Central Australian Aboriginal Congress Inc.
25 Gap Rd. PO Box 1604 Alice Springs NT 0871 PH (08) 8951 4400 FAX (08) 89530350

Central Australian Aboriginal Congress Submission to Improving Maternity Services in Australia Review

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1. What models for maternal services for rural and remote communities are working well?

The Central Australian Aboriginal Congress was founded in 1973 on Arrernte land in Alice Springs in the Northern Territory. A grass roots Aboriginal movement in collaboration with non-Aboriginal activists led to the 1967 referendum and subsequently, a new period in Aboriginal Affairs was established - the era of self-determination. Aboriginal community controlled health services developed within this context including Redfern in 1971 and Congress in 1973.

Congress provides over 50 000 episodes of care each year to a client population of around 8500 individuals of whom about 6700 are permanent residents and 1800 are visitors. The service is made up of eight branches including the Services Branch, the Alukura (birthing and women's health), Male health, the Social and Emotional Well Being Branch, the Education and Training Branch, Childcare, Administration, and Directorate. The Services Branch is the largest branch and employs fourteen Aboriginal Health Workers, eleven nurses and more than ten general practitioners. It operates the general clinic that includes a pharmacy and transport service. There are a range of public health programs that provide outreach services to high needs groups including an early childhood home visitation program, a chronic disease outreach program, a frail aged and disabled program, a school program and a male health program.

In 1973 when Congress was founded infant mortality rates in the Northern Territory were 120 per 1000 live births and the life expectancy of Aboriginal men was 52 years and 54 years for Aboriginal women. Today, infant mortality rates have declined to around 12 per 1000 live births and the life expectancy of Aboriginal men has increased to 59 years and 68 years for Aboriginal women. This represents a gain of 7 years for Aboriginal men and 14 years for Aboriginal women. The gap for Aboriginal women, 15 years, is now closing.

It cannot be said that there has been no improvement although there is still a long way to go.

Since 1995 the average birth weight of Aboriginal babies has been almost as good as that of non Aboriginal babies and in 2006 was still more than 3200gms with a low pre-term birth rate and a corresponding low rate of low birth weight infants at just over 6%. This is about the same as the low birth weight rate for non Aboriginal babies nationally and much better than the NT average of 13%.

The Northern Territory Aboriginal Health Planning Forum has developed a typology for comprehensive primary health care services as well as 19 core performance indicators. There are 4 domain areas in this model. Domain 1 is Clinical Services and social and preventative programs and includes 7 key focus areas:

1. Health Service Access.
2. Antenatal Care.
3. Immunisation.
4. Early Childhood.
5. Chronic Disease Management.
6. Well Person Screening.
7. Cervical Screening.

In this model Maternal and Child health is the core responsibility of all primary health care services and all services need to ensure that they employ at least one midwife and one nurse that is skilled in early childhood if these core services are going to be effectively delivered. This is possible now it simply requires a re-assessment of the priorities of the former role of Remote Area Nurses with the introduction of new GPs into remote communities which is occurring throughout the Northern Territory. The second domain is Management and Support services and this focuses on Human resource management and quality improvement. Domain 3 is linkages policy and advocacy and Domain 4 is community involvement and community development. The comprehensive primary health care model must include antenatal care, women's health and early childhood programs as core services and programs. It is the most appropriate infrastructure through which these programs can be delivered in remote Aboriginal communities.

Congress Alukura by the Grandmothers Law

The women's health and birthing service has been able to provide high quality, accessible antenatal care as part of a community controlled comprehensive primary health care service. The community controlled, culturally safe, participatory framework that developed the Alukura within a comprehensive primary health care service is what is needed and has achieved good outcomes. This model has also worked for the Townsville Aboriginal and Islander health service. It is preferable to promote the comprehensive primary health care model rather than vertical programs that are not community controlled.

In the early 1980's research and consultation with central Australian Aboriginal women was commissioned to address the need for appropriate health and birthing options. Several hundred women were consulted in 60 different Aboriginal communities with 11 language groups. Aboriginal Women discussed the need for traditional law & birthing practices, the experience of birthing & health care under 'white', predominantly male medical supervision and the fact that mainstream health services were failing Aboriginal women. The research and consultation culminated in an Aboriginal Women's "Birthrights" Conference in Alice Springs in 1984 which generated the philosophy, aims and objectives of the "Alukura Model" which is premised on "Women's health & birthing being Women's Business. Congress responded by establishing the Alukura, an Arrernte word meaning "women's camp" to provide antenatal & postnatal care and promote women's health checks

What then are the key features of the Alukura model that are working and could be applied more broadly within the health system?

Alukura incorporates a distinct philosophy and operates within a purpose built facility built on a special women's site for women only. Alukura employs 3 midwives who are primarily responsible for the antenatal care and there are about 120 live births in our health service area each year. The majority of these women attend Alukura for all or some of their antenatal care.

There are 3 key elements of Alukura's underlying philosophy. Firstly it acknowledges that Aboriginal peoples are distinct and viable cultural groups with our own cultural beliefs & practices, law & social needs. Secondly, it recognises that every woman has the right to participate fully in her pregnancy & childbirth care, and determine the environment and nature of such care. Finally, it recognises that every Aboriginal woman has the right in pregnancy and childbirth to maintain and use her own heritage, customs, language and institutions. Although Alukura has struggled to live up to the cultural imperative of this philosophy it has provided a space in which Aboriginal women feel culturally safe and can access high quality antenatal care. The success of this approach can be measured in the improvement that has occurred over time in the access of pregnant women to antenatal care in the first trimester. In 1986 to 1990 only 21% of pregnant women presented in the first trimester and this had increased to 33% for the period 1991-1995. In recent years the rate has been between 60 and 70%. This has probably contributed to the improvement in birth weights in Alice Springs.

Another successful aspect of the Alukura model in recent years was an agreement with Alice Springs Hospital that has enabled midwives employed by Alukura to attend to low risk women in labour and birth.

The Alukura model importantly places midwifery care within the realm of primary health care, treating pregnancy, birth and parenting as a normal life events, rather than a hospital/acute episode.

In addition to the necessary clinical aspects of maternity care, Aboriginal health services are extremely well placed to provide other equally important aspects of care:

1. culturally appropriate for Aboriginal women
2. continuity of care through named midwife and group practice models
3. community based primary health care approaching pregnancy and birth as a normal process

However they are rarely, if ever funded to provide full midwifery services and the focus tends to be on antenatal care only, thereby fragmenting maternity care. For too long midwifery services have been aligned with the hospital and medically dominated models rather than community based midwifery and primary health care approaches.

2. What are the key elements to applying such models more broadly?

There needs to be a sustainable way of funding community based midwifery and this could be achieved through needs based grant funding on a population basis. It is particularly true in remote areas that "Fee for Service" alone would be insufficient to fund and support a midwifery led model of care. The combination of grant funding and Fee for Service, known as mixed mode funding, would be the ideal as this allows a stable funding core for a known population with a dynamic element that is able to respond to unusual demands from the population or visitors.

For a true midwifery led model of care, which is known to improve outcomes for both mother and baby, midwives working in midwifery led models of care such as group practice or case loading need to be able to work independently and claim Medicare, such as the 16400 item, instead of relying on GP claims. They also need to be able to make direct referrals to obstetricians and other disciplines as required

It does not really matter which level of government provides the funding for midwifery led, salaried maternity services as long as there is a long term secure funding source. However, given that it is primarily the Commonwealth government that funds primary health care and States and Territories fund hospitals, it would protect the funding of community based midwifery better if it is provided by the Commonwealth leaving states and territories to fund the component of care provided within hospitals that cannot be provided by offering community based midwives visiting rights.

The Commonwealth should fund non-hospital community based midwifery practices in Aboriginal health services and other primary health care services through the establishment of a dedicated program such as the alternative birthing program that originally funded the Congress Alukura. Without this dedicated Commonwealth program Alukura would never have got going.

Midwifery group practices have been demonstrated to work in both hospital and community settings as long as there is adequate management and obstetric support. All women should have the option of community based birthing centres, separate to the hospital, known as 'stand alone birth centres'. This is what the Alukura has provided and it provides a valuable choice for women who are suitable for birthing outside of hospitals. However, many birth centres are often hospital based but separate to main delivery suite. Such birthing centres are still too closely allied to the hospital culture and are far less likely to reduce the high intervention rate compared with community based birthing centres with midwives employed from within the primary health care sector.

3. What aspects of the Australian context are driving high intervention rates?

There are a number of factors driving the high intervention rates:

1. Dominance of medical-Obstetric model for maternity services
2. Lack of continuity of care
3. Lack of empowerment of women in the birthing process through mechanism such as a clearly documented birth plan made in advance of any hospital admission
4. The culture of fear of litigation leading to the practice of defensive medicine and attempts to eliminate all risks rather than properly consider the costs of attempting to eliminate all risks
5. Shortage of midwives
6. Poor skill base of both midwives and obstetricians particularly to support normal labour and birth
7. Women's choice especially for women with full private health insurance where a planned caesarian section is chosen over a vaginal birth
8. Lack of an evidence based approach

There are a number of examples of Obstetric practices that are driving up the intervention rates. Firstly, not all obstetricians will allow a "trial of scar" so that once a woman has had the first caesarian she is doomed to all future births being through caesarian section. This approach is commonplace despite contrary evidence. Secondly, new study results have revealed that it is safe to allow breech babies to be born vaginally although not all obstetricians will do this – many still perform a caesarian section for all breech births. Finally, the length of time a woman is allowed to be overdue is another factor as this varies between obstetricians and can lead to women being artificially induced first and then a caesarian or straight to a caesarian depending on the obstetrician.

In Australia there is a strong tendency for midwives not to work across the full spectrum of care; antenatal, intrapartum and postnatal care. They then quickly become deskilled in certain aspects of midwifery care and not able to provide full care.

There are very limited options for out of hospital birth which are known to reduce caesarean section rates. There needs to be an increase in continuity of care through the implementation of midwifery group practice models or caseloading models accompanied

by increased opportunity to give birth other than in hospital, such as in birth centres or home birthing outside of the obstetrically dominated environment.

Even within hospitals – if they have good continuity of care (such as group practice models) this reduces intervention rates. Such practice works n hospital setting when fully supported by management and obstetric teams. An environment of midwifery led care, based primarily in the community setting with access to hospital when required, needs to be created to achieve such outcomes.

4. What actions are required to address this?

All obstetricians and midwives need to be made individually accountable in applying evidence based practice assessed through file auditing against agreed national guidelines and other relevant benchmarks.

More fundamentally, it is imperative that more low risk births are able to occur outside of hospitals and that community based midwives can attend to higher risk women in hospitals if the high rate of intervention is to be reduced. This is also consistent with the Primary Health Care approach which requires the promotion of the most cost effective options for services delivery using the lowest level of technology necessary. It also promotes models of service delivery that empower the community and women to take greater control over their maternity care. Midwifery care is endorsed by the World Health Organisation as the most appropriate care in normal births (WHO 1996)[1] Continuity of care by one midwife through pregnancy, birth and postnatally has been shown to be the best possible model and this can best offered by midwives working in the community setting as part of a comprehensive primary health care service.

Is out of hospital birthing a safe and cost effective option?

Home birthing is a very cost effective model of care with a total cost of about $1500 - $2500 per birth (AIMS 2001)[2].

The Cochrane review states that:

> There is not strong evidence to favor either home or hospital birth for selected low-risk pregnant women. In countries where it is possible to establish a home birth service backed up by a modern

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[1] World Health Organisation (WHO). 1990 *Care in Normal Births: a practical guide*. World Health Organisation, Geneva.

[2] Buckley S J, 2001. "Home Birth Fact Sheet", *Association for the Improvement in Maternity Services (AIMS) Australia Journal*, Sept 2001, Vol. 8 No 1, p 13

> hospital system, all low- risk women should be offered the possibility of considering a planned home birth…"(Olsen 1999)[3].

This is further confirmed by Enkin et al (2000: 251)[4]:

> Women who have no factors that contraindicate a home birth, and who prefer a planned, attended home birth with facilities for prompt transfer to hospital if necessary, should not be advised against this.

This evidence strongly suggests that it is very safe and even preferable for low risk women to be offered the chance to birth outside of hospitals. This will significantly reduce the intervention rates.

However, it is also critical that community based midwives are able to offer birthing for all of their women so that there is continuity of care for all women and not only low risk women. This requires community based midwives, operating as part of the primary health care sector, to have the right to care for women in public hospitals under the clinical supervision of the hospital obstetric and maternity team. This means that for higher risk women or women who choose to birth in hospital they can also maintain continuity with the midwife who has been providing their antenatal care and will provide their post natal care.

Congress Alukura is in the process of finalising a revised MOU with Alice Springs Hospital to allow this practice in Alice Springs. In this MOU the responsibility for clinical supervision will be clearly defined. In order for this approach to be applied more generally, the Australian Health Care Agreements need to acknowledge the need for community based midwives to be able to work within public hospitals to provide birthing services in accordance with agreed hospital maternity guidelines and protocols. This will mean that hospital based midwives will only be required to provide birthing services for women who do not have a community based midwife. There will need to be skeleton staff only within hospitals in this model.

5. What, if any, are key support services, including peer support which warrant national coverage?

Peer support is an important issue in Aboriginal communities where it is too often assumed family support is there and often it's not. There is a lot of evidence internationally that peer support programs compliment midwifery and can more fully support a woman to achieve success in early parenting. Culturally appropriate peer

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[3] Olsen O, Jewell MD. 1999. Home versus hospital birth (Cochrane Review). In: The Cochrane Library, issue 2, Oxford: Update Software

[4] Enkin *et al* 2000 *A Guide to Effective Care in Pregnancy and Childbirth* Third Edition Oxford University Press

support programs need to be developed with recurrent funding, Congress Alukura, for example, has employed a traditional grandmother as a key support person for women who choose to give birth at the Alukura.

Attention and funding needs to be given to developing peer support programs. Whilst professional care can go so far, peer support programs build on a community's capacity for families to support one another in a culturally suitable and sustainable manner. Peer support can work particularly well when support and infrastructure are provided by a service, enabling training, incentives and career development for peer supporters. Areas where peer support can be very successful include breastfeeding, teenage parenting and postnatal depression.

Likewise doula programs can provide women with support in pregnancy, labour and birth, and early parenting by women from their own cultural groups. Whilst women have a strong tradition of supporting each other in these times, the development of such programs enable more women to access such support, particularly in situations where social isolation exists or lack of family support. Peer support and doula programs could work extremely well for Aboriginal and Torres Strait Islander families, they would need to be properly funded and supported. A further positive outcome of such models can be the further development of peer supporters etc. to become midwives, thus addressing the current lack of Aboriginal and Torres Strait island midwives. The Inuit midwifery program provides an inspiring example of where this has been achieved, in an extremely remote area.[5]

Another increasingly important support service is the Patient Information and Recall System. Congress currently uses a system called Communicare which has the capacity to report on the key performance indicators contained in the current Alukura operational plan (see attachment 1). Examples of key performance indicators that we use are:

1. The proportion of pregnant women who present in the first trimester for antenatal care
2. The proportion of pregnant women who have had 4 or more antenatal visits during their pregnancy
3. The proportion of pregnant women who receive their antenatal care from one, two or more midwives
4. The Proportion of low birth weight, normal and high birth weight babies
5. The average birth weight
6. The proportion of pregnant women who smoke and drink and have had a brief intervention

These types of PIs are looked at in 3 monthly reviews of the attached Alukura operational plan and they allow us to evaluate the effectiveness of our maternity services. Alukura has been leading a research project funded through the Cooperative research Centre in Aboriginal health on the further development of quality antenatal care indicators.

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[5] http://www.naho.ca/inuit/midwifery/english/index.

6. What is required to ensure the quality and consistency of key support services?

Home visitation is now a key support service/along with universally accessible antenatal care. This needs to be made available at least to all first time mothers and probably for all other mothers.

Women from different cultural backgrounds need cultural brokerage and interpreter services. Transport services are often critical for ensuring that there is good access to care. Congress employs 4 drivers across the health service including a dedicated driver for Congress Alukura.

Gender specific services can be really important and the Alukura is a good example of such services being able to offer culturally secure accessible maternity services.

It is also important that pregnant women, especially those from lower socioeconomic backgrounds, can access free services. Financial barriers should not be allowed to reduce the access of any pregnant women to antenatal care services and unfortunately, many GPs do not bulk bill, especially in rural and remote areas. Salaried midwives working in grant funded community health services address this barrier.

7. How is current Commonwealth funding targeted?

Commonwealth funding is currently poorly targeted as antenatal care is delivered primarily through GPs. As there is a large maldistribution of GPs there is a maldistribution of access to antenatal care. This is not offset through a structured program to provide grant funding for antenatal care even in areas where GPs choose not to work. This is partly compensated by providing antenatal care in public hospitals but this is not a good model compared with the integration of maternity care into primary health care.

The solution to this is to move to a weighted population health funding model which provides grant funding for midwifery led care throughout Australia according to need. Weightings need to include remoteness, increased morbidity, language allowances and additional costings due to other factors recognised in the Commonwealth Grants Commission Community health weightings. This grant funding could be complemented through fee for service Medicare payments directly to midwives but this will not be sufficient on its own to build a sustainable service, especially in rural and remote areas.. It is vital that a service can offer competitive salaries to attract midwives without an overreliance of Fee for Service.

It is also important to accept that a woman's right to access quality antenatal care should not be dependent on her ability to take out private health care insurance. Private health insurance should only be a choice/not an essential part of core maternity services.

Regional agreements between public hospitals and midwifery led care services?

There needs to be Australia wide agreement between public hospitals and the primary health care sector to ensure effective and fully collaborative integrated maternity services.
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8. What are the key professional development needs for the maternity workforce?

In order to raise the standard for midwifery competency skills the ACMI provides an excellent framework through Midwifery Practice Review and this should be a regular component of all midwives work. It is also important to ensure that midwives are working across the whole episode of maternity care: antenatal, intrapartum and postnatal care.

Obstetricians and midwives need to follow evidence based practice and be accountable through reflective practice which should include file auditing and the reporting of key performance measures such as interventions rates.

In rural and remote regional centres there needs to be on site nursing and midwifery training, not just off site.

The option to undertake the 3 year direct entry midwifery course needs to be increased. This produces highly committed, specialist practitioners often with a vocational calling for midwifery. It also needs to be made compulsory for student midwives on all courses (1 year or 3 year as above) to have placements in community settings so this is seen as a core part of midwifery rather than a highly specialised area. Post-nurse midwifery training needs to be increased to18 months, in line with the UK practice, so they can become skilled and experienced midwives, with adequate time for mentoring and consolidation of practice including community based placements.

Midwife identified positions are also needed to reduce pressure on Remote Area Nurses and to ensure a high level of quality midwifery care in all remote communities. Midwives need to be based in communities across Australia, providing as much care as possible in community setting where women are with family, who provide her with support and cultural safety.

9. How will models of workforce support vary in rural and urban settings?

It is imperative that health professionals, including midwives, work within multidisciplinary teams as part of comprehensive primary health care as this provides an effective support base in the most remote areas and overcomes the social and professional isolation of solo and single discipline practice. In addition to this working as part of an effective multidisciplinary team helps to ensure higher quality of care and health professionals who know they are contributing to quality care are more likely to be satisfied with their work and be retained.

Community based midwifes all need to link up for professional development activities and peer support. This should also include midwives employed in local hospitals where the community based midwives are also working.

10. What are the potential areas for change to expand midwife-led care across antenatal, birthing and postnatal services?

As discussed earlier there needs to be a new needs based population funding model to enable salaried midwives to work as part of the primary health care sector. These midwives need to be able to birth low risk women at home or in community based birthing centres and higher risk women in local hospitals in accordance with agreed protocols and procedures. This will require a dedicated Commonwealth funding program which includes funding for the development of community based birthing centres

There also needs to be more opportunities for nurses and midwives to train in regional and remote centres as this is an effective means of attracting staff to these areas.

It is worth considering the need to establish a standard midwife : population ratio that could assist to ensure that the midwifery workforce is both equitably distributed and able to meet the antenatal, birthing and postnatal needs in all communities. For Aboriginal women, in the experience of Congress, this requires about 1 midwife for every 1500 people. Midwives working in Aboriginal health should have a case load of about 30 women rather than the mainstream figure of 40 because of the additional morbidity of Aboriginal women and the additional effort needed in cross cultural communication.

11. What are the existing effective models for midwife-led maternity services?

Group practice; a named midwife provides majority of care, labour and birth will be attended by named midwife when on call or a midwife from the group practice, of usually 4-6 midwives.

Case loading: a named midwife provides full care for each woman on her case load, on call 24/7

Both of these can be provided for both high and low risk women. High risk women are often denied true midwifery input and yet they seek to benefit from the emotional, support, cultural and more holistic approach of midwifery that can compliment obstetric care

Midwifery-led models of hospital care: where women are in the care of a midwife unless referral to an obstetrician is required.

12. What are the key workforce barriers to integrated models of care?

Relationships between disciplines of midwifery and obstetricians: true understanding and respect of each others area of expertise needs to be established. Australia is slow to adopt and does not have a strong history of midwifery-led care. Joint training / work shopping between the parties in different sites could improve working relations. There is a need to move away from the existing obstetrically dominated model. The true cost of such an approach in terms of outcomes for mothers and babies as well as the financial cost needs to be made explicit.

Relationships between community PHC settings and secondary hospital maternity unit the bulk of midwifery care should be moved out of the hospital. The hospital then needs to provide a base for community midwives to attend their clients in labour, birth etc., with minimal hospital base staff for support and daily running of the unit.. This requires a commitment to partnership working. Currently hospitals receive the funding and call the shots. The power base needs to be somewhat reversed. The hospital should provide a skeleton staff only.

13. What key infrastructure is needed?

Community based infrastructure is required including birthing centres and capital to expand the capacity of the primary health care sector to undertake the proposed increased role in maternity services. Improved understanding and support for midwifery-led care at high levels of the management of state and territory health departments is necessary to support these models.

14. Are there other issues the Review should consider?

There is a need to shift the focus from antenatal care to the whole spectrum of maternity care which includes birthing and post natal care. This will require a significant but very worthwhile shift from the current Australian focus.

Finally, in order to offer true informed choices in maternity care women need to be given appropriate information about the outcomes, risks and benefits of the different service models. This should be made available to the public through appropriate and accessible communication including a public campaign promoting the benefits of normal birth.