We would like to reiterate our concern about the emphasis on risk within the discussion paper’s Clinical standards of care (Maternity). As we commented in our initial response to the Transforming Health discussion paper (attached here as Appendix 1 for reference), it is important to focus on both the assessment and management of risk and the avoidance of unnecessary intervention. The means to reducing maternal and neonatal mortality includes the reduction of unnecessary intervention and the appropriate use of technology as much as timely access to emergency care. Evidence now points to primary midwifery care for women of all risk as the optimal way to reduce adverse outcomes, with referral and transfer as required. To this end, we would also like to point out that the ongoing problem of eligible midwives’ access to insurance needs to be addressed as a matter of urgency.

Clinical standard of care 218 addresses the state’s high caesarean section rate and aims that all caesarean sections are performed according to the SA perinatal practice guidelines and that women considering a caesarean are informed of the risks. We would also like to see this standard expanded to include evidence based protocols on the appropriate use of other clinical interventions such as induction of labour, artificial rupture of membranes, electronic foetal monitoring, episiotomy and epidural use, with a view to reducing these intervention rates. We also propose dedicated, evidence based standards to support women’s choices in opting for a vaginal birth after a caesarean (VBAC) or vaginal breech birth. Collaborative clinics designated to these purposes have excellent outcomes and support women’s increased options within the safety of the maternity care system with streamlined transfer where required.

We believe that Clinical standard 219 should specify that midwives are the most appropriate care giver for all pregnant women: ‘All women need a midwife, some need a doctor too.’ As we showed in our first submission to the Transforming Health discussion paper, the evidence now shows that to achieve ‘Best care, first time, every time’ in the maternity sector, midwifery care continually provides better outcomes, with no increase in adverse outcomes. To this end, we believe that Clinical standard 220 should be expanded to ‘all women should have access to a known midwife’ in order to achieve these better outcomes for all South Australian women.

We are concerned about the inequity of access to midwifery models of care for South Australian women who are identified as having moderate or high risk factors during pregnancy and would like to see Clinical standard of care 233 expanded to recommend that women with complex pregnancies should also receive the support of a lead midwife, as all women will need midwifery care throughout pregnancy and birth, even if consulting obstetric and medical specialists.

Care needs to be taken with deciding on numbers for standard 221 & 238, as closing smaller rural and regional maternity services often does not work in women’s favour.
With respect to the 6 quality principles of the Transforming Health document, primary midwifery-led care speaks to all 6. SA Health is therefore in a position to make a real, positive and innovative difference to maternity care by increasing midwifery primary care located out of acute care services across South Australia.

Yours sincerely,

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On behalf of the South Australian branch of the Australian College of Midwives.
APPENDIX 1 – SUBMISSION TO DISCUSSION PAPER

The Australian College of Midwives (ACM) is the peak professional body representing midwifery in Australia. As an organisation, we are also affiliated with the International Confederation of Midwives (ICM). As such, we have close knowledge of current research and international trends in birthing practices, as well as first-hand experience of the needs of birthing women. We are pleased to be able to comment on the Transforming Health discussion paper proposed by SA Health, and applaud the broad vision that it entails. There are some observations about the Clinical standards of maternity care that we would like to address as follows.

There is an emphasis on risk in the discussion paper’s Clinical standards of care (Maternity). While it is important to have emergency measures in place, the midwifery philosophy and models of care that emphasise ‘keeping birth normal’ are known to reduce intervention rates\(^1\). There is also an emphasis on the use of better technology in medical services in the discussion paper, very suitable for medical services; however while timely access to emergency care is one aspect of reducing maternal and neonatal mortality, another aspect, increasingly front and centre as a focus of the global midwifery community, is reducing intervention rates and encouraging appropriate and evidence based use of technology.

To highlight this international focus, we provide two examples of how community midwifery works to positively influence maternal health—these countries both have higher CS and maternal and neonatal mortality rates and higher intervention rates—than Australia currently.

1) **United States: Regionalising care in freestanding birth centres**

Keynote speaker at the International Confederation of Midwives’ Congress (Prague 2014), Dr. Lisa Kane Low (US) described a case study where a community midwifery program that provided care to women in their environments (schools, soup kitchen and prisons) in a low socio-economic area was replaced by a centralised maternity centre. The new centre had better facilities, but resulted in more medical policies that decreased women’s access to the birth centre (eg no first births), and disengagement by the women. Ultimately, the number of women able to access the new site halved. This ‘template of technology’, where women are categorised according to medical risk protocols is a global challenge to normal birth. Dr. Low addressed the need for ‘midwifery where women work, live and play’ and cited a case in Honduras, where they achieved a decrease in maternal mortality by regionalising care in freestanding birth centres.

2) **Brazil: Opening birth centres, implementing midwifery led care, review of the labour environment and provision one-to-one support in labour.**

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Dr Maria do Como Leal, medical doctor and epidemiologist (Normal Birth Conference, UK 2013), reported on Brazil’s high obstetric intervention rate in birth; a 52% caesarean section rate and only 15% of births being facilitated by midwives, with 85% of births doctor attended, and in the private sector, non-labour CS is 300% higher. A 2011 federal program to reduce maternal and infant mortality called Rede Cegonha is implementing best practice in labour and birth care. This includes the opening of birth centres (alongside and in-hospital), implementing midwifery led care, providing ambiance/environment for birth, and provision of a birth ‘companion’ or one-to-one support in labour. Forty-two birth centres had been opened by 2013 and 280 birth centres are expected to be complete by 2015. This is an example of exemplary interdisciplinary collaboration by government, obstetricians and midwives working with current best evidence to implement best practice in maternity care.

Conversely, while other countries are increasing women’s access to community birth centres, Australia is closing down smaller maternity units. There is increasing concern in midwifery circles about the medicalisation, centralisation and fragmentation of maternity services, the increasing health inequities and costs in relation to benefits, and the failure of the current system to deliver the policy goals of healthy and socially equitable birth practices as outlined in the National Maternity Services Plan, 2011 (NMSP). There are flaws in the current method of funding maternity care within medically dominated fee-for-service structures and acute hospital budgets, which drives unnecessary clinical interventions, increased expenditure, short-term adverse health outcomes and the potential for future chronic disease.²

There is now clear evidence that continuity of midwifery care is associated with better outcomes for women, reduced use of routine interventions, and more efficient use of resources. Midwifery care is most effective when it is located in the community, and integrated into the health system with effective teamwork and referral mechanisms and sufficient resources³. We note on p. 16 of the discussion paper that ‘teams that work in the community can help people manage their conditions at home, with less disruption to their daily lives’. This comment is most pertinent to maternity care. As pregnancy is not an illness, but a normal, physiological life event⁴, it is a perfect example of something easily managed in the home unless there are complicating factors. In fact, this is in line with the NMSP Principle 1, having care located close to where the women live, and Principle 7, which refers to the health practitioner working to their full scope of practice (NMSP 10 Principles are re-stated as Appendix 1 for convenience). We are delighted to see you highlight nurse practitioners and extended care paramedics, who are ‘highly trained’ to provide care in the home (discussion paper p. 25) and would like to bring to your attention the International definition of a midwife (Appendix 2); you will note that for all midwives, scope of practice includes home and the community, throughout the continuum of the perinatal period. Midwives—all midwives, not only Medicare eligible midwives—are therefore an excellent resource to draw on when trying to relocate health services out of the acute care setting.

⁴ National Maternity Services Plan 2011, p 25.
We are also concerned about inequity of access to midwifery continuity of care models in South Australia (NMSP Principle 5). There is greater demand for MGP than the current models within the metropolitan hospitals can meet. We highly recommend that SA Health consider implementing more birthing centre and community midwifery options for women. While 3500 women a year in South Australia now get access to publicly funded health Midwifery Group Practices (MGPs), there are still 17 000 women who cannot. More publicly funded MGP models across the metropolitan and country areas would enable more women to access this best practice model of maternity care. These MGPs do not need to be built within hospitals, but only require good transfer options. Freestanding birth centres are used across the UK with excellent outcomes and a recent NSW study comparing freestanding birth units (FMU) and hospital labour wards found the women in the FMUs were significantly more likely to have a spontaneous vaginal birth, with no increased adverse effects on mother or baby.

There is considerable inequity in access to midwifery models of care for South Australian women who are identified as having moderate or high risk factors at booking and during pregnancy. MGPs involving women of ‘all risk’ have lower intervention and operative birth rates than their associated hospital labour wards. Women and their babies who are diagnosed with risk factors benefit from continuity of midwifery care integrated with collaborating medical and allied health services. This has been shown to result in a reduction in routine interventions that contribute to maternal and infant morbidity and create an unnecessary cost on the health system. The importance of lead midwifery care cannot be underestimated, even where specialist consultation is required. To this end, we recommend in relation to Clinical standard of care 233 that women with complex pregnancies should also receive the support of a lead midwife, as all women will need midwifery care throughout pregnancy and birth, even if consulting obstetric and medical specialists.

The ongoing problem of eligible midwives’ access to insurance, access agreements and collaboration needs to be addressed as a matter of urgency, and while the new Policy Directive is a move in the right direction, it unfortunately does not reflect the National legislation Clause 8 amendment that changed the collaborative agreement from being with a private obstetrician to a health facility. As the reason that this amendment was proposed was because obstetricians were declining to collaborate with midwives, we hope that having a policy based on outdated legislation does not impede the process. As shown in the examples on page one, sweeping reform can best be made when obstetricians and midwives can work together to implement best evidence and models of care. Additionally, the AMIC (Aboriginal maternal infant care) program needs to remain funded and available to all ATS1 women and their families to address the health challenges as

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outlined on p. 16 of the discussion paper and as set out in NMSP Principle 4. Indigenous women also benefit from MGP models and are another group that have limited access. Clinical standard of care 218 addresses the state’s high caesarean section rate and aims that all caesarean sections are performed according to the SA perinatal practice guidelines and that women considering a caesarean are informed of the risks. We support this proposal. We are eager to see a reduction in the rate of primary caesarean sections and would also like to see dedicated VBAC clinics in the community, within MGP models, to reduce the likelihood of subsequent caesarean sections. We would also like to see this standard included for other clinical interventions during labour, including induction of labour, episiotomy and epidural use, with a view to reducing intervention rates; where SA perinatal practice guidelines are lacking, the UK NICE guidelines—which are extensively researched, transparent, and peer-reviewed—could be referred to. A world class health system would include all clinical intervention during labour tailored to the need of the woman, performed according to evidenced based guidelines and provided after a discussion of benefits and risks of the intervention.

With respect to the 6 quality principles of the Transforming Health document, primary midwifery-led care speaks to all 6. SA Health is therefore in a position to make a real, positive and innovative difference to maternity care by increasing midwifery primary care located out of acute care services across South Australia.
Appendix 1

10 Underpinning principles, National Maternity Services Plan 2011

1 Maternity care places the woman at the centre of her own care. Such care is coordinated according to the woman’s needs, including her cultural, emotional, psychosocial and clinical needs, close to where she lives.

2 Maternity care enables all women and their families to make informed and timely choices in accordance with their individual needs. The planning and provision of maternity care is informed by women and their families.

3 Women and families in rural and remote Australia have improved and sustainable access to high-quality, safe, evidence-based maternity care that incorporates access to appropriate medical care when complications arise.

4 Governments and health services work to reduce the health inequalities faced by Aboriginal and Torres Strait Islander mothers and babies and other disadvantaged populations.

5 Maternity services offer continuity of care across the pregnancy and birthing continuum as a key element of quality maternity care for all women and their babies.

6 Maternity care will be provided for all women and their babies within a wellness paradigm, utilising primary health care principles while recognising the need to respond to emerging complications in an appropriate manner.

7 The potential of maternity health professionals is maximised to enable the full scope of their specific knowledge, skills and attributes to contribute to women’s maternity care.

8 Maternity services provide high-quality, safe, evidence-based maternity care within an expanded range of sustainable maternity care models.

9 Maternity services are staffed by an appropriately trained and qualified maternity workforce sufficient to sustain contemporary evidence-based maternity care.

10 Maternity services operate within a national system for monitoring performance and outcomes and guiding quality improvement.

Commonwealth of Australia, Department of Health, National Maternity Services Plan, 2011
Appendix 2

ICM International Definition of the Midwife
A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery.

Scope of Practice
The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care. A midwife may practise in any setting including the home, community, hospitals, clinics or health units.

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