

RURAL MATERNITY SERVICES: INVESTING IN THE FUTURE

...good health and wellbeing in rural and remote Australia

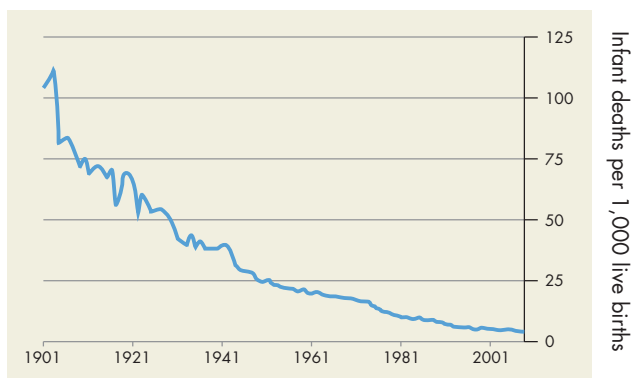
Small rural maternity units can provide safe birthing services; mothers and babies are placed at risk when these services are not available locally. Closing rural maternity services doesn't make economic sense for families, the health care system or regional development. It also reduces the opportunities for midwives and procedural doctors to train and work in the bush. This exacerbates the workforce shortages that often lead to these closures in the first place. Modest re-investment can reverse this downward spiral.



Every woman in Australia has the right to safe maternity services as close as possible to her own community. This includes antenatal, birthing and postnatal care.

The steep fall in infant mortality in the early 20th century was due mainly to the general introduction of ante- and post-natal care and the move to birthing managed by well-trained staff in a professional setting. In rural Australia this setting was often a small local hospital.

Infant mortality in Australia 1901-2001



ABS cat 1370.0, 2010

But in recent years, safety, cost, workforce and demographic issues have led to the closure of more than half Australia's small maternity units. In 1991 there were 325; in 2007 there were just 156.

Safety

Safety is everyone's priority, but there is more to safety than technology, throughput, specialisation and systemic

approaches. A metrocentric focus on these factors has too often led health authorities to assume that small rural maternity units are unsafe. However, research has demonstrated that they are at least as safe as larger city hospitals and that quality care can be provided in units with relatively few births when local expertise is supported by on-going professional education, good teamwork and back-up systems for mothers and babies who need special care.

A woman's concept of safe maternity care includes the safety that lies in locally accessible services, close family and friends and the support of familiar health professionals. If she has to be a long way from home she may be anxious about the costs of travel and accommodation, the father's time off work and difficulties in arranging childcare for older children. Research suggests that women will knowingly trade off some elements of clinical risk for physical and psycho-social safety.

Quality ante-natal care underpins good obstetric and lifetime health outcomes, but the closure of a birthing unit very often means local ante- and post-natal care disappear. Travel for these services is not subsidised by government schemes and can be expensive, especially in the many rural and remote places where there is no public transport. So, once again, country people miss out on services that others take for granted.

A 2010 survey of rural families for the NRHA and the Rural Doctors Association of Australia found only 12 per cent of the respondents felt they had good access to maternity services.

Stress in pregnancy can have a negative impact on both mother and baby. A 2011 study indicates that women who have to travel for more than one hour to access maternity

care are nearly eight times as likely to experience moderate or severe stress as mothers who have this care close to home.

Financial and travel difficulties and fear of a lonely transfer to a distant hospital for delivery leads some mothers to avoid accessing healthcare during pregnancy until birth is imminent. They and their babies may then have to face the additional hazards of travel in labour.

Cost

In the short term, health authorities may save money if they close small rural maternity units, but the cost is high to mothers and babies in terms of increased risk, to families in terms of direct and indirect costs, and to communities in terms of lost economic activity.

Closing the maternity unit is often the first step in downgrading and eventually closing a hospital. This can have negative impact on the region through loss of health services and employment – and a subsequent loss of population.

Larger hospitals in nearby towns must then handle increased intake. The extra pressure on their staff and facilities may actually increase risk. Several studies have suggested that costs related to poorer obstetric outcomes may rise as local access to relevant services falls.

Procedural GPs and midwives may leave their profession or move elsewhere if they lose the opportunity to practise locally. Without proceduralists to provide obstetric, anaesthetic and surgical services, the town's capacity to deal with acute and emergency cases is compromised.

Workforce

Shortage of procedural doctors and midwives can be a major barrier to maintaining small rural maternity services. The number of procedural GPs in rural areas (ie those with obstetrics) fell from 657 to 583 between 2004 and 2009. In the same period the number of rural women who gave birth rose from 83,000 to 88,000.

The prevalence of midwives decreases – but birth rate increases – with distance from the capital cities.

It will be some time before current strategies to increase the maternity care workforce produce significantly more new graduates, and there is no guarantee that enough of them will choose rural practice. So maternity units must concentrate on retaining the workforce they have and deploying it more effectively.

The relevant medical colleges and organisations, supported by a number of government initiatives, are working to recruit and retain more doctors to rural obstetric practice. In the bush, maternity care has always been team care, but adequate numbers of specialists, GPs and midwives are needed to provide it.

National registration and standardisation, changes to Medicare and some targeted programs are reinforcing the role of midwives at the same time as the professional bodies of all three branches of the team are working on practical ways to enhance collaborative models of care.

However, the recent spread of Direct Entry Midwifery (DEM) courses and separate registration requirements for nurses and midwives is creating a dilemma for small rural hospitals that have long employed nurses with midwifery qualifications for both general nursing and midwifery duties. Higher average rural fertility rates do not mean that more babies are born in all rural areas. The number of births has fallen in some places, due to demographic ageing and urban migration. In some hospitals the volume of births is insufficient to justify employing specialised DEMs who cannot also be rostered for general nursing duties.

New models of care will need to be devised to enable rural hospitals to better utilise the skills of the growing group of DEMs. Fortunately there is already much good work in progress around the country. For example, using DEMs in a caseload system where the midwife works when women require care rather than in a conventional shift schedule has been demonstrated to be cost effective, with midwives caring for more women in the same amount of time. Levels of job satisfaction are very high and the opportunity to work exclusively in their chosen profession is a compelling recruitment incentive for midwives.

Models of care and collaborative networks based on the appropriate use of all members of the team, professional satisfaction, reasonable working hours, reliable locum relief and subsidised professional development are crucial when it comes to attracting and keeping obstetricians, GPs and midwives working in the bush.

Times change

Many rural maternity units were established when transport and communication services were very different and their distribution may not be ideal today. Demographic change means that many communities have fewer people of reproductive age and no longer warrant local birthing services. However where the population profile is younger, communities need their maternity units to be re-instated or new ones established. Where this is not feasible, ante-and post-natal care should be provided locally, via regular outreach (for example) and adequately funded travel and accommodation arrangements put in place for birthing mothers.

Changes in the maternity services system should be based on transparent criteria. The primary consideration is always the safety of mother and baby, but the overall wellbeing of the community should be taken into account too. Research in train to establish an objective tool to measure maternity care needs in the diverse environments of rural Australia is an exciting prospect.

The Australian National Maternity Services Plan shows there are already programs and projects across the country that can help meet the significant challenges of safe local maternity care in non-metropolitan Australia. Rural advocates believe this Plan and the administrative structures set up under recent health reforms should give practical recognition to the right of rural women to local maternity services and to the need to provide appropriate services as an investment in regional sustainability.