⁴ Government of Western Australia (2002) *Focus on the Future: The Western Australian State Sustainability Strategy*. Consultation Draft. The Department of the Premier and Cabinet, Perth.

⁵⁵ T Thomas, C Douglas, H Cohen (2002) *Health and Sustainability*, A Background Paper for the State Sustainability Strategy.

⁵⁶ Douglas, N. Robinson, J. Fahey, K. "Inquiry into obstetric and gynaecological services at King Edward Memorial Hospital 1990 – 2000" (November 2001) WA government printer, Perth, WA.

⁵⁷ Office of Safety & Quality in Health Care (2003) "*Introduction to Clinical Governance – A background paper.*" Information Series No.1.1 Department of Health Govt. of WA.

complaints⁵⁸ and staff reactions^{59, 60} reported in WA media, suggest that these problems appear to persist amongst some clinicians.

Nursing and Midwifery; New Vision, New Directions (Nov 2001)

This document⁶¹ states that to address the challenges of the midwifery (and nursing) workforce requires innovative strategies, including effective utilisation of the profession and its future to ensure delivery of quality care. Recommendation 6 advocates, “*That health services actively work with staff towards removing inflexible practices that inhibit nurses and midwives accessing employment which may be achieved by funding innovative practice*”. This report like statements of the OSQH⁶² express concern about a culture of silence within health professions to conceal witnessed adverse events, errors or negligent practice in order to protect reputations or minimise risks of litigation. The report confirms that such concealment has negative impacts on the retention and psychological well being of midwives, as well as their professional integrity and relationships with both colleagues and clients. This report recommends that ways be found to provide midwives with means to contribute information based on their unique perspective of health care delivery. It calls for professional leaders to challenge the culture of silence and enhance practices based on evidence, including the ability of midwives to provide advanced quality care working both autonomously and collaboratively. The document calls for funding of joint appointments between industry and universities to provide clinical leadership and strategic directions for the development of increased partnerships and collaborations with the WA midwifery profession.

WA Homebirth Policy & Guidelines for Risk Management (1991 and 2001)

In this 1991 policy⁶³ and its 2000 review⁶⁴, the DoH WA has acknowledged that appropriately experienced and accredited midwives can provide a quality service to WA women who plan to homebirth. Both documents aim to support and guide the practices of midwives who offer homebirth services to WA families consistent with public and professional standards. Still in 2004, highly experienced CMP midwives, accredited to practice independently by ACMI, cannot get admission rights to WA public hospitals as recommended by both these documents and the former Metropolitan Health Services Board.

The Enhanced Role of the Midwife Project

In January 1999, WA acted on the 1998 NHMRC report⁶⁵, which confirmed the trend in all Australian states for many midwives to assume increasing responsibilities in their daily practices. A committee reviewed practices and formulated guidelines to legitimise ordering by midwives of basic pharmacological substances and routine tests as part of their care during an uncomplicated pregnancy, birth and post-natal period. The guidelines expect that midwives “in partnership with healthy women” will undertake these activities. A partnership between the DoH WA and Flinders University SA has initiated a course of study for accreditation of senior WA midwives performing these practices⁶⁶.

⁵⁸ Rasdien. P, “*Stillbirth devastates couple.*” West Australian Newspaper 6th January 2004.

⁵⁹ O’Leary. C, “*Doctor lacked support KEMH.*” West Australian Newspaper 2nd February 2004.

⁶⁰ Rasdien. P, “*Midwives call for action.*” West Australian Newspaper 2nd February 2004.

⁶¹ Report of the WA Study of Nursing & Midwifery (Nov 2001) “*New Vision, New Direction*”. Department of Health Govt. of WA.

⁶²Office of Safety & Quality in Health Care (2003) “*Introduction to Clinical Governance – A background paper.*” Information Series No.1.1 Department of Health Govt. of WA.

⁶³Health Department WA (1990) “Homebirth Policy and Guidelines”.

⁶⁴ Department of Health WA (2001) “Homebirth Policy and Guidelines for Management of Risk Factors”

⁶⁵ NHMRC (1998) “*Review of Services Offered by Midwives*” Commonwealth of Australia, Canberra.

⁶⁶ <http://www.nursing.health.wa.gov.au/midwifery/enhanced.cfm?show=list4>

Statewide Obstetric Services Review (2002).

MC WA was among many groups who made submissions in response to the release of this review⁶⁷. These responses remain unpublished, consequently their consideration by the government, maternity service providers or the community has not occurred. The review claimed to promote the needs of all key stakeholders, however this report was written with token consultation with individual consumers and little reference to evidence or concerns beyond the sphere of obstetricians. For example this report does not address the problems due to fragmentation of services or the level medical interventions in the birth experiences of the healthy majority of WA women, rather its recommendations of increased centralised institutional care would have additional negative impacts for most families.

Though this report does support the establishment of more birth centres in WA, there is no indication as to the proffered model of care of these units. Meanwhile WA hospital based maternity services only offer team or shared care models, despite the superior benefits to all of primary midwifery models.

MCWA acknowledges that this report does support the establishment of a professorial chair of midwifery and the Enhanced Role of the Midwife project. However MCWA endorses responses by CMWA⁶⁸ that the recommendation for Internet and increased information handouts is limiting in its accessibility and relevance to the educational needs of diverse and disadvantaged maternity consumers. Thus MC WA joins their call for the expansion of local, midwife-staffed resource centres, as well as other interactive adult learning prenatal education opportunities as currently conducted by consumer groups; CMWA, Birthrites or Peel PR&MS groups.

WA Health Reform Committee (2003 –2004)

Discussion papers⁶⁹ for public “consultations” toward this major restructuring of WA public health services, sought minimal and restricted consideration of any maternity services reform, except relocation and consolidation of tertiary services. This omission is astonishing, as the costs of childbirth are a significant constituent of total health service budgets. Subsequent submissions by individuals and consumer groups requesting reformation of future WA maternity services seem not to have been considered. Instead the maternity service recommendations of this committee⁷⁰ are those of the aforementioned Cohen report which will maintain the status quo despite the current and inherent problems and costs.

Overall Recommendation

As per the NMAP document, Maternity Coalition WA recommends that the WA government funds access for all WA women to the choice of primary midwifery care, as part of state wide, public maternity services.

Part B: Means of the Initial Implementation of NMAP in WA.

1) Expansion of the Community Midwifery Western Australia (CMWA) and Community Midwifery Program (CMP).

This service began in 1995 at the Fremantle Women’s Health Centre, with federal ABS funding to provide 1-to-1 midwifery care for 70 women in the South Metropolitan area, primarily for home births. In 1997, CMWA⁷¹ assumed the contract for the Program. From June 1999, following a positive independent evaluation additional equivalent state government funding increased client numbers to 150 births per annum. Along with midwife staffed resource centres

⁶⁷ Department of Health Western Australian Statewide Obstetric Services Review, “*Report of the Working Group; An integrated maternity service a new way forward.*” Discussion Paper April 2003. Deputy Director General of Healthcare: Department of Health WA.

⁶⁸ Community Midwifery WA (2003) “*Response to the Cohen Report*” <http://www.communitymidwifery.iinet.net.au/cohen.html>.

⁶⁹ Health Consumers’ Council WA (Inc) “*Discussion papers and agenda; Community Consultation Health Reform Committee.*” November 2003 www.health.wa.gov.au/hrc.

⁶⁷ Health Reform Committee Final Report. “*A Healthy Future for Western Australians.*” Department of Health Government of WA www.health.wa.gov.au/hrc/finalreport/index.cfm.s

⁷¹ Community Midwifery WA www.communitymidwifery.iinet.net.au

in Fremantle, Leederville, Armadale and Midland, CMWA also provides midwife-led prenatal education including Active Birth workshops in four Perth locations. CMWA services promote informed choices for women. These services are accessed by a range of women (including Program and non-Program clients), confirming their desirability and acceptability despite limited promotion and hours of availability.

When independent midwives worldwide lost access to affordable Professional Indemnity insurance in 2001, WA Riskcover⁷² recognised the outstanding outcomes and unique quality assurance (QA) processes of CMWA by supporting the government's adoption of insurance cover for CMP midwives. These QA processes include; (1) all CMP clients have the opportunity to formally evaluate their own care and to contribute to the overall development of services through participation in management committees, (2) the records of each CMP client are reviewed by the Director of Midwifery on discharge (3) CMP case reviews are regularly undertaken through the Program's Clinical Review Group. Additionally two independent evaluations of the program, its outcomes and processes have been published by CMWA.

The CMP service produces more normal, positive outcomes than any other service in Australia. 69% of CMP⁷³ women have natural labours without artificial induction or pain relieving drugs followed by spontaneous births at home. Meanwhile less than 14% of women in WA hospitals⁷⁴ labour without drugs and more than 30% end labour with a surgical delivery. WA Midwives Notification statistics confirm that WA hospital intervention rates are consistent with rising national trends, (eg; Caesarean section rate at 27.6% in 2001, from 15.6% in 1986) with only 25.7% women who begin labour spontaneously able to achieve a vaginal birth without augmentation. Some of these sad experiences in current WA hospital-based services have raised momentary concerns in the state's newspaper^{75, 76}. Although the former Health Minister Bob Kucera told a gathering at the DoH WA; "*It (CMP) is the Gold Standard of midwifery services in Australia*"⁷⁷ little is widely known or reported about the program.

Demand for CMP service continues to exceed the limited number of funded places (150 out of 24,000+ WA births per year), despite minimal promotion.⁷⁸ Meanwhile ACMI accredited midwives working for the CMP are under-employed with too few clients shared between them⁷⁹. In the past other accredited midwives have been forced to leave the program due to the professional and ethical dilemmas of the need to work outside the program to meet their financial obligations. Yet two positive independent evaluations and numerous public demonstrations of support by consumers⁸⁰, plus supportive recommendations of the WA Legislative Council⁸¹ have not resulted in increased government funding of CMP services.

Recommendation 1.

Maternity Coalition WA recommends that the WA government provide immediate additional funding for Community Midwifery WA to accept all suitable applications to the Community Midwifery Program and to provide the full range of support services, such as community resource centres and prenatal education programs, for these families.

⁷² Reibel T, Program Manager, Community Midwifery Program personal communication, October 2001

⁷³ Community Midwifery WA "Community Midwifery Program Statistics 1996 – 2003", April 2004.

⁷⁴ Gee, V. (2003) "*Perinatal Statistics in WA, 2001 ; Nineteenth Annual Report of the Midwives Notification System*". Department of Health WA.

⁷⁵ O'Leary. C, "*Doctor lacked support: KEMH.*" West Australian Newspaper 2nd February 2004.

⁷⁶ Rasdien. P, "*Stillbirth devastates couple.*" West Australian Newspaper 6th January 2004.

⁷⁷ At launch of Health Department of WA Homebirth Policy and Guidelines for Management of Risk Factors 2001.

⁷⁸ Thorogood C, Thiele B. Hyde K. Centre for Research for Women. "*Community Midwifery Program (WA) Evaluation November 1997 – December 2001*" Community Midwifery Program (WA) 2003
<http://www.communitymidwifery.iinet.net.au/Eval97-01.PDF>

⁷⁹ Reibel T, personal communication, Feb 2002.

⁸⁰ O'Leary. C, "*Women rally for midwives*" West Australian, 22nd November 2003.

⁸¹ "*Report of the Standing Committee on Constitutional Affairs in relation to A Petition requesting that Community Based Midwifery be included in State Health Services*" December 1996-9 Report Number 48, WA legislative Council

2) Replication of CMWA and CMP.

Since 2001 consumer group Birth Choices South West WA Inc; based in Busselton, Bunbury and Margaret River, have lobbied the local area health service to initiate a community based midwifery service like the CMP. In their submissions Birth Choices has sought government recognition of the ongoing inequities for rural women to access the services of experienced midwives and midwifery options of care not available through current regional public or private maternity services⁸².

To attain personal midwifery care often requires regional and rural WA families to incur additional costs for accommodating as well as recruiting and employing midwives from other locations. The SW group has chronicled⁸³ evidence of local demand, for 33 women have engaged the services of a local midwife for homebirths over the last 4 years. This is significant as the service provided by this midwife has never been advertised, so demand has occurred due to "word of mouth" and in the face of myths and misinformation about the safety of homebirth. The group believes that if the service were publicly funded, including provision of community promotion of the option, uptake would be dramatic, as has happened in New Zealand. Currently over 71% of New Zealand women choose midwives as their Lead Maternity Carers compared to 1% in 1990 when their government gave them equity of access to midwifery care⁸⁴.

Meanwhile the South West has experienced a significant loss of General Practitioner based maternity services, as six GP-Obstetricians in the Busselton area have withdrawn services. Along with the closure of small maternity units at Harvey, Pemberton, Donnybrook and Augusta, the service at Manjimup is presently in jeopardy, with only 1 GP in the area willing to support local births. The South West group and NMAP propose that community-based midwives are a valid and safe means to give rural women the support to safely birth in their communities. This group and MC WA, challenges the WA government to cease the current discrimination against rural families in denying them access to a community midwifery program, particularly in light of the benefits to communities of this model of care. Meanwhile Denmark District Hospital has provided local women with the options of homebirth and waterbirth with-in the constraints of their centrally set budget for at least 5 years⁸⁵. Thus midwifery led care in WA can be a reality when there is health service management open to the diverse needs of their community and different means to safely meet those needs.

MC WA also feels the above state average birth outcomes at Kalgoorlie, Geraldton and other regional hospitals due to collaborative efforts between local midwives and women, deserves government enhancement through funding of a local community based midwifery option. Experiences of midwifery led options in other regional centres across Australia like Broken Hill (NSW), Wangaretta (Vic) and Mackay (Qld) confirms that such an undertaking is valid and sustainable in rural areas.⁸⁶

Recommendation 2.

Maternity Coalition WA recommends that the WA government provide immediate funding to replicate Community Midwifery WA services, beginning where there is current demand by consumers and midwives.

3) WA Hospital Based Caseload Midwifery Options.

In February 2004, when the Women's and Children's Hospital offered Adelaide women the option of caseload care through their "Midwifery Group Practice" they were overwhelmed by positive consumer and midwifery responses. Previously a comparative audit confirmed evidence of the cost efficiency of this model of care. As WCH recognises that high-risk women

⁸² Evans, C. President Birth Choices South West WA Inc, personal communication February 2004.

⁸³ Malavisi, P. 2004. Independent Midwife South West WA statistics.

⁸⁴ New Zealand Health Information Service. "Report on Maternity 2000 & 2001". April 2003.
<http://www.moh.govt.nz/moh.nsf>

⁸⁵ Personal communication to P Malavisi SW Birthchoices from S Roberts DoN Denmark District Hospital, April 2002.

⁸⁶ Homer C, Brodie P, Leap N, "Establishing Models of Continuity of Midwifery Care in Australia: A resource for midwives and managers." (2001) Centre for Family Health and Midwifery, UTS Sydney.

have an increased need for the advantages of continuity of midwifery care, the Adelaide MGP care choice is not limited to low risk women. This service is providing care in a mixture of settings, including the hospital, the community or a woman's home. Initially the program was to meet the needs of 500 women in the first year, however this number has been doubled to meet the demand⁸⁷. Adelaide women also have the availability of 2 midwifery led birth centres and a community based primary midwifery service.

In March 2004 the Ryde Hospital rather than close, as recommended by the NSW Greater Metropolitan Taskforce (GMTT), began offering women caseload midwifery care. This change was achieved under the leadership of Prof. Sally Tracy, through a joint appointment between the University of Technology Sydney and North Sydney Area Health Service⁸⁸. Since then other NSW hospitals listed for closure by the GMTT prior to the last election have rallied to demand their own midwifery led options. Subsequently the NSW Minister of Health has announced that Belmont and Shellharbour hospitals⁸⁹ will soon join the Sunshine Hospital in Victoria in preparing to offer the option of caseload midwifery.

Meanwhile in WA women, families and midwives have no access to local examples of these options rather there is talk and experience of contraction of local medically based services without any discussion of replacements. Groups of midwives in both WA metropolitan and regional hospitals, some under threat of closure, have expressed their desire to undertake such options to MC WA and others, including their managements.

3.1) WA Caseload Birth Centres.

In their response to the Cohen review the Peel PR&MS Group proposed the establishment of a caseload midwifery-run birth centre at Murray Districts Hospital in Pinjarra. This is proffered to counter local escalating intervention and caesarean section rates and to remedy the loss of birthing choices since the closure of the Mandurah Birth Centre (MBC). Peel consumers have also demonstrated demand for the option of homebirth since 2002 when an accredited midwife began offering this service in the area⁹⁰.

Though the MBC was established using federal ABS funding, it was a shared-care model, rather than "a free and alternative" place of birth for local women. Unpublished Commonwealth funded independent evaluations of this and other ABS hospital based services, revealed many problems such as over servicing and conflicts of interests among local doctors, even amongst those recruited to these services⁹¹. Whilst the 1995 Legislative review and local GP divisions supported the opening of shared care options at the Swan Districts and Mandurah units, women remained ill-informed by many doctors of these birthing options, resulting in low attendance numbers and poor wide-spread knowledge of the possible advantages of this option. The Swan Districts birth centre closed due to staffing difficulties which overseas evidence shows could have been overcome by caseloading the midwives⁹² rather than rotating midwives in and out of this unit.

Though clients of the MBC had 100% confidence in the midwives and experienced positive outcomes, the birth centre service was discontinued rather than reformed when Peel Health Campus was privatised in 1998. The concerns of the PR&MS Group were confirmed when the West Australian published birth statistics⁹³, which revealed Peel women have the second highest elective caesarean section rate in Perth. This article also explored the general lack of

⁸⁷ Cornwall. C, 2004 "Midwifery Group Practice is born at WCH Adelaide." Australian Midwifery News Vol 4 No1, Feb.

⁸⁸ Tracy S. "Proposal for a primary health care model of maternity services at Ryde Hospital; The introduction of Ryde Midwifery Group Practice." Midwifery Research & Practice Development Unit Northern Sydney Health. December 2003.

⁸⁹ Letter from M Iemma to B O'Farrell (NSW Shadow Minister of Health) M04/1274, forwarded 20/7/04.

⁹⁰ Wattis, L. Community Midwife. Personal communication, 2004.

⁹¹ Thorogood C "Evaluation of the Mandurah Birth Centre" unpublished

⁹² Leyshon, L. (2004) "Integrating caseloads across a whole service: the Torbay model." MIDRIS Midwifery Digest vol 14, Supp1 Mar 2004 pp9 –11.

⁹³ Rasdien. P, "The Caesarean Debate" West Australian Newspaper 14th February 2004.

awareness or concern about the current escalating rates of this procedure and some of the risks of caesarean births for women.

Meanwhile despite supportive evidence and issues like informed consent raised in the 2001 Douglas inquiry⁹⁴, obstetric control of the FBC is still evident in 2004. For example options which are accepted and promoted interstate and overseas such as waterbirths are prohibited in the only WA birth centre. MCWA feels this service needs to be re-configured to operate as a woman-centred, midwifery led care unit, not under obstetric limitations.

Recommendation 3.

Maternity Coalition WA recommends the WA government provide funding to re-configure small WA maternity units, particularly those listed for closure by the Obstetric Services Review and Health Reform Committee reports, into midwifery led units or units with caseload birth centres.

4) Midwifery Co-ordination of WA Midwifery Services.

Consistent with the aforementioned documents, and concerns raised in the Australian Council of Safety & Quality in Health Care paper on 'Safe staffing, MCWA feels that the WA government needs to recognise the safety, primacy and efficacy of midwifery knowledge and skills in the care of healthy WA women. Positive discriminating action is needed to counter many of the entrenched inequities between Australian midwives and doctors such as *"workplace bullying and cultural attitudes associated with hierarchical decision-making structures, which can undermine effective teamwork and the delivery of optimal evidence based care"*⁹⁵.

Recommendation 4.

Maternity Coalition recommends that the WA government fund a Professorial Chair of Midwifery, jointly appointed by the Department of Health WA and WA Schools of Nursing and Midwifery to co-ordinate development of WA hospital based caseload options of care.

5) Consumer Consultation in WA Maternity Services.

WA government and DoH espousal of consumer consultation and consideration in the provision of health services are poorly supported by current and past experiences of WA maternity service clients. For example previous loss, plus current limited and restricted midwifery options with-in WA maternity services compare poorly to those in other states. MC WA has shown in this document that the processes and reports of the State-wide Obstetric Services and Health Reform Committee reviews are strong examples of WA government token consultation of consumers. This tokenism exacerbates the lack of choice in WA particularly when compared to increased service options and examples of more open statewide consumer consultation in other states like NSW⁹⁶ and promised local midwifery options across Victoria⁹⁷. To redress this and the other inequities raised in this document requires committed WA political leadership and facilitation toward true partnerships between all stakeholders for healthier WA communities.

Recommendation 5.

Maternity Coalition recommends that the establishment and management of all WA maternity service options involve meaningful consultation with local consumer groups.

6) Professional Midwifery Standards of Practice for WA Maternity Services.

The Australian College of Midwives has progressively developed a set of professional standards and codes of practice to guide Australian midwives in the ethical performance of their duties⁹⁸.

⁹⁴ Douglas, N. Robinson, J. Fahey, K. *"Inquiry into obstetric and gynaecological services at King Edward Memorial Hospital 1990 – 2000"* (November 2001) WA government printer, Perth, WA.

⁹⁵ Australian Council of Safety & Quality in Health Care.(ACSQHC), Consultation paper on Safe Staffing, December 2003.

⁹⁶ Minister of Health NSW News Release 6th August 2004 "Minister announces health Consultation dates".

⁹⁷ Department of Human Services Victoria, "Future directions for Victoria's Maternity Services"

www.health.vic.gov.au/maternitycare/pubs.htm

⁹⁸ ACMI "Code of Practice for Midwives", "Code of Ethics for Midwives", "Standards of Competency for Midwives", Australian College of Midwives Incorporated www.acmi.org.au.

The latest of these protocols⁹⁹ has been developed to give every current midwife in Australia an evidence-based set of guidelines to help with decision-making about if, when and how to consult with doctors when caring for women during pregnancy, birth and early weeks of mothering. They are based on abundant and referenced international research as well as Australian adaptation of similar guidelines from the Netherlands, New Zealand and Ontario, Canada. They are relevant to every setting in Australia where midwives work caring for women and their babies. Prof Tracy at the Midwifery Practice and Research Development Unit, Northern Sydney Area Health Service consulted midwives, obstetricians, paediatricians and consumers in the drafting of these guidelines. Thus these guidelines and the aforementioned protocols are appropriate standards to guide the practices within all WA caseload midwifery services.

Recommendation 6.

Maternity Coalition recommends that all WA midwifery options are established according to Australian College of Midwives Incorporated (ACMI) professional standards and codes including the ACMI National Midwifery Consultation and Referral Guidelines.

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Appendix A

Endorsements

Endorsements of “Implementing NMAP in WA” have been received by MC WA from the following groups (in alphabetical order);

- Australian College of Midwives Inc. (Western Australian Branch),
- Baby Friendly Hospital Initiative Western Australia State Committee
- Birth Choices South West WA Inc.,
- Birthplace Support Group Inc.,
- Birthrites, Healing after Caesarean Section.
- Community Midwifery WA
- Health Consumers’ Council of WA,
- Peel Pregnancy Resources & Midwifery Support Group Inc.