1. Abstract

Australia has a sound safety record in maternity care but there are concerns that women have a lack of choice with respect to types of care they can access, and that good maternal health outcomes are not consistent across the country and population groups. As part of its election commitments, the new federal government promised to reform maternity services. As one of its first steps it conducted a review of maternity services. This survey reports on the outcomes of the review report.

2. Purpose of health policy or idea

The Maternity Services Review was undertaken by the Australian Government's Chief Nurse and Midwifery Officer (a newly established position). The review is seen by the government as a key step in developing a national maternity services plan (Roxon 2009).

The aims of the Review were to:

- elicit a range of perspectives on maternity services in Australia
- identify key gaps in current arrangements
- determine what change is required
- determine what is needed for change to occur, and
- inform the priorities for national action, and the development of the Plan.

Main objectives

The Review has made numerous recommendations to the government for consideration. In summary these include (Department of Health and Ageing 2009):

- changes to improve choice and availability of a range of models of maternity care for Australian mothers by supporting an expanded role for midwives, including consideration of changes to Commonwealth funding
arrangements and support for professional indemnity insurance for midwives

• changes including an expanded role for midwives to take place within a strong framework of quality and safety

• new national cross-professional guidelines be developed to support collaborative multidisciplinary care in line with best practice, along with a system for advanced midwifery professional requirements

• improved national data collections and targeted research to support a safety and quality framework and allow the impact of changing models of care to be effectively monitored

• changes to support the expansion of collaborative models of care, improved access for rural and Indigenous mothers and reduced workforce pressures (particularly in rural and remote areas of Australia): consideration of targeted additional support to attract and retain a rural maternity workforce-including midwives, GP obstetricians, GP anaesthetists-and improved access to specialist obstetric care

• assisting Australian women in being better able to make decisions about their maternity care by accessing comprehensive reliable information: consideration of better access to a range of information on antenatal, birthing and postnatal care and options, including internet resources and the establishment of a single integrated pregnancy-related telephone support line.

Type of incentives

The most important recommendation, in terms of incentives, is related to expanding access to Medicare and the Pharmaceutical Benefit Scheme for midwives. Traditionally, the publicly funded Medicare program has subsidised services delivered by medical providers. However, in more recent years, the coverage of services has expanded to include, for example, allied health services such as psychology.

Medicare is a fee-for-service scheme, providing a fixed subsidy for different types of medical services and procedures delivered in the out-of-hospital setting as well as for private inpatients. Patients have been responsible for paying any charges levied by providers above the Medicare subsidy out of their own pockets which, in the case of obstetrician led care, can be large. In addition, there is the Medicare Safety Net which provides additional insurance for those who reach a certain amount of out-of-pocket costs for Medicare services delivered in the out-of-hospital sector. Whilst the Safety Net applies to all Medicare services, it has been particularly beneficial to those who use obstetric services. The Safety Net has significantly increased the amount of public funding flowing to private obstetrician led care - further entrenching this particular model of care.

Expanding Medicare to include midwives could potentially increase the amount of public funding to other models of care and make these a more viable option for women. However, there are a number potential downsides to expanding this fee-for-service program.

1. Firstly, midwives will presumable be able to charge fees higher than the Medicare rebate meaning that patients may face out-of-pocket costs for these services.

2. Secondly, government run public hospitals may reduce midwife run clinics and shift funding responsibilities to Medicare.

3. Thirdly, some midwives will presumable switch employment from public hospitals to private community based provision - potentially creating workforce pressures in the public hospital setting.

4. Fourthly, in a fee for service setting there is a greater potential for over-servicing and provider moral hazard.

These potential implications would have to be considered carefully before proceeding down the Medicare route.
3. Characteristics of this policy

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<tr>
<th>Degree of Innovation</th>
<th>traditional</th>
<th>innovative</th>
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<tbody>
<tr>
<td>Degree of Controversy</td>
<td>consensual</td>
<td>highly controversial</td>
</tr>
<tr>
<td>Structural or Systemic Impact</td>
<td>marginal</td>
<td>fundamental</td>
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<tr>
<td>Public Visibility</td>
<td>very low</td>
<td>very high</td>
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<tr>
<td>Transferability</td>
<td>strongly system-dependent</td>
<td>system-neutral</td>
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Many of the recommendations in the Review are broadly supported by women and providers. For example, there is unlikely to be much controversy around the need for a telephone support line or for improved data and research. However, some recommendations contained in the Review are controversial and have already received considerable media attention. Most visibly has been the recommendation to expand the role of midwives and fund midwife services through Medicare.

4. Political and economic background

Australia offers a range of maternity services to women. These include models of care led by an obstetrician, midwife (or group of midwives), or GP. However, the model chosen by women is often a function of income, locality and/or private health insurance status rather than clinical need.

Funding structures underline tensions between midwives and obstetricians

There are considerable tensions between midwives and obstetricians about what constitutes appropriate models of care. The tensions are underlined by the way Australia fund maternity services. Most obstetricians receive a substantial part of their income by providing services to wealthier sections of the community on a fee-for-services basis. Midwives, on the other hand, are most often salaried and employed by public hospitals and provide care to public patients.

Importantly, obstetrician services are eligible for reimbursement under Australia’s Medicare program - whereas midwife services generally are not. This has meant that doctors providing obstetric services have access to uncapped public funding whereas funding for services provided by midwives are by-and-large capped.

One of the key reasons for undertaking the review is that there has been a dramatic increase in the number of interventions over recent years as well as reported differences in maternal outcomes for some sections of the community.

Increasing numbers of caesarean sections

In the fifteen years to 2006 the percentage of births by caesarian section increased from around 17% to around 31%. This percentage is high compared to the OECD average of 22%. Furthermore, there is considerable variation in the caesarian section rate by locality. For example, in Tasmania the caesarian section rate is 27% and in Queensland it is 33%. At the same time women who go to private hospitals are almost 50% more likely to undergo caesarean section compared to those who go to public hospitals. In general, women who deliver their baby in private hospitals are more likely to have obstetrician led care whereas those who go to public hospitals are more likely to have midwife led care. These dramatic rates of increase have led to concerns that these interventions are not performed on the basis of clinical need and may therefore lead to unwarranted risks to mother and babies (see report New rules for caesarean sections (11) 2008).

Differences in maternal outcomes for different groups
Risk factors and health outcomes for rural and Indigenous women and babies are considerably poorer in Australia. Maternal mortality rates for Indigenous women are more than two and a half times as high. In addition, Indigenous women are more likely to have preterm babies, have a higher proportion of low birthweight babies than non-Indigenous women and have higher rates of neonatal deaths. Pregnant Indigenous women generally have poorer access to antenatal care and use fewer obstetric services than their non-Indigenous counterparts (Department of Health and Ageing 2008).

Furthermore, rural and remote women face higher rates of maternal deaths and experience significantly higher rates of neonatal deaths compared to those living in metropolitan areas. Outer regional Australia accounted for 10% of the population, 10% of births and 16% of maternal deaths. Remote and very remote areas account for 3% of the population, 3% of births and 7% of the deaths. Rural women also have poorer access to maternity care arising from the reduced availability of rural maternity units, and GPs and obstetricians (Department of Health and Ageing 2008).

5. Purpose and process analysis

**Origins of health policy idea**

The call to widen the role of midwives and provide women with greater choice of care has been persistent over the last two decades. Earlier calls to allow midwife services to be eligible for Medicare benefits have been rejected - due in no small part - by resistance from medical provider groups.

The current call for reforms follows the adoption of a commitment to reform maternity services as part of the Australian Labor Party platform, subsequent election commitments and the election of a federal Labor government in November 2007.

In undertaking the review, the government received over 900 submissions from individuals and organisations. It heard that whilst Australia’s dominant models of maternity care involve a conventional medical model in either a public or private hospital setting there is overwhelming demand for other types of models such as those delivered in birthing centres. The review highlighted a number of local programs that provides good examples of other potential models including ones where women are cared for by a small group of midwives in a stand alone centre but with the possibility of referral to a nearby hospital.

**Initiators of idea/main actors**

- Government
- Providers
- Civil Society

**Stakeholder positions**

In conducting the Maternity Services Review, over 900 submissions by various stakeholders were received. There have been persistent calls from numerous bodies to expand the role of midwives and provide additional funding for models of care to give women greater access and choice.

Midwives are currently restricted in the types of care they can provide because their services are generally not insurable under the Medicare program, they can not order tests, can not prescribe drugs and cannot access affordable indemnity insurance. At the same time obstetricians and medical provider groups have cautioned against
independent midwife practices. For example, the president of the Australian Medical Association stated that she feared “the introduction of a system where women are pressured into having a 'natural birth' that puts them and their baby at risk. Too often in other countries, including New Zealand, the midwife model means obstetricians are only called in when the 'natural birth' has become a medical emergency” (Capolingua 2009).

**Actors and positions**

Description of actors and their positions

**Government**

Minister for Health and Ageing

very supportive

strongly opposed

**Providers**

Doctor groups

very supportive

strongly opposed

Nurses and midwives

very supportive

strongly opposed

**Civil Society**

Patients and patient organisations

very supportive

strongly opposed

**Influences in policy making and legislation**

Not applicable

**Legislative outcome**

**Actors and influence**

Description of actors and their influence

**Government**

Minister for Health and Ageing

very strong

none

**Providers**

Doctor groups

very strong

none

Nurses and midwives

very strong

none

**Civil Society**

Patients and patient organisations

very strong

none

**Positions and Influences at a glance**

**Adoption and implementation**

The Government has made a commitment to consider the recommendations in the review as part of its development of a national maternity services plan.

**Monitoring and evaluation**

Not applicable

**Results of evaluation**

Not applicable
6. Expected outcome

The Review thus far has only made recommendations and it is not yet clear which, if any, of these it will adopt and turn into policy.

The dominant models of maternity care are an artefact of Australia's funding system and do not encourage optimum care or risk management strategies. The current system has encouraged high levels of interventions and allocation of highly specialised medical care to a large number of women with low levels of risk. In this way, Australia may have a good record in maternal health but it is also likely that this system has contributed to inefficiencies, inequities and dissatisfaction.

The current recommendation to expand Medicare eligibility to midwife services may boost the number and types of models of care available to women but as reported above there are a number potential risks as well (see section 2 on 'incentives' in this survey). The proposals here are similar to the reforms undergone in the area of psychology. In 2005, the government expanded Medicare to cover psychology services (also see HPM 8/2006 and HPM 9/2007). This has increased the amount of funding going towards mental health but has also had a number of other consequences. With these reforms more patients may be facing higher out-of-pocket costs for psychology services. One explanation for this is that more psychologists are practicing in private practice and fewer are providing services in the public, 'free of charge', setting. This may cause a redistribution of services from poorer sections of the community who can not afford the out-of-pocket costs to wealthier sections of the community. The potential is there for this to also occur in maternity services.

The potential impact of the policy can not be assessed at this time because the Government is yet to make a final decision on the recommendations it will implement.
7. References

Sources of Information


Author/s and/or contributors to this survey

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