



Rural Maternity Services.... We can do it differently!! The Why and the How The costs and the evidence

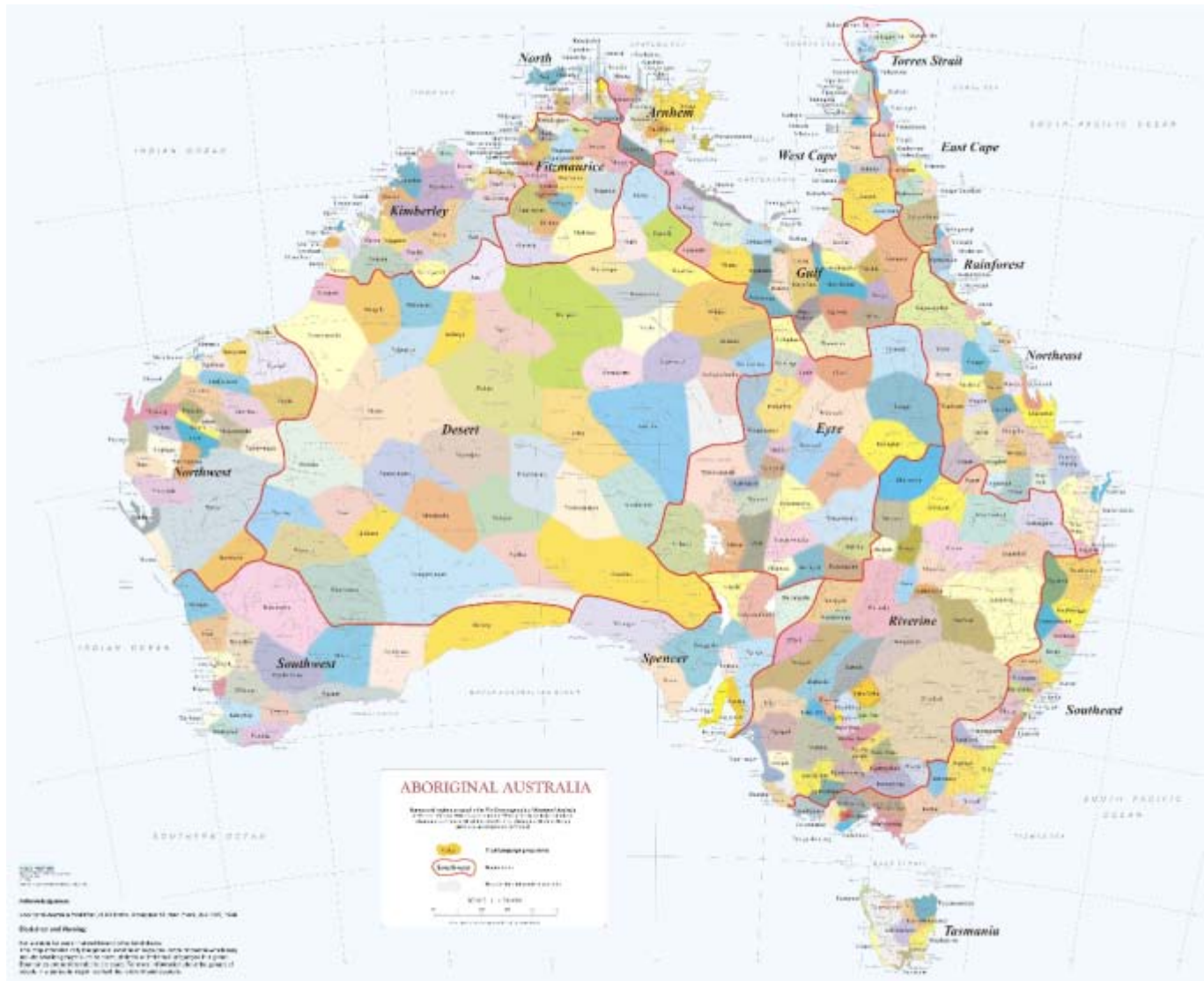
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Permission has been granted for all photos

Acknowledgement to Country



Why?

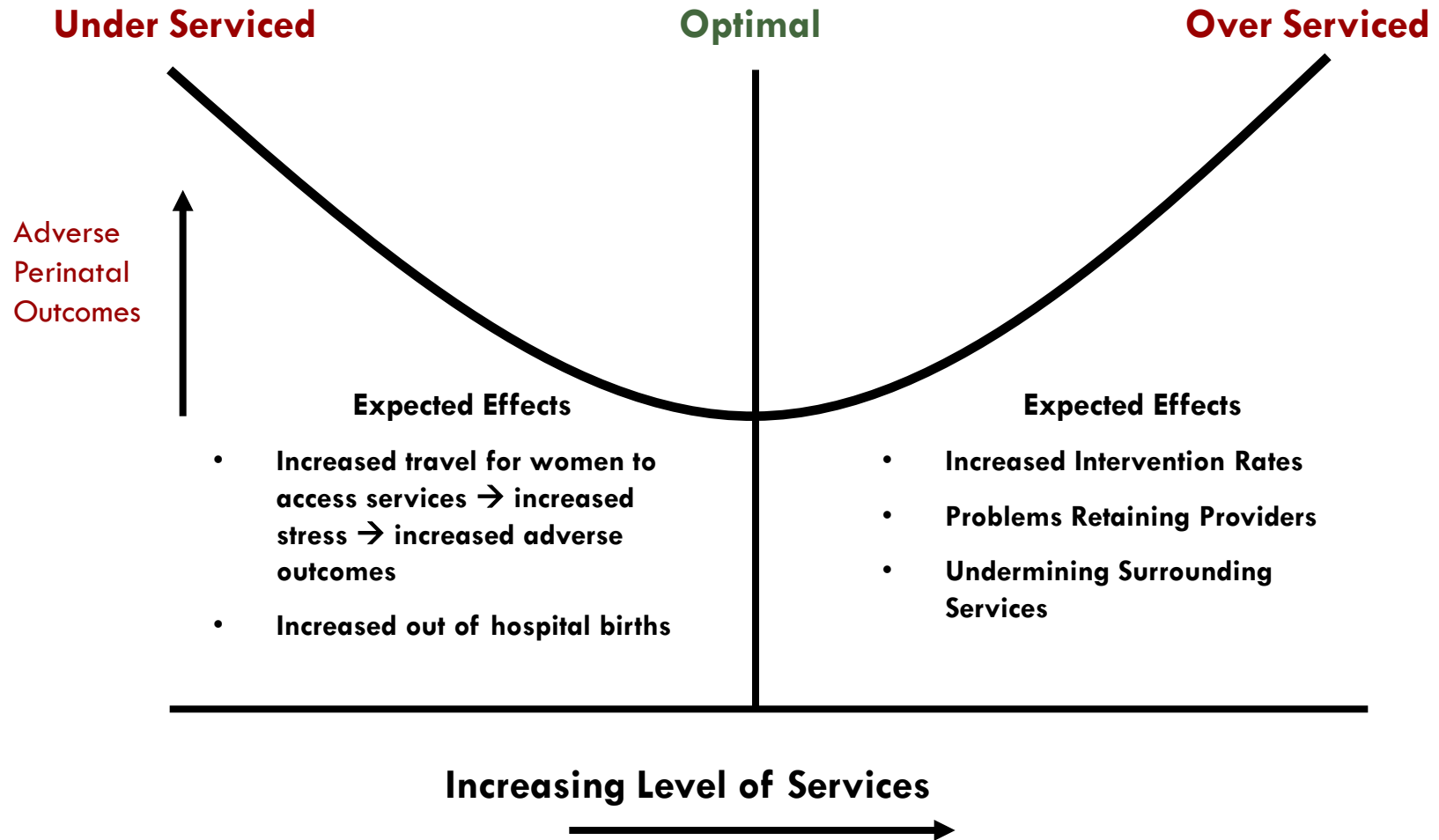
Maternity Services Review, 2009

- It is vital that approaches to change are **evidence-based** and take full account of **consumer preferences**
- Priority areas include
 - R & R
 - Aboriginal and Torres Strait Islander women

Where birthing women live

	Aboriginal and Torres Strait Islander Women	Non-Indigenous Australians
Cities	27%	71%
Inner regional	19%	18%
Outer regional	26%	9%
Remote	29%	2%

Why... Level of maternity services and population need

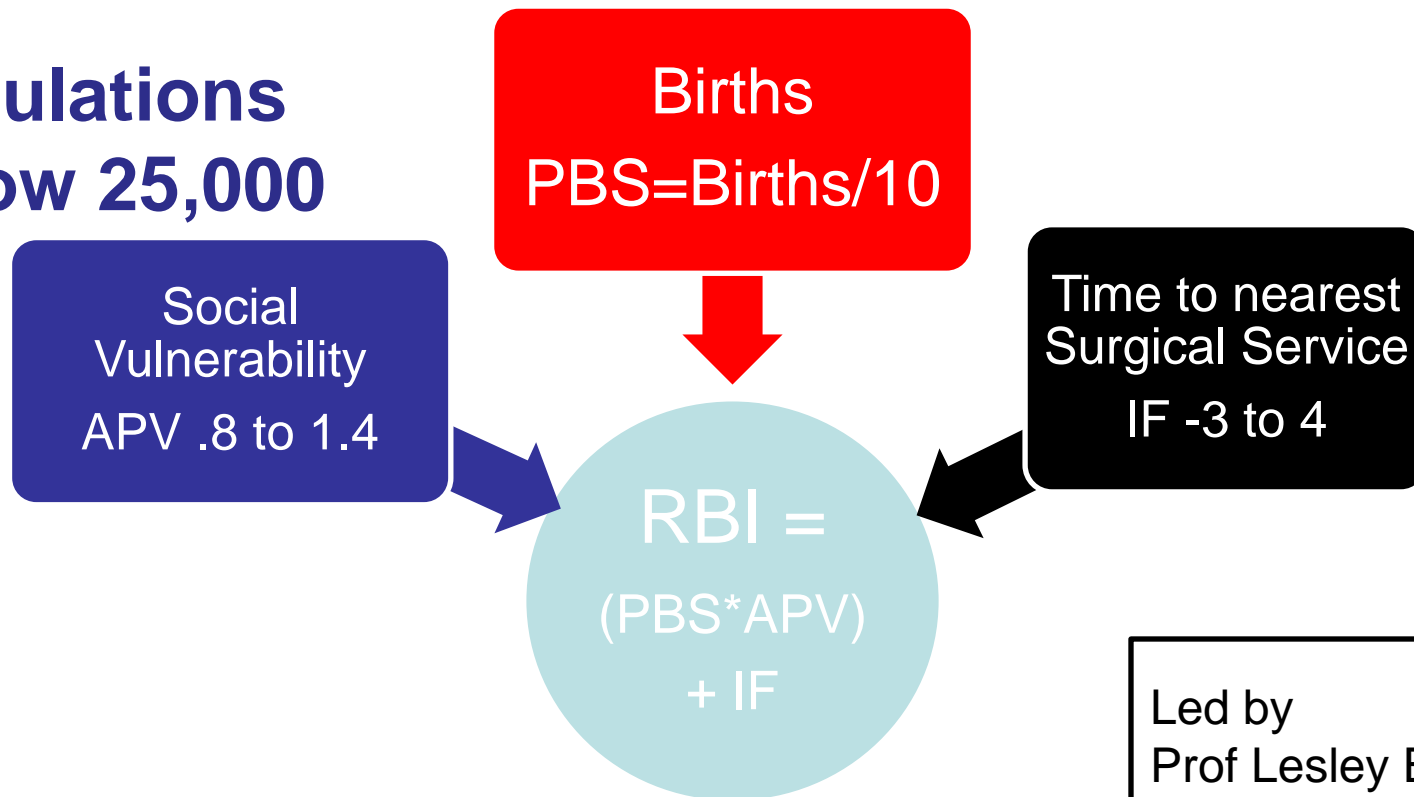




What is the ARBI?

Australian Rural Birthing Index based on the Canadian Model and being tested

**For
populations
below 25,000**



NZ – Evidence on primary units

- 51/58 units in rural or remote settings
 - 31 are > 1 hour from tertiary services
 - Weather a problem – services continue
 - 23% of Maori women birth in primary units
- 39,667 births- 16,453 low risk women (41.47%)
 - Homebirth: planned 9.36% actual 83%
 - Primary maternity unit: 16.25% actual 90%
 - Secondary/tertiary: planned 74.36% actual 99%
- Hunter, M., et al., Do low risk women actually birth in their planned place of birth and does ethnicity influence women's choices of birthplace? NZCOM Journal, 2011. 44: p. 5-11.

Netherlands - evidence travel time to hospital

- Population cohort 2000 – 2006
- 751,926 singleton term hospital births
 - +ve relationship b/n longer travel time (>20 mins) &
 - total mortality (OR 1.17, 95% CI 1.002–1.36)
 - neonatal mortality in 24 hrs (OR 1.51, 95% CI 1.13–2.02)
 - adverse outcomes (OR 1.27, 95% CI 1.17–1.38)
- **We need services close to home**

Ravelli A, Jager K, de Groot M, Erwich J, Rijninks-van Driel G, Tromp M, Eskes M, Abu-Hanna A, Mol B. Travel time from home to hospital and adverse perinatal outcomes in women at term in the Netherlands. BJOG 2010

The Evidence – UK – place of birth

BMJ

BMJ 2011;343:d7400 doi: 10.1136/bmj.d7400 (Published 24 November 2011)

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64,000 'low risk' births in 4 settings (2008-2010)

Free standing units (Level 11)

Safe for mother and baby

Benefits for the mother

RESEARCH

Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study

 OPEN ACCESS

Birthplace in England Collaborative Group

Changing the way midwives work

– Cochrane review

- 11 RCTs; n=12,276 women
- Reduced: antenatal hospitalisation, miscarriage, epidurals, episiotomy, instrumental births, NICU admission
- Increased: known midwife in labour, spontaneous vaginal births, feelings of control during labour and birth and breastfeeding initiation

– COSMOS – Low Risk

- Reduced CS

– M@NGO - All risk

- Reduced: Inductions, elect CS, PPH, LOS, Cost
- Clinically significant – reduction in CS,
- Increased Breastfeeding 6 weeks & 6 months

The evidence..... The costs

- Low Risk MGPs
 - Ryde Freestanding level 2 (sometimes 3)
 - MGP cost saving **\$927** per woman
 - Camden
 - Cost saving of **\$418** per woman
 - Gold Coast MGP
 - Cost savings per mother infant pair **\$825**
- High Risk MGPs
 - Darwin Remote Aboriginal model
 - Cost savings mother infant **\$703** (↓ Acuity in labour, CS & LOS infant)
 - M@NGO – Sydney /Brisbane
 - Cost savings per woman **\$567**

Why?

Midwifery care

Birth as close to home and family as possible

Culture of confidence in normal birth

Risk in perspective

Healthy women, babies

Cascade of Normal

Spontaneous labour

Intact perineum

Pain as part of childbirth

Spontaneous birth

Vicki Van Wagner, 2009

How ?



- Its not business as usual
 - Eg. BMid workforce
 - Eligible midwives in private models
- We must not try and reopen service in the same way we did in the past
- Different models – women centred not professional or industry centred

How ? UK case studies

- Positive organisational culture
- Learning climate
- Commitment to audit and review
- Positive and respectful relationships
- Resilience depends on flexibility and the strength of the structure
- The hub and spoke model - support to freestanding units

National Maternity Services Plan

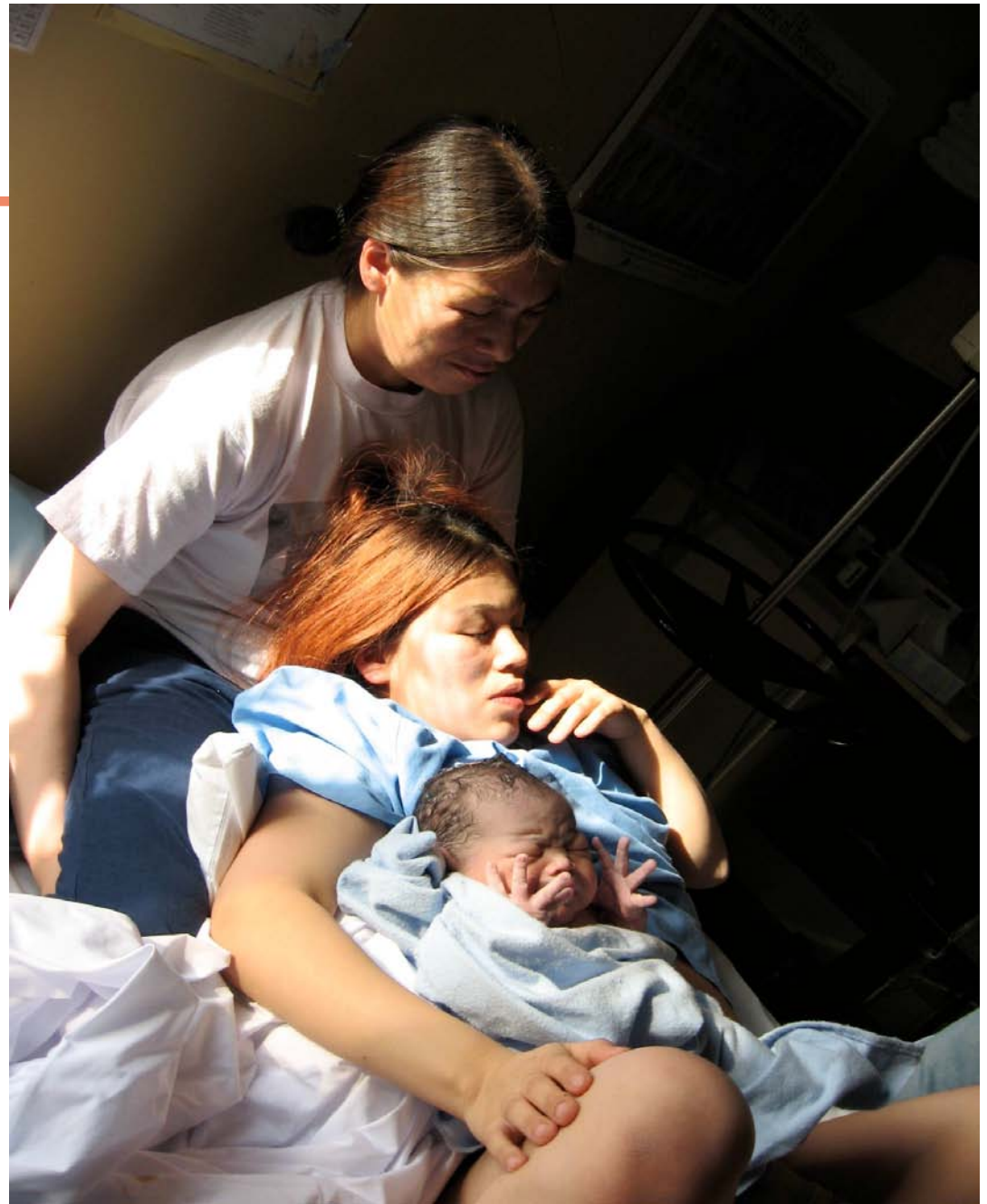
- Released 2011: Birthing on country-2.2.3

The initial year	The middle years	The later years	Signs of success
<p>2.2.3 AHMAC undertakes research on international evidence-based examples of birthing on country programs.</p>	<p>Australian governments develop a framework, including an evaluation framework, for birthing on country programs.</p> <p>Australian governments develop a pilot for a birthing on country program which includes a consultative selection process with Aboriginal and Torres Strait Islander communities and local maternity care professionals to identify initial birthing on country sites.</p>	<p>Australian Governments establish birthing on country programs.</p> 	<p>Birthing on country programs for Aboriginal and Torres Strait Islander mothers are established.</p> 

Why?

“to bring birth
back to the communities
is to bring back life . . .”

Puvurnituq elder 1988



Why? Bringing birth back:

- Builds capacity
- Restores skills and pride
- Inter-generational support and learning
- Promotes healthy behaviours
- Supports self determination
- Integration of traditional and western medicine



Birthing on Country

Maternity Services Inter Jurisdictional Committee

- Lit review
- Workshop (Alice 2012)
- National reform
- Exemplar sites
 - Urban, rural, remote, very remote
- Next...
 - Steering committee
 - EOI for sites



Birthing on Country

Maternity Service Delivery Models

A review of literature

An Evidence Check Rapid Review

commissioned by the

Maternity Services Inter Jurisdictional Committee

and funded by the

Australian Health Ministers' Advisory Council

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How... Darwin System Redesign –5Cs

- Working in partnership – better outcomes for women from remote - and cheaper!
- Town based MGP with Aboriginal workers and elder woman + designated midwives in remote communities
- Communication, Coordination, Collaboration Continuity, Choice
- *“Loved by stakeholders and its saved money”*
- *“I think it’s made us think differently, as service providers ... it’s just lifted the game”*

How ?

Health systems will not naturally gravitate towards equity - **unprecedented leadership** is needed.

Dr Margaret Chan, WHO Director-General, 2008

Thank you!!



**Birthing
Services
Ahead**

