Australian Health Ministers' Conference

# National Maternity Services Plan

2010

**National Maternity Services Plan**

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# Endorsement by Health Ministers

**National Maternity Services Plan**

The Australian National Maternity Services Plan sets out a five year vision for maternity care in Australia.

*Five Year Vision*

*Maternity care will be woman centred, reflecting the needs of each woman within a safe and sustainable quality system. All Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live. Provision of such maternity care will contribute to closing the gap between the health outcomes of Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Appropriately trained and qualified maternity health professionals will be available to provide continuous maternity care to all women.*

The Australian National Maternity Services Plan is a product of Australian governments working together to develop a consistent, strategic framework to guide the realisation of this vision.

In putting together the Plan, Australian governments have been mindful of maintaining Australia's high standard of safety and quality in maternity care, while seeking to improve access to services and choice in models of care. Key considerations also include increasing and supporting the maternity workforce, strengthening infrastructure, as well as building the evidence-base on what works well in Australia.

Particular attention is given in the Plan to meeting the needs of women and their families living in rural and remote areas; the need to improve birth outcomes for Aboriginal and Torres Strait Islander people; and the special requirements of women who are vulnerable due to medical or other risk factors.

Significant consultation with key medical professionals and midwifery stakeholder groups occurred during the Plan's development and the time, effort and advice of all involved is acknowledged and appreciated.

Through the Plan, Australian governments have committed to a range of activities. Some of these activities continue or build on existing programs, while some are aimed at providing a better basis for future service delivery such as the development and adoption of planning tools, and agreement to report against national maternity indicators.

The Australian National Maternity Services Plan was endorsed by the Australian Health Ministers' Conference (AHMC) on 12 November 2010. Australian governments will continue to report to AHMC on progress against the Plan and benefits delivered to Australian women and their families over the coming five years.

Hon Dr Kim Hames MLA
Chair
Australian Health Ministers' Conference

# Acronyms and abbreviations

| | |
|---|---|
| ACSQHC | Australian Commission on Safety and Quality in Health Care |
| AHMAC | Australian Health Ministers' Advisory Council |
| AHMC | Australian Health Ministers' Conference |
| CALD | culturally and linguistically diverse |
| COAG | Council of Australian Governments |
| GP | general practitioner |
| HPPPC | Health Policy Priorities Principal Committee |
| HWA | Health Workforce Australia |
| MBS | Medicare Benefits Schedule |
| MSIJC | Maternity Services Inter-Jurisdictional Committee |
| MSOAP | Medical Specialist Outreach Assistance Program |
| NPA | National Performance Authority |
| OECD | Organisation for Economic Co-operation and Development |
| PBS | Pharmaceutical Benefits Scheme |
| the Plan | National Maternity Services Plan |
| UK | United Kingdom |

# Contents

## Figures



## Tables

# Introduction

## The National Maternity Services Plan

Maternity care in Australia is among the safest in the world, with low maternal and perinatal mortality rates compared with other nations in the Organisation for Economic Co-operation and Development (OECD).

However, some sectors of the population, including Aboriginal and Torres Strait Islander people and rural and remote communities, experience considerable health inequalities and social disadvantage, which are compounded by limited provision of quality maternity care and can lead to less favourable outcomes for these mothers and babies. Many Australian women also experience restricted birthing choices, despite the wide range of maternity care models practised in Australia.

The National Maternity Services Plan (the Plan) recognises the importance of maternity services within the health system and provides a strategic national framework to guide policy and program development across Australia over the next five years.

Against a background of general review and reform of national health care services, all jurisdictions have shown their commitment to providing high-quality, woman-focused maternity care within available resources. The Plan builds on this work to reflect a joint understanding and commitment on ways to develop and improve maternity services in Australia, within the context of wide-ranging changes in the healthcare landscape.

The Plan focuses on primary maternity services during the antenatal, intrapartum and six-week postnatal periods for women and babies. While recognising the importance of linkages to a range of specialist services, it does not specifically address these specialist services.

## Background to the Plan

A range of inquiries and reviews by the Australian Government have informed maternity services reform and initiatives, including:

- *Options for Effective Care in Childbirth*[1]
- *Review of Services Offered by Midwives*[2]
- *Rocking the Cradle: A Report into Childbirth Procedures*[3]
- *Improving Maternity Services in Australia: The Report of the Maternity Services Review*[4]

These reviews involved extensive consultation with stakeholders. The most recent review, the National Maternity Services Review, canvassed a wide range of issues relevant to maternity services, including antenatal services, birthing options, postnatal services up to six weeks after birth, and peer and social support for women in the perinatal period. The consultation process consisted of stakeholder submissions and roundtable forums.

The Maternity Services Review concluded in February 2009 with the release of *Improving Maternity Services in Australia: The Report of the Maternity Services Review*.[4] This report made 18 recommendations in the key areas of:

- safety and quality
- access to a range of models of care
- inequality of outcomes and access
- information and support for women and their families
- the maternity workforce
- financing arrangements

The review identified improved choices and information about maternity care for pregnant women as a priority, while maintaining the existing high standards of safety and quality. Support for a collaborative maternity workforce was also highlighted, with a particular emphasis on maximising the capacity of appropriately skilled midwives in the provision of maternity care. Access issues for rural and remote women, and Aboriginal and Torres Strait Islander women, were also identified as priority areas for improvement in Australian maternity services.

## Development of the Plan

In September 2009, the Australian Health Ministers' Conference (AHMC) agreed to progress the Plan as a priority. The Australian Health Ministers' Advisory Council (AHMAC) delegated responsibility for the Plan's development to their Health Policy Priorities Principal Committee (HPPPC) for strategic direction.

The HPPPC commissioned Campbell Research and Consulting Pty Ltd to develop the Plan. Their brief included an engagement strategy with all jurisdictions, as well as consultations with key stakeholders, which took place between January and April 2010.

The Plan has three parts:

1. Maternity care in Australia: including details of the current services and maternity outcomes in Australia.
2. The National Maternity Services Plan: including the principles underpinning the Plan and detailed actions against the priorities of the Plan.
3. Implementation of the Plan: including responsibilities, implementation strategies and the first year implementation plan.

Details of recent AHMAC projects aimed at improving maternity care in Australia are provided in Appendix A. Details of other Australian Government and state and territory initiatives, including the priorities of the Plan they address, are provided in Appendixes B and C.

## Context for the Plan within the changing healthcare landscape

The Maternity Services Plan has been developed within the context of broader changes to Australia's health and hospital systems. On 13 February 2011 all Australian Governments signed a Heads of Agreement on National Health Reform and committed to signing a full National Health Reform Agreement by 1 July 2011. Building on elements of the April 2010 National Health and Hospitals Network Agreement, the Heads of Agreement sets out the shared intention of the Commonwealth, state and territory Governments to work in partnership to improve health outcomes for all Australians and to ensure the future sustainability of the Australian health care system.

Under the Heads of Agreement state and territory governments are system managers for public hospital services and take the lead role in public health, while the Commonwealth has a lead role in delivering primary health care reform and will take full funding, policy, management and delivery responsibility for a national aged care system.

The Commonwealth and state and territory governments will work together on system-wide policy and state-wide planning for GP and primary health care services, because it impacts on the efficient delivery of hospital services and other state funded services, and because of the need for effective integration across Commonwealth and state funded health care services.

The reforms will change the way Australian hospitals and health care services are run. They will deliver better care to Australians by streamlining health care across the sectors of the health system, and by improving the quality of patient care through high performance standards.

### Five year vision

Maternity care will be woman-centred, reflecting the needs of each woman within a safe and sustainable quality system. All Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live. Provision of such maternity care will contribute to closing the gap between the health outcomes of Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Appropriately trained and qualified maternity health professionals will be available to provide continuous maternity care to all women.

# Part 1
## Maternity care in Australia

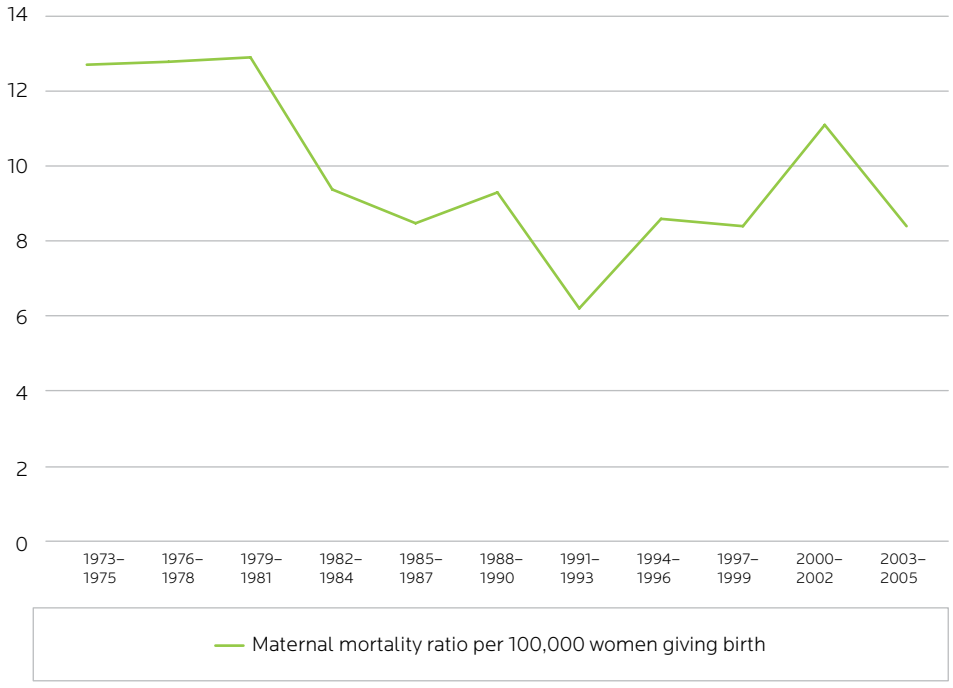
# The current environment

Australia has made significant gains in improving the safety of pregnancy and childbirth over the past century. It is now one of the safest countries in the world in which to give birth or to be born. However, this is not the case for Aboriginal and Torres Strait Islander people.

## Maternal and perinatal outcomes

Australian women have experienced substantial decreases in maternal mortality rates over the past century. The rate stabilised in the 1980s to approximately 10 deaths per 100,000 live births.[4]

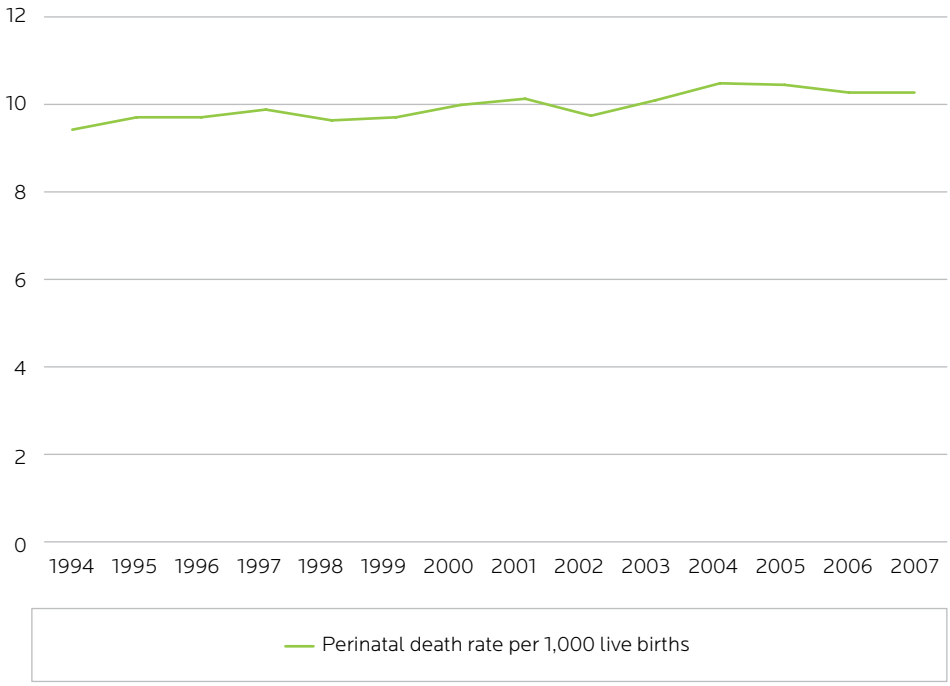
**Figure 1** Maternal mortality rate in Australia (1973–75 to 2003–05)




Source: AIHW 2008, Maternal deaths in Australia 2003–05[6]

Australia's perinatal mortality rates have declined from 21.7 perinatal deaths per 1,000 births in 1973[7] to 10.3 perinatal deaths per 1,000 births in 2007[8 9] — a decline of 53%.

**Figure 2** Perinatal mortality rate in Australia (1994–2007)




Source: AIHW Australia's mothers and babies 1994 to 2007 (multiple)[10-19]

Compared to other OECD nations, Australia's maternal and perinatal mortality rates remain relatively low. Nevertheless, valid and reliable comparisons between OECD nations may be constrained by variations in definitions, such as the gestational age and weight thresholds of infants.

## Aboriginal and Torres Strait Islander outcomes

The exception to these positive outcomes are those for Aboriginal and Torres Strait Islander women, who continue to experience substantially poorer maternal and perinatal outcomes — characterised by higher rates of death, preterm birth and a higher proportion of low birthweight babies[9 13-19] — compared with their non-Indigenous counterparts. In 2007, 1.3% of Aboriginal and Torres Strait Islander mothers experienced perinatal death, compared with 0.7% of non-Aboriginal and non-Torres Strait Islander mothers.

Numerous initiatives designed to provide culturally competent services have been developed in recent years, including many strategies under the Closing the Gap initiative of COAG.

## Fertility

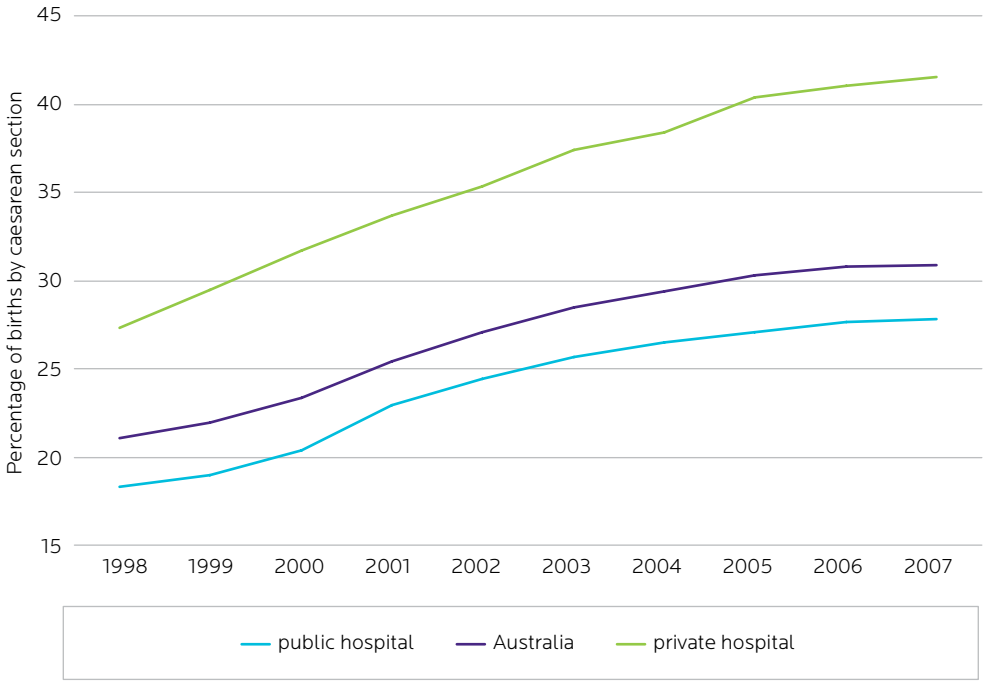
Australia is currently experiencing a 'baby boom'. The total fertility rate in 2008 was 1.97 babies per woman, up from 1.92 babies per woman in 2007.[20] The most recent increase in total fertility rate, between 2007 and 2008, was chiefly due to births by women aged 30 to 39 years who accounted for 55% of this increase. The total fertility rate also increased in five states and territories during 2008. The exceptions were Victoria and the Australian Capital Territory, where rates were similar to 2007 levels, and the Northern Territory, where the total fertility rate was slightly lower.[21]

While the high fertility rate is heightened by Australia's increasing population, particularly in women of reproductive age, the intergenerational report by the Australian Government Department of Treasury[22] projects that the total fertility rate in Australia will fall marginally to 1.9 babies per woman by 2013, and remain at this level to 2050.[22]

## Interventions

Although the majority of Australian women have vaginal births (i.e. vaginal births including vaginal breech, forceps and vacuum), there appears to be a trend away from normal birth. Australia has high rates of births by caesarean section (30.9% of births in 2007) compared with the OECD average of 25.7% of births. This rate is increasing in both the public and private sectors, but continues to be substantially higher in the private sector (Figure 3).[13-19]

**Figure 3** Proportion of births by caesarean section operation by hospital sector (1998–2007)




Source: AIHW Australia's mothers and babies 1998 to 2007 (multiple)[10-19]

High rates of caesarean section are often compounded by a lack of support for vaginal births after caesarean section, emphasising the need to prevent the primary caesarean section.[23] For example, 83% of women giving birth by caesarean section in 2007 had previously given birth by this method.[9] The proportion of women having caesarean section without labour has also increased from 11.9% in 1998 to 18.1% in 2007.[9]

In 2007, 7.4% of all births in Australia were preterm, with an almost 20% increase in the proportion of normal risk women having a preterm birth from 1994 to 2004, and a 12% rise in preterm birth overall.[23] Concerns have been expressed in other countries that the rising rate of late preterm birth (from 34 weeks gestation) may be associated with increasing obstetric intervention,[24] particularly increasing rates of induction of labour and caesarean section operation.[25 26]

Other forms of intervention, including induction of labour, are also high: 25.3% of mothers had an induced labour in 2007, while a further 20% of all mothers had augmented labour.[9] Unfortunately, the data on reasons for interventions cannot be examined at a national level, as it is not captured consistently across the jurisdictions.

The rise in interventions, including the reason and their impact on women, babies and the health system, is the subject of considerable debate among health professionals and consumers. Issues requiring further investigation include:

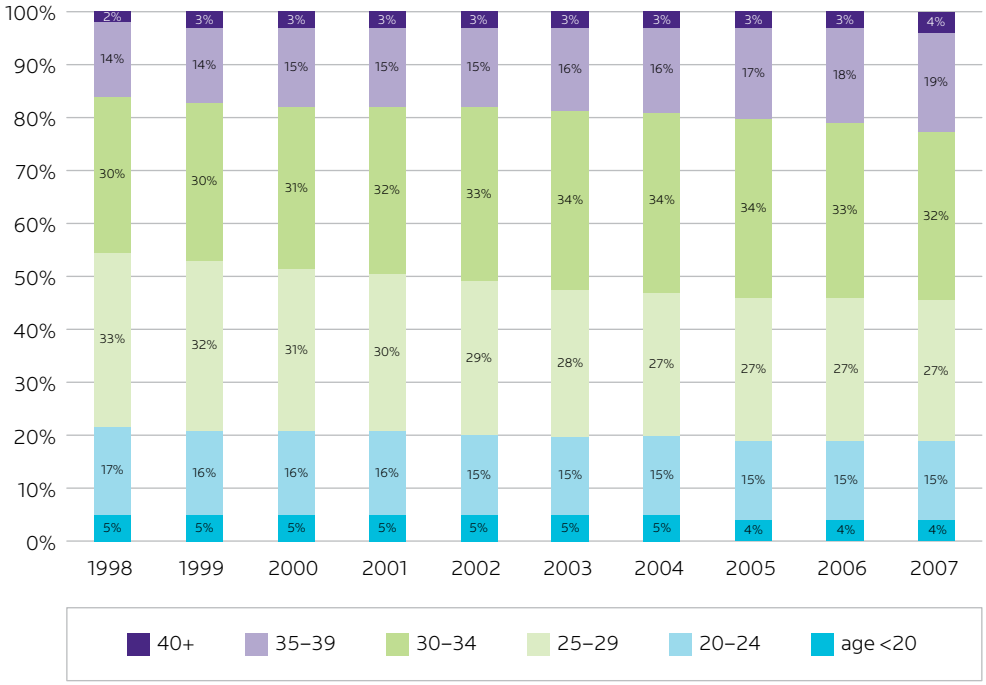
- agreement of identified clinical indicators for specified interventions that are compared across maternity services of the same service capability
- dissemination of evidence for interventions, including support such as education strategies, for both consumers and clinicians

## Age of mothers

Australian women are, on average, giving birth at a later age. The percentage of women giving birth who were aged 35 years or older increased from 16% in 1998 to 22.3% in 2007, while the ages of women who gave birth that year ranged from younger than 15 years to 56 years.[9] The mean maternal age has also progressively increased over the past 10 years from 28.9 years to 29.9 years.

From 1998 to 2007, the proportion of women giving birth in the 30–34-year age group has grown, while the proportion of women giving birth in the 25–29-year age group has declined. The proportion of women in the under-20-year and 20–24-year age groups has remained relatively stable during this period (Figure 4).

**Figure 4** Maternal age by age groups (1998–2007)




Source: AIHW Australia's mothers and babies 1998 to 2007 (multiple)[10-19]

Adverse maternal and perinatal outcomes are associated with younger and older mothers.[9] The general trend towards an older population of women giving birth has implications for maternity and neonatal services, including the capability of services to respond to complex pregnancies. While numbers of adolescent mothers have declined over the past decade from 5.1% to 4.1% in 2007, there has been an increase in the number of adolescent mothers in some vulnerable groups, particularly Aboriginal and Torres Strait Islander people. Pregnant adolescent mothers continue to require specialised support and tailored service provision.[9]

## Obesity

An obesity epidemic in Australia is affecting all sectors of the health system, including maternity services. Obesity rates for pregnant women are not reported at a national level, and there are limited numerical data on mortality and morbidity outcomes for obese women and their babies.

Maternal obesity is a significant risk factor for adverse outcomes and comorbidity during pregnancy and childbirth. Medical risks include maternal conditions such as diabetes, thromboembolism and hypertension,[27] and a threefold risk of operative births, including caesarean section operation.[28] For babies, maternal obesity carries a higher risk of stillbirth, birth injury, admission to neonatal intensive care, and a higher risk of childhood obesity.[29 30]

The increase in obese pregnant women requires a response that incorporates an increased capability for maternity services to provide appropriate care to both the mother and baby. While maternity services have a limited capacity to address the factors leading to women being overweight or obese in pregnancy, broader health strategies were proposed by the Preventative Health Taskforce in the National Preventative Health Strategy. The Australian Government's response to the National Preventative Health Strategy outlines how the proposals will be progressed.[31]

## Smoking, alcohol and drug use

The consumption of cigarettes, alcohol and illicit substances by pregnant women increases the likelihood of adverse outcomes during pregnancy and birth.

Mothers who smoke during pregnancy have higher proportions of babies with poorer perinatal outcomes than mothers who do not smoke. In 2003, the proportion of liveborn, low birthweight babies (less than 2500 grams) of mothers who smoked was 10.6% — twice that of babies of mothers who did not smoke (5.1%). The odds of preterm birth at less than 37 weeks gestation was 60% higher in babies of mothers who smoked than in babies of mothers who did not smoke.[32]

Maternal alcohol consumption can harm the fetus in a number of ways. Although the risk of birth defects is greatest with high, frequent maternal alcohol intake during the first trimester, alcohol exposure throughout pregnancy (including before pregnancy is confirmed) can have consequences for development of the fetal brain.[33]

Women who are pregnant and use illicit drugs have increased maternal and fetal morbidity. These women sometimes find it difficult to access traditional referral services to maternity care, and often present late in pregnancy for antenatal care, or wait until labour to access health services. They are also unlikely to disclose their drug use. While maternity care provision is complicated by legal, social and environmental problems, as well as a prevalence of negative attitudes of health professionals, pregnancy can be seen as a window of opportunity for the provision of education, choices and support.[34]

These factors therefore require a specialised response to manage their associated risks. Preventative strategies, including pre-pregnancy education, are currently being implemented through the National Preventative Health Strategy.[31] Women who consume these substances also need earlier access to antenatal care and a maternity care pathway that provides appropriate links to specialised clinical services, particularly allied health and social support services, and including neonatal services.

# Provision of maternity care

Maternity care in Australia includes antenatal, intrapartum and postnatal care for women and babies up to six weeks after birth. This care is provided in a variety of public and private settings, and is supported by service capability frameworks, workforce, funding, information and data, and technological infrastructure.

## Models of care

The Maternity Services Review identified a wide range of maternity care models currently practised in Australia, and estimated 92.7% of Australian women receive care through one of four models: private maternity care, combined maternity care, public hospital care and shared maternity care.[4] It is important to standardise nomenclature and definitions across the range of models to facilitate meaningful analysis and program comparisons.

In 2007, the majority (97.0%) of Australian women gave birth in conventional labour ward settings, with far smaller proportions accessing birth centres (2.2%) or having planned homebirths. There was also a small cohort of women who gave birth before they reached a hospital. Of the women who gave birth in a hospital, 70.2% (196,960 women) were in the public system and 29.8% (83,713 women) were in the private system.[19]

Continuity of care, as a feature of maternity care, is very important for women. There is an increasing demand for midwifery continuity of care models. There are also many women who choose to access continuity of care from general practitioners (GPs) and specialist obstetricians. It is recognised that these choices should be respected and supported by improved access for those who choose to use them.

The place of birth is a decision for women and their partners and families, with a number of women choosing to give birth at home. There is a continuing demand for planned homebirth to be made available through the public health system,[4] resulting in the provision of public homebirth services in several jurisdictions within a safety and quality system. Midwifery Group Practices providing care in the hospital and the community are the usual providers of public homebirth care. Women who choose homebirth also use private models with care provided by a privately practising midwife.

While the overall proportion of homebirths is expected to remain small, demand for homebirth is anticipated to continue.[4] Evaluation of individual publicly funded homebirth programs, together with further consideration of the two year National Registration and Accreditation Scheme exemption on the requirement for midwives to hold professional indemnity insurance, will provide an evidence base for further planning decisions.

## The woman's journey

The provision of continuous care across the maternity pathway by a known carer has been demonstrated to have a beneficial impact on outcomes.[9 35 36] Continuity of care enables women to develop a relationship with the same caregiver(s) throughout pregnancy, birth and the postnatal period.

Providing continuity of care across the entire maternity care continuum requires a collaborative and flexible approach from maternity services and the maternity workforce, supported by integration of services, including:

- effective consultation and referral pathways
- effective clinical networks
- collaborative interdisciplinary professional relationships
- sound information sharing and communication channels

This collaborative approach to maternity care is particularly important for those women and babies whose care requires linkages to specialist services.

Transitions from maternity care into child and family health care should also provide continuity of care through a robust system of early referral and information transfer in the postnatal period.[37]

Some women may experience maternity care that is not well coordinated as they move between:

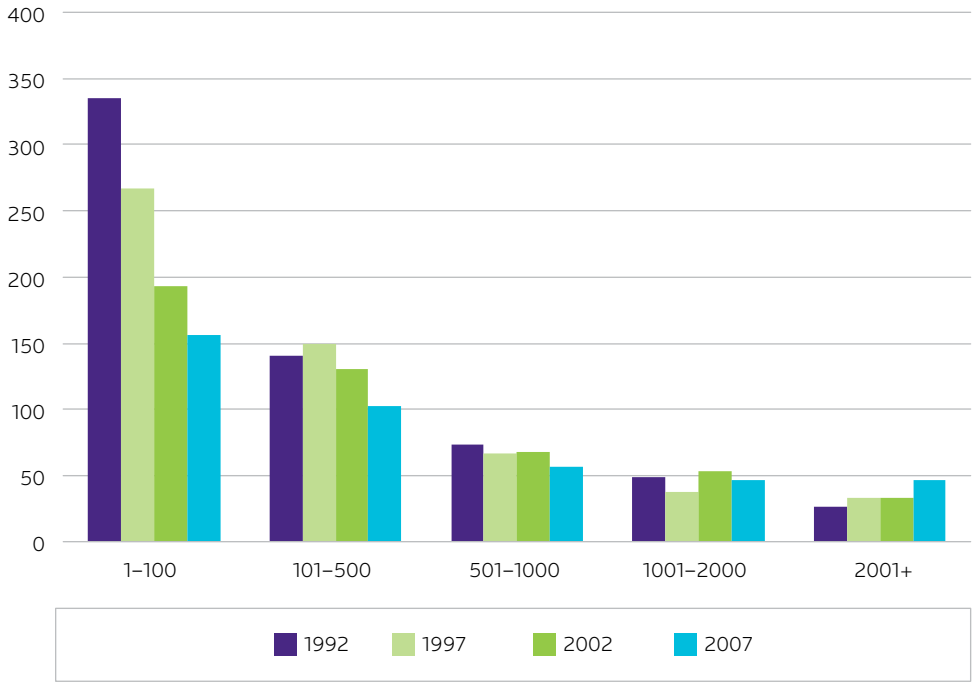
- public and private systems
- remote, rural, regional and metropolitan locations
- primary, secondary and tertiary levels of care
- different maternity care professionals

Fragmented funding pathways across different aspects of the health system can result in a lack of continuity of carer as women transition from pregnancy to birth and parenthood. This fragmentation can adversely affect the maternity experience and outcomes for women and their families.

## Rural and remote services

The trend of population and workforce movements to larger centres over the past decade has seen a decline in the number of facilities able to provide full maternity care for women in rural and remote areas. For example, the number of hospitals and birth centres supporting 1–100 births each year declined from 335 facilities in 1992 to 156 facilities in 2007 (Figure 5).[13-19]

**Figure 5** Distribution of hospitals and birth centres by annual number of births




Source: AIHW Australia's mothers and babies 1998 to 2007 (multiple)[10-19]

Maternal and perinatal mortality rates are also higher among rural and remote families.[4] Achieving sustainable, lower capacity rural and remote maternity services that are networked to higher levels of care for consultation, referral and ongoing management has become a focus of Australian governments in recent years.[8 38-42]

These services require an appropriately skilled workforce with collaborative networks to secondary and tertiary services, including timely consultation and referral pathways. A key component is providing information technology infrastructure that can improve access to specialist consultation between networked maternity services.

The provision of community-based maternity care in remote locations is also an important strategy for providing care to women in remote parts of Australia. There are outreach programs providing services in parts of Australia;[4] however, many women still experience difficulties accessing maternity services near to where they live.

## Clinical services capability

The framework of clinical services capability is an important element of the safety and quality of maternity care.[43] A maternity clinical services capability framework, which outlines the key principles underpinning the provision of safe and effective maternity care, serves two major purposes:

- to provide a standard set of capability requirements for maternity care by public and private maternity services
- to provide a consistent language for health care providers and planners when describing maternity services and planning maternity service developments

When applied across maternity services, these underlying standards and requirements for similar services protect patient safety and augment clinical risk management.

While most jurisdictions currently have services capability frameworks (also known as role delineation), AHMAC through HPPPC, has agreed to develop a nationally consistent clinical services capability framework for maternity services, drawing on existing jurisdictional frameworks.

## The maternity workforce

The provision of maternity care depends on a robust, well-distributed and highly skilled professional maternity workforce. However, the maternity sector is currently experiencing workforce shortages that are expected to become more acute as the maternity workforce ages.[4]

There has been a shortage of obstetricians, general practitioner obstetricians and general practitioner anaesthetists, particularly in rural and remote Australia, for a considerable period of time. The midwifery workforce is reasonably well distributed on a per capita basis across regional and remote Australia; however, access to midwifery care is affected by distance.

A number of initiatives, backed by significant investments, have been implemented to address current workforce shortages and better equip Australia's health system, and to meet the growing demand for health services into the future. The November 2008 COAG agreement[44] to train more doctors, nurses and allied health professionals included expanded clinical training places for undergraduate medical, nursing and allied health students, additional ongoing GP training places, and additional specialist training places in the private sector.

Further support for the health workforce has been demonstrated by Australian governments in April 2010[5] through a commitment to training more GPs; more places each year for junior doctors to experience a career in general practice during their postgraduate training period; and training more specialist doctors over the next decade.

The development of direct-entry midwifery courses in many Australian jurisdictions has increased the numbers of midwifery students who, with access to clinical training and experience, will bolster the maternity workforce over the coming years. A number of initiatives have also been designed to encourage retired midwives back into the workforce.

As a result of the Maternity Services Review, the Australian Government is providing financial support for to up to 110 GPs in rural and remote areas for training in anaesthetics or obstetrics through the GP Procedural Training Support Program. The Program aims to improve access to obstetric and anaesthetic services for women living in rural and remote communities.

It will be necessary to ensure all maternity care professionals are utilised to their full scope of practice, and that new, smarter ways of working are introduced to maximise the use of their specialist knowledge and skills.

## Funding of maternity services

Limited available information about the cost of providing maternity care was noted in *Improving Maternity Services in Australia*: *The Report of the Maternity Services Review* as a constraint to examining maternity service funding.[4]

Total expenditure on maternity services across Australian governments in 2004–05 was $1,672 million.[9] This expenditure is mostly associated with hospital births (92% of total funding), with a majority of that funding (70%) attributed to public hospital expenditure.[9] State and territory governments fund and develop maternity services in accordance with local policies and planning needs for health services across their state or territory.

Private health insurance also makes a significant funding contribution to maternity services. Private health insurers pay benefits for maternity services for hospital treatment (in-hospital) and general treatment (out-of-hospital). The Australian Government indirectly contributes towards this funding through the Private Health Insurance Rebate.

Hospital treatment benefits provides substantially more funding than general treatment benefits. Statistics concerning the benefits paid for hospital treatment are available from the Hospital Casemix Protocol data collection.

Statistics concerning the benefits paid for general treatment are available from the Private Health Insurance Administration Council (PHIAC). According to PHIAC, private health insurers paid benefits of approximately $1 million in 2008–09 and $800,000 in 2009–10 for maternity services under general treatment. This comprised approximately 9,000 services in 2008–09 and 7,000 services in 2009–10.

Information about new funding arrangements under the Heads Agreement for National Health Reform (COAG, February 2011 and April 2010),[5a] can be found at page 3 (under Context for the Plan).

a Discussions are continuing with Western Australia to seek their agreement to these reforms. All other state and territories are signatories to the agreement.

## Information and data

Advanced communication technologies are considered a key component to increasing the capacity of maternity services to provide high-quality care. Australia's Health Ministers have responded to this opportunity through their commitment to the development of e-health technology and unique identifiers for all consumers.[45] Such technology will significantly enhance communication and information transfer between maternity services, and result in substantial benefits to Australian women, their babies and families.[b] The implementation of the National Woman-Held Pregnancy Record will complement the electronic information systems. The handheld record is designed to improve communications between health professionals, and to include women in decision making about their care.

States and territories capture a range of detailed data on maternal and perinatal outcomes that forms a national perinatal data collection that is collated by the Australian Institute of Health and Welfare. This data informs systematic reviews at a national level, and allows trends in maternal and perinatal outcomes to be reported.

Jurisdictional data are inconsistently reported in terms of the data and definitions used. The Maternity Services Review[4] recommended that consistent, comprehensive national data collection, monitoring and review for maternal and perinatal mortality and morbidity be implemented. This will require data elements with consistent definitions to be used across all jurisdictions.

b http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2010-hmedia09.htm

# Australian maternity services in an international context

Significant reform in maternity services has occurred in New Zealand, the United Kingdom (UK) and Canada in recent years. A number of national action plans, strategic frameworks, policy statements, clinical practice guidelines and jurisdictional policy documents from these countries have been considered to provide an international context for maternity service reform in Australia. Many of these documents were produced through consultation and an appraisal of evidence in each jurisdiction in a similar process to that informing maternity service reform in Australia.

The challenges faced in Canada, New Zealand and the UK include workforce shortages, low population density and remoteness in Canada and New Zealand, addressing service integration, rising intervention rates, providing a consistent approach to the provision of care and targeted initiatives for Indigenous and other disadvantaged population groups.

Continuity of care has been identified as an important feature of maternity care, particularly emphasised in New Zealand and the UK where a wellness paradigm for pregnancy and childbirth is promoted. New Zealand and the UK have also identified woman-centred care, access to a range of models of maternity care, and a capacity for women to make informed choices about their care as underlying principles to guide reform.[46 47] Differences across provinces in Canada include the regulation status of midwives to attend births, prescribe drugs and order tests.[48] Achieving national consistency has been identified by the Canadian health system as a priority. Recent developments in Canada include the promotion of collaborative interdisciplinary maternity care.[49]

Access to maternity services for women in rural and remote locations remains a challenge for New Zealand and Canada.[49 50] Canada has developed family birth centres in remote areas in response to community demand and community control of health funding. The implementation of these successful models uses community development approaches and the education of local Indigenous women as midwives.[51] Timely transfer and access to specialists are also key aspects of these innovative models. Aboriginal communities in Canada have been engaged to develop an Aboriginal Birthing Strategy, including midwifery-managed 'birthing on country' models.[51]

To achieve high-quality and consistent midwifery care that fully utilises the midwives' scope of practice, the UK has a well-developed system of 'midwifery supervision'.[52] Supervisors of midwives are senior clinicians or managers who undertake training to enable them to 'supervise' other midwives, as part of their core role.

The UK has invested in the development of a national evidence base and standards for maternity care, including clinical practice guidelines.[53] The national evidence base is more fragmented in New Zealand and Canada.

# Part 2
## The national maternity services plan

# The Plan

The Plan will provide a strategic national framework to guide policy and program development over five years. It aims to improve, coordinate and ensure greater access to maternity services in Australia.

For the purpose of this Plan, *maternity care* refers to antenatal, intrapartum and postnatal care for women and babies up to six weeks after birth. Strong relationships and linkages between maternity, neonatal and other specialist services are vital to quality maternity care. This Plan acknowledges these links, but does not address specialist services in detail.

The Plan will:

- provide all Australians with clear statements of commitments by Australian governments
- set high-level directions and priorities
- guide policy and program development to improve, coordinate and ensure greater access to maternity care for Australian women and their families

Under the Plan, the majority of care for a healthy pregnant woman will be provided and coordinated by an individual or team of maternity carers, including midwives, GPs, obstetricians, anaesthetists, GP obstetricians and GP anaesthetists. Other health care providers may also be required to ensure women and babies receive care appropriate to their needs. These include, but are not limited to, allied health professionals, gynaecologists, neonatologists, and child and family health nurses.

## Priorities for the Plan

Priorities for maternity care, identified through review and consultation, reflect the high demand for maternity services that are responsive to the needs of all Australian women, their partners and families. Priorities for the Plan encompass four areas: access, service delivery, workforce and infrastructure.

### Priority 1 Access

1.1 Increase access for Australian women and their family members to information that supports their needs for maternity care.

1.2 Increase access for Australian women and their family members to local maternity care by expanding the range of models of care.

1.3 Increase access for women and their family members in rural Australia to high-quality maternity care.

1.4 Increase access for women and their family members in remote Australia to high-quality maternity care.

### Priority 2 Service delivery

2.1 Ensure Australian maternity services provide high-quality, evidence-based maternity care.
2.2 Develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people.
2.3 Develop and expand appropriate maternity care for women who may be vulnerable due to medical, socioeconomic and other risk factors.

### Priority 3 Workforce

3.1 Plan and resource to provide an appropriately trained and qualified maternity workforce that provides clinically safe woman-centred maternity care within a wellness paradigm.
3.2 Develop and support an Aboriginal and Torres Strait Islander maternity workforce.
3.3 Develop and support a rural and remote maternity workforce.
3.4 Facilitate a culture of interdisciplinary collaboration in maternity care.

### Priority 4 Infrastructure

4.1 Ensure all maternity care is provided within a safety and quality system.
4.2 Ensure maternity service planning, design and implementation is woman-centred.

## Actions in the Plan

The actions identified in the Plan will be coordinated to build upon planning and service developments already underway. Cultural change across maternity services will be ongoing throughout the life of the Plan and beyond. All governments are committed to long-term improvements in maternity services and will use this Plan as a strategic framework to guide investments and service developments.

Actions are identified as being in:

- the initial year of the Plan: Year 1
- the middle years of the Plan: Years 2 and 3
- the later years of the Plan: Years 4 and 5, and beyond

Signs of success are identified against actions to demonstrate the achievements under this Plan.

# Principles for maternity care

Maternity care should be evidence-based and woman-centred, and acknowledge pregnancy, birth and parenting as significant life events for women.

Woman-centred maternity care is responsive to women's needs and preferences, and enables them to access objective, evidence-based information that supports informed choices about their maternity care. Woman-centred care also requires service planning and provision that is designed and implemented to respond to the needs of Australian women within a safety and quality system.

## A wellness paradigm

The underpinning philosophy of primary maternity services is that birth is a normal but significant physiological event, and that different women have different needs in relation to pregnancy and childbirth.[36]

This wellness paradigm for pregnancy and childbirth acknowledges that pregnant women are predominantly well because pregnancy and birth are normal physiological life events. Clinical decisions about medical intervention should be informed by this understanding.

While acknowledging the desirability of a wellness paradigm, it must be recognised that the maternity system needs to provide for timely, urgent and unexpected escalation to higher levels of care. A study reported that 55% of women whose babies suffer perinatal death have no recognisable risk factors at the beginning of pregnancy, and 28% have none at the onset of labour.[5]

## The principles

The Plan is underpinned by 10 principles for maternity care (below) that build on principles previously agreed by Health Ministers for the provision of primary maternity services in *Primary Maternity Services in Australia: A Framework for Implementation*.[36]

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.

# Priority 1 — access

## **Action 1.1** Increase access for Australian women and their family members to information that supports their needs for maternity care

*(Aligned with Principles 1, 2, 6, 8, 10)*

This Plan identifies communication strategies to facilitate women's awareness of the available information and their options for care. The provision of objective information related to services, and access to it, enables women and their families to make informed choices about their maternity care.[4]

Several AHMAC-sponsored projects, including the development of National Core Maternity Indicators and National Maternal and Perinatal Mortality and Morbidity Reporting (see Appendix A), will provide access to outcome and indicator information about maternity care.

Further related actions can be found in Actions 2.1.2 and 4.1.5.

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **1.1.1** The Australian Government expands the National Pregnancy Support Helpline (the Helpline) to provide information, counselling and referral, 24 hours a day, 7 days a week.<br>The Helpline identifies gaps in the availability of evidence-based information. | The Australian Government sources or develops additional evidence-based information. | The Australian Government continues to source or develop additional evidence-based information.<br>The Helpline ensures that information remains contemporary.<br>The Australian Government evaluates the Helpline. | Use of the Helpline measured by the number of calls received.<br>Australian people report satisfaction with the Helpline. |
| **1.1.2** | | AHMAC identifies objective information resources for women and their families.<br>AHMAC undertakes a gap analysis of objective information resources for women and their families. | Objective information resources for women and their families are identified and a gap analysis undertaken. |

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **1.1.3** AHMAC endorses the first 10 core maternity indicators. | AHMAC endorses the remaining core maternity indicators.<br>Reporting begins.<br>AHMAC considers making available nationally consistent and accessible maternity service outcomes and core maternity performance data to inform women and their families. | Reporting continues.<br>AHMAC agrees and makes available a set of nationally consistent and accessible maternity service outcomes and core maternity performance data. | Women have access to nationally consistent and accessible maternity service outcomes and core maternity performance data. |

AHMAC = Australian Health Ministers' Advisory Council

## **Action 1.2** Increase access for Australian women and their family members to local maternity care by expanding the range of models of care

*(Aligned with Principles 1, 2, 3, 5, 6, 7, 8)*

Recent reviews and strategies developed by Australian governments have responded to demand and focused on the need for a range of models of care to be made available to women. Continuing to provide a range of maternity care options, including homebirth, is a priority of the Plan. Continuity of carer, a wellness paradigm, and woman-centred care using primary health care principles have also been identified as important features of maternity care for all women.[4 8 36 38-42 55 56]

Women's access to safe and high-quality maternity care that accommodates their individual preferences varies by location. Women residing in metropolitan areas generally have greater access to a wider range of models of maternity care compared with women in rural and remote areas.

Women's access to care is improved through the provision of local maternity services. Locally-based care also facilitates the participation of the women's partners and families in the maternity experience. Services that can be sustained in local settings are particularly important in rural and remote Australia, where women and their families have limited access to the major centres of care. Women in very remote locations may receive care locally through outreach services.

While the provision of local birthing services in remote areas remains challenging, the local provision of antenatal and postnatal care in rural and remote Australia is a priority.[57] The provision of antenatal and postnatal care in non-hospital, local settings is critical to improving access to antenatal and postnatal care for all women and their families.

A range of models of maternity care are already available. These include combinations of local obstetricians, anaesthetists, GP obstetricians, GP anaesthetists, midwives, as well as fly-in obstetricians, anaesthetists and midwives.

All models of maternity care should incorporate robust systems and processes to maximise safety and minimise harm. The safety and quality of locally-provided maternity care is supported through the expansion of care pathways for consultation and referral between local primary services and secondary and tertiary services. Specialist input is facilitated through clinical networking and information technologies, such as videoconferencing, allowing women to access specialised care while remaining in their local communities.

The Australian Government is taking action to increase access by expanding the range of models of care available to women and their families. Access to the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) forms part of the Australian Government's initiatives for expanding the role of midwives in providing maternity services. This will enable women to access the services provided under the MBS and subsidies for certain medicines prescribed by midwives under the PBS. The provision of a professional indemnity insurance scheme for eligible midwives may facilitate the sustainability of private midwifery-managed models. The extent of the development of practice models, facilitated through these reforms, will be dependent on a range of factors, including the practice choices of individual midwives. The feasibility of any potential business models has yet to be tested.

For MBS items for in-hospital treatment, private health insurers must pay benefits of at least 25% of the MBS fee. For MBS items for out-of-hospital treatment, insurers are not permitted to pay any benefits. Many insurers currently pay benefits for services provided by midwives. Insurers will have to restructure their products to ensure they are compliant with the *Private Health Insurance Act 2007* and proposed changes to MBS items, and are obliged to provide reasonable notice to members prior to making changes to benefits, and this period of notice is usually interpreted as 60 days.

Over time, as standards and cost-effective models are developed, it might be possible to expand the number of services available in small communities for women with normal risk factors. Some jurisdictions are exploring options to reinstate safe and sustainable maternity services in some communities where they were previously withdrawn.

Further related actions can be found in Actions 2.2.3, 3.2, 3.3, 4.2.1 and 4.2.2.

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **1.2.1** Australian governments facilitate increased access to midwifery-managed models of care for normal risk women, e.g. midwifery group practice or birthing centres, while maintaining support for choice of, and access to, medically managed models of care.<br>Australian governments facilitate increased access for public patients to midwifery and medical practitioner continuity of carer programs. | Australian governments establish the baseline for the number of women accessing midwifery-managed care.<br>Australian governments establish the baseline for the number of women accessing continuity of carer programs in each maternity service. | Australian governments evaluate women's access to midwifery-managed and midwifery continuity of carer programs. | Increased numbers of normal risk women access midwifery-managed maternity care.<br>Increased numbers of women access continuity of carer programs. |
| **1.2.2** Jurisdictions develop consistent approaches to the provision of clinical privileges within public maternity services, to enable admitting and practice rights for eligible midwives and medical practitioners. | Jurisdictions use best endeavours to facilitate the clinical privileges, admitting and practice rights of eligible midwives.<br>Jurisdictions monitor the provision of consistent clinical privileges, admitting and practice rights for eligible midwives and medical practitioners. | Jurisdictions evaluate access to clinical privileges, admitting and practice rights for eligible midwives and medical practitioners in maternity services. | Eligible midwives have the opportunity to access clinical privileges, admitting and practice rights in public health care settings.<br>There is a consistent approach to the provision of clinical privileges, admitting and practice rights for eligible midwives and medical practitioners in all jurisdictions. |

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **1.2.3** NMBA endorses a standard for a safety and quality framework, which includes an assessment of clinical risk, for the provision of private homebirth as part of the agreed two-year exemption on the requirement for midwives to hold professional indemnity insurance in order to register as a midwife.<br>States and territories investigate options for the provision of publicly funded homebirth care. | Health Ministers will review the exemption in 2012.<br>States and territories consider the implementation of publicly funded homebirth models based on findings of their investigations. | States and territories evaluate publicly funded homebirth programs. | Women have increased access to homebirth. |
| **1.2.4** States and territories identify the characteristics of maternity care programs that utilise midwives to their full scope of practice. | States and territories consider the implementation of maternity care programs that utilise midwives to their full scope of practice. | States and territories evaluate maternity care programs that utilise midwives to their full scope of practice. | Increased numbers of midwives are utilised to their full scope of practice. |
| **1.2.5** The Australian Government enables increased availability of private primary maternity services by private maternity professionals through the introduction of MBS and PBS items and professional indemnity insurance for eligible midwives.<br>The Australian Government undertakes consultations with private health insurers through the peak bodies (AHIA and HIRMAA) to assist insurers to meet their legislative obligations under the Act. | The Australian Government monitors the effectiveness of the introduction of MBS and PBS items and professional indemnity insurance in increasing access for women to local, private primary maternity services. | The Australian Government evaluates the effectiveness of the introduction of MBS and PBS items and professional indemnity insurance in increasing access for women to local, private primary maternity services. | Women have increased access to local private, primary maternity services in all jurisdictions. |

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **1.2.6** AHMAC identifies the availability of access to public antenatal care in a range of local community settings.<br>AHMAC considers the inclusion of appropriate data items to measure access to public antenatal care in a range of local community settings in a reporting framework (See Action 1.1.3) | States and territories consider and implement mechanisms to increase access to public antenatal care in local community settings. | AHMAC evaluates access to public antenatal care in local community settings. | An increased number of women are accessing public antenatal care in local community settings. |
| **1.2.7** | AHMAC identifies the availability of access to midwifery postnatal care outside hospital settings, to at least two weeks after birth. | States and territories consider and implement mechanisms to increase access to midwifery postnatal care, outside hospital settings, to at least two weeks after birth. | Women have increased access to midwifery postnatal care, outside hospital settings, for at least two weeks after birth. |

AHIA = Australian Health Insurance Alliance; AHMAC = Australian Health Ministers' Advisory Council; HIRMAA = Health Insurance Restricted Membership Alliance of Australia; MBS = Medicare Benefits Schedule; NMBA = Nursing and Midwifery Board of Australia; PBS = Pharmaceutical Benefits Scheme

## **Action 1.3** Increase access for women and their family members in rural Australia to high-quality maternity care

*(Aligned with Principles 1, 3, 8, 9)*

Access to maternity services for rural women has been affected by population movements and workforce supply in recent years. Specific initiatives to address the implications resulting from these consolidations, such as more limited access to maternity services for women in rural and remote Australia, have included:

- outreach services, including the Medical Specialist Outreach Assistance Program (MSOAP)
- rebates for women who must travel to receive care
- measures to ensure the sustainability of services in rural and remote Australia

Many women in rural and remote Australia who require complex care will continue to travel away from home to receive appropriate care in secondary and tertiary centres. The Plan includes strategies to ensure that women who travel to receive care are cared for within a wellness paradigm that includes their partners and family members.

The Plan includes strategies to ensure the sustainability of primary maternity services, including birthing services, in rural and remote communities and to ensure women can access care in secondary and tertiary services as needed, and are supported by strategic workforce initiatives (see Priority 3 for further discussion of workforce issues). Actions also build on existing initiatives, which will be expanded to include a range of maternity care professionals providing outreach services to rural and remote communities. Tools to inform future planning will underpin maternity service planning and delivery in rural and remote communities (see Action 4.2.1).

Specific issues related to services in remote Australia are addressed in Action 1.4.

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **1.3.1** The Australian Government expands MSOAP to include multidisciplinary maternity care teams. | The Australian Government evaluates the expansion of MSOAP to include multidisciplinary maternity care teams.<br>AHMAC identifies the availability of access to state and territory programs of outreach services to rural and remote locations. | The Australian Government considers recommendations arising from the evaluation of the expanded MSOAP.<br>AHMAC considers mechanisms to expand state and territory programs of outreach services to rural and remote locations.<br>AHMAC evaluates access to outreach maternity services to rural and remote locations. | Women in rural and remote Australia have increased access to outreach maternity services. |

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **1.3.2** AHMAC endorses a National Strategic Framework for Rural and Remote Health, which includes objectives and strategies to address access to health services in rural Australia. | AHMAC evaluates the introduction of strategies under the National Strategic Framework for Rural and Remote Health to assess its impact on improved access to rural maternity services. | AHMAC considers implementation of further strategies to support the sustainability of rural maternity services. | Access to maternity services for women in rural areas is improved. |

AHMAC = Australian Health Ministers' Advisory Council; MSOAP = Medical Specialist Outreach Assistance Program

## **Action 1.4** Increase access for women and their family members in remote Australia to high-quality maternity care

*(Aligned with Principles 1, 3, 8, 9)*

Women and their families who live in remote and very remote Australian communities experience extremely limited access to locally available high-quality and culturally competent maternity care.

Community-based primary maternity care that is linked to secondary and tertiary services can provide quality maternity care in these communities, facilitated by technology to provide on-site specialist consultation and referral. This can reduce the need for women to travel away from their families, homes and communities for extended periods of time, and enables family members to be involved in their care.

The provision of primary maternity care requires an appropriately trained and qualified workforce supported by robust quality and safety systems that enable consultation, referral and escalation when necessary.

Maternity service planning and delivery for remote communities, including planning for workforce and infrastructure needs, will be informed by the development of tools to inform future planning (see Action 4.2.1), which will include the introduction of the National Strategic Framework for Rural and Remote Health (in 2010–11).

Many pregnant Aboriginal and Torres Strait Islander women are from remote Australian communities. As stated earlier, the outcomes for these women and their babies are substantially poorer than those for non-Indigenous mothers and babies. These inequalities need to be addressed (see Action 2.2).

Further related actions can be found in Actions 1.3, 2.2, and 3.2.

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **1.4.1** AHMAC identifies the characteristics of successful community-based maternity care in remote locations. | Australian governments implement community-based maternity care in remote locations, based on successful models. | Australian governments continue to implement community-based maternity care in remote locations.<br>Australian governments evaluate community-based maternity care in remote locations. | An increased number of remote communities have access to community-based maternity care. |
| **1.4.2** AHMAC endorses a National Strategic Framework for Rural and Remote Health, which includes objectives and strategies to address access to health services in remote Australia. | AHMAC evaluates the introduction of strategies under the National Strategic Framework for Rural and Remote Health to assess its impact on improved access to remote maternity services. | AHMAC considers implementation of further strategies to support the sustainability of remote maternity services. | Access to maternity services for women in remote areas is improved. |

AHMAC = Australian Health Ministers' Advisory Council

# Priority 2 — service delivery

## **Action 2.1** Ensure Australian maternity services provide high-quality, evidence-based maternity care

*(Aligned with Principles 1, 2, 3, 4, 8, 10)*

Australian governments are working collaboratively to develop an evidence base to inform decision making and quality improvement for maternity services through the development of national frameworks and guidelines.

As a result of the COAG meeting of 19–20 April 2010, the Commonwealth and all states and territories, except Western Australia, agreed to the National Health and Hospitals Network Agreement.[5] A core element of this agreement will be strong national standards and transparent reporting through a new performance and accountability framework.

It is intended that a permanent Australian Commission on Safety and Quality in Health Care (ACSQHC) will develop national clinical quality and safety standards, and work with clinicians to ensure the appropriateness of services being delivered in particular settings. Arrangements for the permanent ACSQHC will be subject to detailed agreement on the scope and financial implications by Health Ministers.

A new National Performance Authority (NPA) will be established from 1 July 2011 as an independent Commonwealth statutory body. The NPA will, through new Hospital Performance Reports and Healthy Communities Reports, provide clear and transparent regular public reporting of the performance of every Local Hospital Network, the hospitals within it, every private hospital and every Medicare Local.

During the transition to these new arrangements, from 1 July 2010, states and territories will make public and private hospital-level data on performance publicly available through a website that will be developed by the Australian Institute of Health and Welfare. Health Ministers will set the timeline and data to be published.

The national safety and quality system for Australian maternity care will consider and build on several current AHMAC initiatives (Appendix A), including:

- National Evidence-Based Antenatal Care Guidelines
- Core Competencies and Educational Framework for Maternity Services in Australia Project
- National Maternity and Perinatal Mortality and Morbidity Reporting
- National Maternity Services Capability Framework
- National Core Maternity Indicators
- National Woman-Held Pregnancy Record
- Australian National Breastfeeding Strategy 2010–2015
- National Perinatal Depression Initiative
- National e-Health Strategy

Actions detailed in the Plan will also contribute to other safety and quality initiatives, including:

- consideration of other national clinical practice guidelines for perinatal care
- development of national interdisciplinary maternity consultation and referral guidelines
- targeted research, including research on clinical indicators and outcomes for mothers and babies
- collection of nationally consistent maternal and perinatal mortality and morbidity data and mechanisms to improve outcomes for mothers and babies

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **2.1.1** AHMAC endorses National Evidence-Based Antenatal Care Guidelines for the first trimester. | AHMAC endorses the full set of National Evidence-Based Antenatal Care Guidelines.<br>Australian governments implement the National Evidence-Based Antenatal Care Guidelines for the first trimester. | Australian governments implement the full set of National Evidence-Based Antenatal Care Guidelines.<br>AHMAC considers the development of other national perinatal clinical practice guidelines. | Maternity professionals utilise the National Evidence-Based Antenatal Care Guidelines. |
| **2.1.2** AHMAC considers the recommendations of the National Maternal Mortality and Morbidity reporting project. | AHMAC recommends a national maternal mortality and morbidity review process to ACQSHC for continuous improvement of maternity care. | ACSQHC continues to work with AHMAC on a national maternal mortality and morbidity review process for continuous improvement of maternity care. | A national maternal mortality and morbidity review process is established.<br>National maternal and perinatal mortality and morbidity reports are produced.<br>National systems and processes will drive improved performance in private and public maternity care. |
| **2.1.3** | AHMAC agrees to recommend to ACSQHC that systems and processes are developed to use statistics, core maternity indicators, and the maternal and perinatal mortality and morbidity review to improve public and private maternity care. | ACSQHC considers the recommendations of AHMAC. Systems and processes for review are formulated to utilise the evidence base resulting from national standardisation, data and reporting. | National systems and processes will drive improved performance in private and public maternity care. |

ACSQHC = Australian Commission on Safety and Quality in Health Care; AHMAC = Australian Health Ministers' Advisory Council

## **Action 2.2** Develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people

*(Aligned with Principles 1, 2, 3, 4, 5, 7, 10)*

Aboriginal and Torres Strait Islander women and babies continue to experience poorer maternal and perinatal outcomes compared with their non-Indigenous counterparts. Australian governments have implemented a range of initiatives developed through community engagement to meet the needs of these women and babies, such as Closing the Gap.

In addition to establishing community-based and community-controlled primary maternity care, the cultural competence of hospital services is critical to the willingness of Aboriginal and Torres Strait Islander women to access services, and to ensuring a positive outcome for both mother and baby.

Partnerships between workers, such as Aboriginal Health Workers, community-based Indigenous workers and Strong Women Workers, medical practitioners and midwives will enable clinically safe and culturally competent care to be provided for Aboriginal and Torres Strait Islander people. Aboriginal Community-Controlled Organisations will be key partners in the provision of such care.

Recognising the significant investment being undertaken through COAG, the Plan focuses on identifying, and, if appropriate, expanding on successful initiatives to assist Aboriginal and Torres Strait Islander women and babies. Strategies to support an Aboriginal and Torres Strait Islander maternity workforce are presented in Priority 3.

Tools to inform future planning will underpin maternity service planning and delivery in rural and remote communities (see Action 4.2.1).

Further related actions can be found in Action 1.4.1.

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **2.2.1** AHMAC identifies the characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander people. | AHMAC undertakes a stocktake of access to culturally competent maternity care for Aboriginal and Torres Strait Islander people.<br>Australian governments expand programs providing culturally competent maternity care for Aboriginal and Torres Strait Islander people.<br>AHMAC identifies mechanisms for evaluating cultural competence in all maternity care settings. | AHMAC evaluates culturally competent maternity care for Aboriginal and Torres Strait Islander people.<br>AHMAC evaluates cultural competence in all maternity care settings. | Increased numbers of Aboriginal and Torres Strait Islander people have access to culturally competent maternity care.<br>Increased numbers of maternity services demonstrate culturally competent maternity care. |

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **2.2.2** Health Ministers recommend to all the National Boards, through the National Registration and Accreditation Sub Committee, that cultural competence is a component of all training, education and ongoing professional development of the whole maternity workforce. | All the National Boards consider cultural competence as a component of all training, education and ongoing professional development of the whole maternity workforce. | All the National Boards evaluate the inclusion of cultural competence training, education and ongoing professional development of the whole maternity workforce. | All training, education and ongoing professional development includes a cultural competence component. |
| **2.2.3** AHMAC undertakes research on international evidence-based examples of birthing on country programs. | Australian governments develop a framework, including an evaluation framework, for birthing on country programs.<br>Australian governments develop a pilot for a birthing on country program that includes a consultative selection process with Aboriginal and Torres Strait Islander communities and local maternity care professionals to identify initial birthing on country sites. | Australian governments establish birthing on country programs. | Birthing on country programs for Aboriginal and Torres Strait Islander mothers are established. |

AHMAC = Australian Health Ministers' Advisory Council

## **Action 2.3** Develop and expand appropriate maternity care for women who may be vulnerable due to medical, socioeconomic and other risk factors

*(Aligned with Principles 1, 2, 3, 4, 5, 9, 10)*

Specific groups of Australians with particular cultural and clinical needs may experience poorer maternity outcomes than the general population. These groups include (but are not limited to) culturally and linguistically diverse (CALD) women; women with pre-existing medical conditions; adolescent mothers; older mothers; obese women; women using cigarettes, alcohol and illicit substances; women experiencing mental illness; and women in prisons.[4] Each of these groups has specific maternity care needs.

Women experiencing domestic violence are at greater risk of complications during pregnancy, such as inadequate weight gain, infection, miscarriage, haemorrhage and low birth weight. Such women are slower to make contact with health services for antenatal care than women who are not exposed to violence, and their babies are more likely to have a problem diagnosed after birth.[58]

Women who have experienced some forms of female genital cutting experience significant problems in pregnancy and birth, including perineal tears, wound infections, separation of repaired episiotomies, postpartum haemorrhage and sepsis.[59] The World Health Organization also recognises the greater risk of newborn deaths among these women.[60]

A range of strategies, which are not addressed specifically in this Plan, have been developed in jurisdictions to meet the needs of vulnerable women and their babies. These strategies include (but are not limited to) the need for maternal and perinatal pathologists, anaesthetists and other tertiary and quaternary specialists. Services also require a sound consultation and referral framework enabling the provision of appropriate advice, ongoing management and escalation (as required) to ensure that access to specialist care occurs seamlessly to maintain continuity of care for these at-risk women (see Action 4.1). These strategies may also apply across broader population groups than those listed above.

Broader strategies, including the National Preventative Health Strategy, the National Breastfeeding Strategy[37] and the National Perinatal Depression Initiative,[61] include initiatives to improve the maternal and perinatal outcomes of at-risk women and babies.[37 62]

The Plan focuses on identifying and, where appropriate, expanding successful maternity care initiatives for at-risk women.

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **2.3.1** Australian governments expand screening for perinatal depression arising from the National Perinatal Depression Initiative.<br><br>Australian governments ensure that training, mentoring and supervision of staff undertaking perinatal mental health screening is provided. | States and territories offer perinatal mental health screening for all women.<br><br>Australian governments continue to provide training, mentoring and supervision of staff undertaking perinatal mental health screening. | AHMAC evaluates the National Perinatal Depression Initiative, including the provision of training, mentoring and supervision of health professionals undertaking perinatal mental health screening. | Universal screening is available for all women.<br><br>Health professionals undertaking perinatal mental health screening are trained, mentored and supervised. |
| **2.3.2** States and territories establish formal referral pathways for women experiencing depression and mental illness with perinatal mental health services.<br>States and territories develop options to overcome separation of mothers from their babies when receiving mental health care. | States and territories expand formal referral pathways for women experiencing depression and mental illness.<br>States and territories expand options for overcoming separation of mothers from their babies when receiving mental health care. | States and territories evaluate formal referral pathways for women experiencing depression and mental illness.<br>States and territories evaluate options for overcoming separation of mothers from their babies when receiving mental health care. | Women experiencing depression and mental illness have timely referral to appropriate professionals by maternity services.<br>There are decreased rates of separation of mothers from their babies when receiving mental health care. |
| **2.3.3** Australian governments progress investigation of evidence-based maternity care models for at-risk women, including:<br>pregnant adolescents<br>women with pre-existing medical conditions<br>CALD communities<br>women in prison<br>obese women<br>women using cigarettes, alcohol and illicit substances<br>older women<br>women experiencing domestic violence<br>women who have experienced various forms of female genital cutting. | Australian governments implement and expand evidence-based maternity care models for at-risk women. | Australian governments evaluate evidence-based maternity care models for at-risk women. | Improved perinatal outcomes for at-risk women and their babies. |

AHMAC = Australian Health Ministers' Advisory Council; CALD = culturally and linguistically diverse

# Priority 3 — workforce

## **Action 3.1** Plan and resource to provide an appropriately trained and qualified maternity workforce that provides clinically safe woman-centred maternity care within a wellness paradigm

*(Aligned with Principles 1, 3, 6, 7, 8, 9, 10)*

The demand for maternity care arising from the current 'baby boom' has been compounded by workforce shortages and the ageing of the maternity workforce, particularly the medical and midwifery workforces.[4] As government initiatives to increase the supply of medical practitioners and midwives through increased enrolments in university courses begin to impact, the specialised education, training and experience required for midwives, obstetricians, GP obstetricians and GP anaesthetists will be supported by the continued attention of all levels of government. The education, skills and knowledge of the maternity workforce will continue to be critical to ensuring the provision of safe and high-quality maternity care.

Health Workforce Australia (HWA),[57] which is in the process of building its capacity, is charged with progressing a systems approach to reviewing Australia's health workforce capacity and projecting demand, following the work of the National Health Workforce Taskforce[63] (see Appendix B). It should be noted that actions for HWA span the entire maternity workforce, across the spectrum from midwives and GP obstetricians, to (including but not limited to) maternal-fetal medicine specialists, perinatal pathologists and obstetric physicians.

Qualifications, defined scope of practice and ongoing professional development ensure that health professionals have the appropriate skills and knowledge to provide high standards of care. Continuing professional development ensures that the skills and knowledge of the workforce remain contemporary.

The Plan addresses workforce issues that facilitate the ongoing development of the maternity workforce to support the provision of safe, high-quality maternity care. Other strategies to support the maternity workforce with particular regard to planning can be found under Priority 4.

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **3.1.1** AHMAC recommends to HWA the investigation of drivers of productivity, performance and retention of the maternity workforce. | HWA investigates strategies to improve productivity, performance and retention for the maternity workforce. | HWA makes recommendations to increase maternity workforce productivity, performance and retention. | The maternity workforce demonstrates increased productivity, performance and retention.<br>Future maternity workforce planning is informed by HWA recommendations. |
| **3.1.2** AHMAC recommends to HWA that work is undertaken to guide the future development of requirements for education and clinical training for the maternity workforce and ensure that training places meet this need. | AHMAC and HWA facilitate increased access to clinical training places for midwives, GP obstetricians, specialist obstetricians, anaesthetists and neonatal paediatricians.<br>AHMAC and HWA develop strategies to increase funding for clinical training places for the maternity workforce. | AHMAC and HWA evaluate access to clinical training places for the maternity workforce. | Future maternity workforce planning is informed by HWA recommendations.<br>Increased clinical training places for maternity professionals. |
| **3.1.3** NMBA applies the professional requirements for the recognition of eligible midwives. | NMBA continues to assess eligible midwives.<br>NMBA works with HWA to monitor the numbers of eligible midwives. | NMBA continues to assess eligible midwives.<br>NMBA works with HWA to monitor the numbers of eligible midwives. | Demonstrated increase over time in the numbers of eligible midwives working in a variety of models and settings. |

AHMAC = Australian Health Ministers' Advisory Council; GP = general practitioner; HWA = Health Workforce Australia; NMBA = Nursing and Midwifery Board of Australia

## **Action 3.2** Develop and support an Aboriginal and Torres Strait Islander maternity workforce

*(Aligned with Principles 1, 2, 3, 4, 5, 6, 7, 9)*

An Aboriginal and Torres Strait Islander maternity workforce that is supported by culturally aware work environments is integral to providing culturally competent, evidence-based maternity care for Aboriginal and Torres Strait Islander women and babies.[4] However, the numbers of Aboriginal and Torres Strait Islander people in the maternity workforce impacts on the capacity to provide this care.

Strategies to boost the numbers of Aboriginal and Torres Strait Islander people in the maternity workforce to support the maternity care needs of Aboriginal and Torres Strait Islander women and babies are addressed in this Plan. The Plan also addresses the provision of culturally competent workplaces that support and retain Aboriginal and Torres Strait Islander people in the maternity workforce (see Action 2.2). Strategies include a national approach by all Australian governments and HWA.

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **3.2.1** AHMAC recommends to HWA that strategies are developed to increase access to a range of programs, including Certificate IV Aboriginal Health Worker, midwifery and medical training, which lead to an increase in the number of Aboriginal and Torres Strait Islander people in the maternity workforce. | HWA implements strategies that lead to an increase in the number of Aboriginal and Torres Strait Islander people in the maternity workforce.<br>HWA monitors the effectiveness of strategies that lead to an increase in the number of Aboriginal and Torres Strait Islander people in the maternity workforce. | HWA evaluates the effectiveness of strategies that lead to an increase in the number of Aboriginal and Torres Strait Islander people in the maternity workforce. | There is an increased number of Aboriginal and Torres Strait Islander people in the maternity workforce across all disciplines and qualifications. |
| **3.2.2** Australian governments, through Closing the Gap initiatives, continue to provide support to increase the number and capacity of Aboriginal and Torres Strait Islander people in the maternity workforce across all disciplines and qualifications. | Australian governments, through Closing the Gap initiatives, continue to provide support to increase the number and capacity of Aboriginal and Torres Strait Islander people in the maternity workforce across all disciplines and qualifications.<br>HWA monitors the effectiveness of initiatives under Closing the Gap that lead to an increase in the number of Aboriginal and Torres Strait Islander people in the maternity workforce across all disciplines and qualifications. | Australian governments, through Closing the Gap initiatives, continue to provide support to increase the number and capacity of Aboriginal and Torres Strait Islander people in the maternity workforce across all disciplines and qualifications. | There is an increased number of Aboriginal and Torres Strait Islander people in the maternity workforce, across all disciplines and qualifications. |

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **3.2.3** The Australian Government provides scholarships (under the Puggy Hunter Memorial Scheme) for the training of Aboriginal and Torres Strait Islander people for the maternity workforce. | The Australian Government provides scholarships for the training of Aboriginal and Torres Strait Islander people for the maternity workforce. | The Australian Government evaluates scholarships for the training of Aboriginal and Torres Strait Islander people for the maternity workforce. | All available scholarships are used by Aboriginal and Torres Strait Islander people to join the maternity workforce. |

AHMAC = Australian Health Ministers' Advisory Council; HWA = Health Workforce Australia

## **Action 3.3** Develop and support a rural and remote maternity workforce

*(Aligned with Principles 1, 3, 5, 6, 7, 9)*

The provision of maternity care for women in rural and remote Australia is particularly affected by maternity workforce shortages.[57] Strategies to increase the rural and remote maternity workforce will enable more women in rural and remote communities to receive maternity care nearer to where they live. This will also enable the women's families to participate in their maternity care experience.

Other strategies to support the rural and remote maternity workforce are detailed throughout Priority 3.

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **3.3.1** The Australian Government continues to provide locum support for the rural maternity workforce.<br>The Australian Government considers expanding locum support for the rural and remote maternity workforce. | The Australian Government continues to provide support for the rural maternity workforce. | The Australian Government continues to provide locum support for the rural maternity workforce.<br>The Australian Government evaluates locum support for the rural and remote maternity workforce. | Australian women in rural and remote Australia have access to continuity of service through the provision of locum support for the maternity workforce. |
| **3.3.2** The Australian Government provides training scholarships to increase the maternity workforce in rural and remote Australia. | The Australian Government provides training scholarships to increase the maternity workforce in rural and remote Australia. | The Australian Government continues to provide training scholarships to increase the maternity workforce in rural and remote Australia.<br>The Australian Government evaluates the provision of training scholarships to increase the maternity workforce in rural and remote Australia. | Training scholarships are available and used by the rural and remote maternity workforce.<br>Women in rural and remote Australia have increased access to local maternity care. |
| **3.3.3** Australian governments explore options for the flexible delivery of education and training for the rural and remote maternity workforce. | Australian governments implement the flexible delivery of education and training for the rural and remote maternity workforce. | Australian governments evaluate the provision of flexible education and training for the rural and remote maternity workforce. | The rural and remote maternity workforce has increased access to education and training. |

## **Action 3.4** Facilitate a culture of interdisciplinary collaboration in maternity care

*(Aligned with Principles 1, 2, 5, 6, 7, 9, 10)*

In 2008, Australian Health Ministers endorsed interdisciplinary collaboration as a key element of providing safe and high-quality maternity care.[36] AHMAC has undertaken a range of projects designed to foster collaboration between maternity professionals (see Appendix A).

An interdisciplinary collaborative approach to maternity care requires a culture that recognises and effectively utilises the individual qualifications, skills and experience of all members of the maternity workforce. This enables all maternity care professionals to work to their full scope of practice and support new, smarter ways of working that will benefit women, their babies and their families.

This Plan describes the initial steps required to develop interdisciplinary collaboration in maternity care across all settings. Interdisciplinary collaborative practice is supported through a range of mechanisms, and will continue to be developed under the auspices of AHMAC as a priority of this Plan.

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **3.4.1** AHWMC considers the recommendations arising from the Core Competencies and Educational Framework for Primary Maternity Services Final Report (June 2010). | Propose that AHWMC works with HWA and AHPRA to implement agreed actions arising from the Core Competencies and Educational Framework for Primary Maternity Services Final Report. | As per the middle years. | Agreed actions arising from the Core Competencies and Educational Framework for Primary Maternity Services Final Report are implemented. |
| **3.4.2** The Australian Government, through the NHMRC, develops National Guidance for Collaborative Maternity Care. | Australian governments consider the use of the National Guidance for Collaborative Maternity Care in the development of maternity care policy.<br>The maternity workforce incorporates the National Guidance for Collaborative Maternity Care in their clinical practice. | The Australian Government evaluates the uptake of the National Guidance for Collaborative Maternity Care. | Health professionals utilise the National Guidance for Collaborative Maternity Care. |

AHPRA = Australian Health Practitioners Regulation Agency; AHWMC = Australian Health Workforce Ministers Council; HWA = Health Workforce Australia; NHMRC = National Health and Medical Research Council

# Priority 4 — infrastructure

## **Action 4.1** Ensure all maternity care is provided within a safety and quality system

*(Aligned with Principles 2, 4, 5, 7, 8, 9)*

A feature of this Plan is ensuring maternity services provide care within a sound safety and quality system, supported by a comprehensive evidence base to inform quality improvement. National quality and safety standards will help to maintain Australia's outcomes for mothers and babies. Establishing and maintaining these standards is a priority as innovative and progressive models of maternity care are implemented around Australia.

Care along the maternity pathway is typically provided across a number of settings and by a number of different providers. Effective communication and coordination is essential to achieve continuity of care across service providers and settings. Ensuring maternity care is well integrated and coordinated also facilitates the appropriate care for women with complex needs.

Standards and programs to support accurate and efficient information transfers between maternity services across the public and private interface in primary, secondary and tertiary settings, including to rural and remote locations, are currently being developed as part of the National E-Health Transition Authority's work program. The national implementation of woman handheld medical records supports women's inclusion in their maternity care and facilitates sharing of information between maternity professionals.[36]

Strategies in this Plan address the linking of maternity services within a robust system of transfer and referral, including links within and from maternity services and specialist services (such as neonatal services) to other areas of the health system, such as preventative health, allied health, child and family health services. Specific action related to a safety and quality framework for the provision of private homebirth is at Action 1.2.3.

The National Registration and Accreditation Scheme (NRAS) for health professions commenced on 1 July 2010. The new system, developed with the agreement of the Council of Australian Governments, for the first time creates a single national registration and accreditation system for 10 health professions, including medical, and nursing and midwifery. National Boards for the professions are now operating with their full functions under the *Health Practitioner Regulation National Law Act 2009*, known as the National Law in participating jurisdictions. The National Boards, including the Nursing and Midwifery Board of Australia, have the over-arching aim of protecting the public.

Maternity care reforms are introducing new ways of working for eligible and privately practising midwives. Working under the new practice requirements of the Nursing and Midwifery Board of Australia requires a structure and process to monitor compliance with these practice requirements, and to provide support for eligible and privately practising midwives.

Elements of the Plan described in this section also align with Action 2.1.

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **4.1.1** The Australian Government works with RANZCOG and ACM to inform the development of consultation and referral guidelines for maternity care. | Australian governments work with RANZCOG and ACM to facilitate the use of consultation and referral guidelines into maternity care. | | Health professionals utilise the consultation and referral guidelines for maternity care. |
| **4.1.2** | AHMAC maps current practices for the transfer of information and referral from maternity care to child and family health care, including general practice. | AHMAC develops and endorses a nationally consistent approach to information transfer and referral from maternity care to child, and family health care, including general practice.<br>States and territories implement a nationally consistent approach to information transfer and referral from maternity care to child, and family health care, including general practice. | All women and babies are referred to child and family health care.<br>Standardised information is shared with child and family health care. |
| **4.1.3** AHMAC develops a national woman-held pregnancy record. | States and territories implement the national woman-held pregnancy record, complementing the PCEHR system. | AHMAC evaluates the use of a national woman-held pregnancy record. | Women have access to the national woman-held pregnancy record for the duration of their maternity care. |
| **4.1.4** The Australian Government, in consultation with key stakeholders, commences planning for the introduction of a PCEHR. | The Australian Government ensures that all Australians who choose to can register online for their PCEHR. Mothers and their newborn children will be a priority implementation group. | The Australian Government further develops the PCEHR. | Personally controlled electronic health records are available for women and babies. |
| **4.1.5** The Australian Government funds the development of nationally consistent maternal and perinatal data collections. | The Australian Government facilitates standardised nationally consistent maternal and perinatal data collections.<br>AHMAC agrees and begins facilitating the capture of standardised nationally consistent data items for the national data collections. | AHMAC facilitates the capture of nationally consistent data items for the national data collections.<br>The Australian Government publishes a report on maternal and perinatal outcomes. | Nationally consistent maternal and perinatal data are collected and reported. |

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **4.1.6** | AHMAC explores options for using innovative technology solutions to provide specialist consultation and care to women in rural and remote locations. | Australian governments facilitate the use of innovative technology solutions to provide specialist consultation and care to women in rural and remote locations.<br>Australian governments review the use of innovative technology solutions to provide specialist consultation and care to women in rural and remote locations. | Increased numbers of women in rural and remote locations receive appropriate specialist consultation and care through the use of innovative technologies in their maternity care. |

AHMAC = Australian Health Ministers' Advisory Council; ACM = Australian College of Midwives; PCEHR = personally controlled electronic health record system; RANZCOG = Royal Australian and New Zealand College of Obstetricians and Gynaecologists

## **Action 4.2** Ensure maternity service planning, design and implementation is woman-centred

*(Aligned with Principles 1, 2, 3, 4, 5, 7)*

The planning, design and implementation of maternity services requires a woman-centred approach to meet the needs of women, and to provide equitable access to appropriate care that is clinically appropriate, culturally competent and provided within broader safety, quality and resource considerations. Women's expectations for their maternity care must also be considered and inform strategic service planning initiatives.

Factors to be considered in service planning, design and implementation of maternity services include:

- birth rates within communities
- geographic factors, such as remoteness
- socioeconomic factors including community levels of social disadvantage
- links to medical specialists, allied health, child and family health, and other services
- resourcing and service capability

A feature of the Plan is the development of a rigorous methodology to assist in woman-centred maternity service planning. This methodology, to be used in the context of broader resource considerations, would be expected to provide some guidance on the reasonable expectation of the local availability of maternity services for varying population centres, including consideration of:

- access to a choice of birthing options
- safety and quality requirements
- numbers and qualifications of maternity care professionals
- workforce/resource implications
- sustainability of the services

The incorporation and adaptation of existing and in-development objective tools will contribute to that methodology. These tools may include:

- a national service capability framework
- Australian Bureau of Statistics birth rate data
- the Rural Birthing Index developed in Canada
- tools currently used by the jurisdictions to inform service planning

An audit of existing tools used to inform service planning, and the mapping of existing maternity services, Aboriginal and Torres Strait Islander services and other relevant services including allied health, will be followed by a gap analysis to identify existing areas of need.

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **4.2.1** AHMAC examines tools to assist in future planning for maternity care, including in rural and remote communities. | AHMAC develops a rigorous methodology to assist in future planning for maternity care, including in rural and remote communities. | Australian governments use the methodology to assist in maternity care planning. | A rigorous methodology is used to assist maternity service planning. |
| **4.2.2** AHMAC develops a National Maternity Services Capability Framework for the provision of maternity care. | All jurisdictions implement a National Maternity Services Capability Framework. | AHMAC reviews the National Maternity Services Capability Framework. | A National Maternity Services Capability Framework is used by all jurisdictions. |
| **4.2.3** Australian governments, through Closing the Gap initiatives, continue to provide supported accommodation and travel options for Aboriginal and Torres Strait Islander women and key family members who travel to access appropriate levels of maternity and neonatal care.<br>States and territories review existing accommodation and transport support mechanisms for women and key family members who travel to access appropriate levels of maternity and neonatal care. | As for year 1.<br>Australian governments explore options for increasing support for women and family members who travel to access appropriate levels of maternity and neonatal care. | Australian governments, through Closing the Gap initiatives, evaluate the provision of supported accommodation and travel options for Aboriginal and Torres Strait Islander women and family members who travel to access appropriate levels of maternity and neonatal care.<br>Australian governments implement strategies for increasing support for women and family members who travel to access appropriate levels of maternity and neonatal care. | Increased number of Aboriginal and Torres Strait Islander women and family members who travel to access appropriate levels of maternity and neonatal care have access to support for accommodation and transport.<br>Increased number of women and family members who travel to access appropriate levels of maternity and neonatal care have access to accommodation and transport support. |
| **4.2.4** | | AHMAC agrees to develop nationally consistent descriptors and definitions for the range of models of maternity care.<br>AHMAC develops agreed nationally consistent descriptors and definitions for the range of maternity care available. | There are agreed descriptors and definitions of the range of maternity care available. |

| The initial year | The middle years | The later years | Signs of success |
|---|---|---|---|
| **4.2.5** The Australian Government introduces MBS and PBS subsidies for antenatal, intrapartum (excluding homebirth) and postnatal services provided by eligible midwives.<br>States and territories use best endeavours to amend the relevant drugs and poisons legislation to enable appropriate prescribing rights for midwives to facilitate access to PBS subsidies for women. | The Australian Government monitors the uptake of MBS and PBS subsidies by women. | The Australian Government evaluates women's access to MBS and PBS subsidies for services provided by eligible midwives.<br>The Australian Government reviews the health care settings under which MBS services for intrapartum care attracts a MBS and PBS subsidy. | There is an annual increase in the number of women accessing PBS and MBS subsidies for services provided by eligible midwives. |

AHMAC = Australian Health Ministers' Advisory Council; MBS = Medicare Benefits Schedule; PBS = Pharmaceutical Benefits Scheme

# Part 3
Implementation of the National Maternity Services Plan

# Implementation

All Australian governments are committed to maternity care reform, and acknowledge the need to maintain this momentum through ongoing implementation and resourcing of the Plan.

The Plan's successful implementation will require a united approach between all Australian governments together with all maternity health service professionals from both the public and private sector and Australian women and their families who use maternity services.

The Plan's implementation will be progressed by governments both independently and nationally under AHMAC. All jurisdictions will report to AHMC via AHMAC and HPPPC.

Implementation will need to be responsive to the areas of health reform under way nationally.

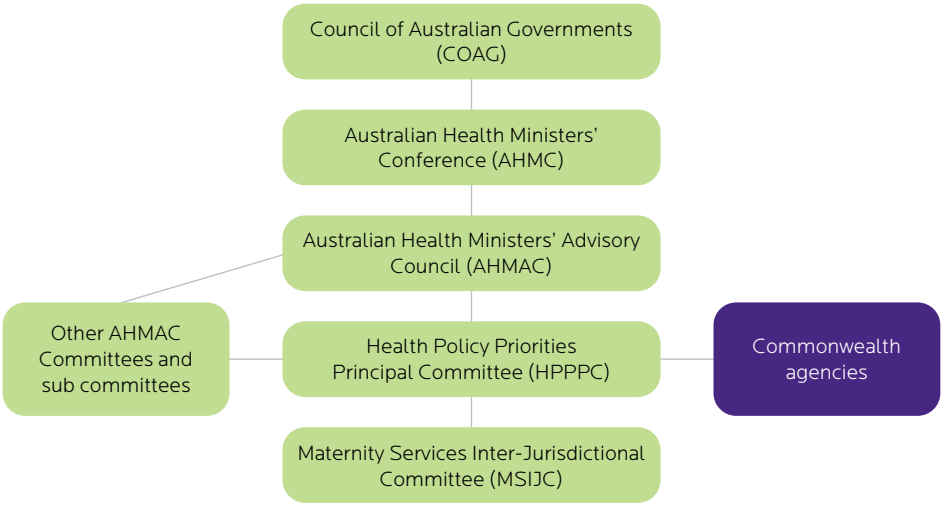
## Governance structure

Implementation, reporting and evaluation of the Plan are the responsibilities of AHMAC. AHMAC will provide regular reports on the Plan's progress and implementation to Australian Health Ministers who will, in turn, report on matters to COAG, where they intersect with broader COAG initiatives.

The Plan's implementation will be progressed through AHMAC's HPPPC and Maternity Services Inter-Jurisdictional Committee. These committees will facilitate collaboration and sharing of information and expertise, and promote national consistency across key issues. Some elements of the Plan will be the responsibility of other AHMAC Principal Committees, as described in the implementation plan.

These governance arrangements are presented in Figure 6.

**Figure 6** Governance of the National Maternity Services Plan



## Overview of key responsibilities and commitments under the Plan

### National

All Australian governments are working collaboratively to further develop an evidence base to inform decision making and quality improvement for maternity services through national frameworks and guidelines. These include a national approach to:

- consistency in data collections
- analysis and reporting on priority issues
- targeted research projects on priority issues
- national consistency in education programs leading to registration of the maternity workforce through accreditation by the Australian Health Practitioner Regulation Agency

All governments, through AHMAC, are responsible for monitoring and evaluating the implementation and achievement of actions in the Plan. AHMAC will also engage with key agencies and expert advisory groups, as required, to implement actions in the Plan.

### Australian Government

The Australian Government will oversee reforms to the maternity workforce, including access to the MBS and PBS for eligible midwives, support for professional indemnity insurance for eligible midwives and the provision of scholarships for maternity professionals.

The Australian Government, through the MBS and PBS, has responsibility for partly funding elements of private maternity services and private maternity professionals, including medical practitioners and eligible midwives for MBS services and as PBS prescribers.

### States and territories

States and territories will facilitate national workforce reforms by amending legislation to allow for their implementation. They will also develop an implementation process to align appropriate nurses/midwives legislation to include prescribing by nurses and midwives within their scope of practice.

States and territories are also responsible for the provision of services in public hospitals and other public maternity services, including providing the infrastructure to network services and for the collection of data for a national dataset.

States and territories will engage with local stakeholders and advisory groups as required to implement the Plan.

### Private sector

The private sector, both individuals and institutions, is responsible for implementing and maintaining national standards of evidence-based care within the sector, including facilitating new roles for eligible midwives. The NPA will oversee the private sector's performance reporting and accountability.

## Implementation strategy

The Plan will be implemented sequentially. This will allow future planning and resourcing decisions to be informed by the outcomes achieved in earlier years, and also acknowledges the ongoing nature of the broader health reform process.

When developing implementation strategies under this Plan, consideration will be given to the impact on neonatal and other specialist services, reflecting the interrelationship between maternity, and neonatal and other specialist services.

### Phase 1: An implementation strategy for the initial year

An implementation plan has been prepared for the initial year, and includes investments and commitments from all jurisdictions to improve maternity services. Over the first year of the Plan, Australian governments will work together to provide a detailed implementation strategy for the subsequent years. The implementation strategy will include the specification of resourcing for each phase of the Plan.

The Phase 1 implementation plan is provided below (page 61).

### Phase 2: An implementation strategy for the middle and later years

The implementation of middle and later year actions (years 2–5) will depend in part on the outcomes of the first year of the Plan. Phase 2 can then reflect changes to the maternity care environment that result from the broader health reforms occurring nationally.

Implementation will also include the reassessment and incorporation of any necessary amendments or additions to the Plan once Actions, including 4.2.1 and 4.2.2, are further progressed.

The implementation strategy for Phase 2 will be finalised by the end of Year 1 of the Plan.

### Phase 3: Review of the implementation strategy for the later years

The implementation strategy for the middle and later years of the Plan will be reviewed in Year 5, to ensure actions and responsible parties remain appropriate as national health reform agendas are advanced.

## Monitoring, evaluation and reporting

Monitoring of the implementation of the Plan and evaluation of the outcomes achieved will be important elements of the Plan.

An annual report of the Plan will be provided by AHMAC to the Health Ministers. This report will comprise reports from all jurisdictions and AHMAC Principal Committees on progress against the actions of the Plan.

Evaluation of the Plan will take place during Year 5 to review achievements and outcomes against the Plan, make recommendations for future actions for maternity services in Australia and inform development of the next Plan. Evaluation of achievements will be aligned with the key priority areas for the Plan.

The annual reporting and national evaluation will primarily use existing materials rather than create new data collections that would impose an additional data-reporting burden on jurisdictions. New reporting activities under the National Health and Hospitals Network will also be considered as appropriate. Existing materials that will inform reporting and evaluation include:

- existing sources of information available through monitoring activities identified in the Plan
- jurisdictional evaluations of particular relevant initiatives to specified questions of national significance
- national reports on maternity care outcomes
- significant reports available on other relevant issues that have implications for maternity care

The evaluation in Year 5 may require specific data collections and evaluation where there are gaps in existing data sources. The Australian Government has commissioned an evaluation framework for Australian Government maternity reform activities identified in the Plan.

AHMAC will consider options for the further evaluation and monitoring of the Plan's implementation and achievements, such as specific descriptive and interpretive data collection and/or special purpose evaluation and collection activities. These activities must also acknowledge the sequential development of an implementation strategy.

## Phase 1: An implementation plan for the initial year

**1.1** Increase access for Australian women and their family members to information that supports their needs for maternity care

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 1.1.1 | The Australian Government expands the National Pregnancy Support Helpline (the Helpline) to provide information, counselling and referral 24 hours a day, 7 days a week<br>The Helpline identifies gaps in the availability of evidence-based information | Australian Government<br>Australian Government | Australian Government through the 2009–10 maternity reform budget package | Helpline is established<br>Gap analysis completed |
| 1.1.3 | AHMAC endorses the first 10 core maternity indicators | HPPPC – Maternity Services Inter-Jurisdictional Committee | Funding provided through AHMAC cost-shared budget 2008–09 | The first 10 core maternity indicators are endorsed by AHMAC |

**1.2** Increase access for Australian women to local maternity care by expanding the range of models of care

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 1.2.1 | Australian governments facilitate increased access to midwifery-managed models of care for normal risk women e.g. midwifery group practice or birthing centres, whilst maintaining support for choice of and access to, medically managed models of care<br>Australian governments facilitate increased access for public patients to midwifery and medical practitioner continuity of carer programs | Australian governments | Funded within jurisdictional budgets | Increased access to midwifery-managed models of care for normal risk women and continuity of carer programs is facilitated |
| 1.2.2 | Jurisdictions develop consistent approaches to the provision of clinical privileges within public maternity services, to enable admitting and practice rights for eligible midwives and medical practitioners | States and territories | Using existing resources | A consistent approach to provision of clinical privileges for eligible midwives and medical practitioners in public health care settings is developed |

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 1.2.3 | NMBA endorses a standard for a safety and quality framework, which includes an assessment of clinical risk, for the provision of private homebirth as part of the agreed two-year exemption on the requirement for midwives to hold professional indemnity insurance in order to register as a midwife<br><br>States and territories investigate options for the provision of publicly funded homebirth care | NMBA<br><br>Australian governments | Using existing resources.<br><br>Funded within jurisdictional budgets | Safety and quality framework for the provision of private homebirth is endorsed by the NMBA<br><br>Expanded options for the provision of publicly funded homebirth care are explored |
| 1.2.4 | States and territories identify the characteristics of maternity care programs that utilise midwives to their full scope of practice | States and territories | Funded within jurisdictional budgets | Maternity care programs that use midwives to their full scope of practice are identified |
| 1.2.5 | The Australian Government enables increased availability of private primary maternity services by private maternity professionals through the introduction of MBS and PBS items, and professional indemnity insurance for eligible midwives<br><br>The Australian Government undertakes consultations with private health insurers through the peak bodies (AHIA and HIRMAA) to assist insurers to meet their legislative obligations under the appropriate Act | Australian Government | Australian Government, through the 2009–10 maternity reform budget package | MBS and PBS items and professional indemnity insurance for private primary maternity services by private maternity professionals within community settings |
| 1.2.6 | AHMAC identifies the availability of access to public antenatal care in a range of local community settings<br><br>AHMAC considers the inclusion of appropriate data items to measure access to public antenatal care in a range of local community settings in a reporting framework (see Action 1.1.2) | HPPPC — Maternity Services Inter-Jurisdictional Committee<br><br>Australian governments | Using existing resources | The availability of existing access to public antenatal care in a range of local community settings is identified<br><br>Access to public antenatal care in a range of local community settings is considered by AHMAC in a reporting framework |

## **1.3** Increase access for women and their family members in rural Australia to high-quality maternity care

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 1.3.1 | The Australian Government expands MSOAP to include multidisciplinary maternity care teams | Australian Government | Australian Government through the 2009–10 maternity reform budget package | Multidisciplinary maternity care teams are included in an expanded MSOAP service |

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 1.3.2 | AHMAC endorses a National Strategic Framework for Rural and Remote Health, which includes objectives and strategies to address access to health services in rural Australia | HPPPC — Rural Health Standing Committee | Funding provided through AHMAC cost-shared budget 2009–10 | National Strategic Framework for Rural and Remote Health is published |

**1.4** Increase access for women and their family members in remote Australia to high-quality maternity care

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 1.4.1 | AHMAC identifies the characteristics of successful community-based maternity care in remote locations | HPPPC — Maternity Services Inter-Jurisdictional Committee, the Rural Health Standing Committee, and the National Aboriginal and Torres Strait Islander Health Officials Network | Using existing resources | The characteristics of successful community-based maternity care in remote locations are identified by AHMAC and disseminated to Australian governments |
| 1.4.2 | AHMAC endorses a national strategic framework for rural and remote health, which includes objectives and strategies to address access to health services in remote Australia | HPPPC — Rural Health Standing Committee | Funding provided through AHMAC cost-shared budget 2009–10 | National Strategic Framework for Rural and Remote Health is published |

**2.1** Ensure Australian maternity services provide high-quality, evidence-based maternity care

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 2.1.1 | AHMAC endorses National Evidence-Based Antenatal Care Guidelines for the first trimester | APHDPC — Child Health and Wellbeing Subcommittee | Additional funding has been provided through AHMAC cost-shared budget 2010–11 | National Antenatal Clinical Practice Guidelines for the first trimester are endorsed by AHMAC |
| 2.1.2 | AHMAC considers the recommendations of the National Maternal Mortality and Morbidity reporting project | HPPPC — Maternity Services Inter-Jurisdictional Committee | Using existing resources | The recommendations of the National Maternal Mortality and Morbidity reporting project are considered by AHMAC |

**2.2** Develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 2.2.1 | AHMAC identifies the characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander people | HPPPC — Maternity Services Inter-Jurisdictional Committee | Using existing resources | The characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander people are identified |
| 2.2.2 | Health Ministers recommend to all the National Boards, through the National Registration and Accreditation Sub Committee, that cultural competence is a component of all training, education and ongoing professional development of the whole maternity workforce | AHMC | Using existing resources | AHMC recommends to all the National Boards that cultural competence is a component of all training, education and ongoing professional development of the whole maternity workforce |
| 2.2.3 | AHMAC undertakes research on international evidence-based examples of birthing on country programs | HPPPC — Maternity Services Inter-Jurisdictional Committee | Additional resources required from the AHMAC cost-shared budget | Research on international evidence-based examples of birthing on country programs is undertaken |

**2.3** Develop and expand appropriate maternity care for women who may be vulnerable due to medical, socioeconomic and other risk factors

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 2.3.1 | Australian governments expand screening for perinatal depression arising from the National Perinatal Depression Initiative[61]<br>Australian governments ensure that training, mentoring and supervision of staff undertaking perinatal mental health screening is provided | Australian governments | Funded within jurisdictional budgets | Training, mentoring and supervision of staff undertaking perinatal mental health screening is provided |
| 2.3.2 | States and territories establish formal referral pathways for women experiencing depression and mental illness with perinatal mental health services<br>States and territories develop options to overcome separation of mothers from their babies while receiving mental health care | States and territories | Funded within jurisdictional budgets | Formal referral pathways for women experiencing depression and mental illness are established with perinatal mental health services<br>Options for evidence-based maternity care for women receiving mental health care are developed |

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 2.3.3 | Australian governments progress investigation of the range of models of maternity care for at-risk women, including:<br>- pregnant adolescents<br>- women with pre-existing medical conditions<br>- women from CALD communities<br>- women in prison<br>- obese women<br>- women using cigarettes, alcohol and illicit substances<br>- older women<br>- women experiencing domestic violence<br>- women who have experienced various forms of female genital cutting | States and territories | Funded within jurisdictional budgets | Options for evidence-based maternity care for at-risk women are investigated |

**3.1** Plan and resource to provide an appropriately trained and qualified maternity workforce that provides clinically safe women-centred maternity care within a wellness paradigm

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 3.1.1 | AHMAC recommends to HWA the investigation of drivers of productivity, performance and retention of the maternity workforce | HWPC with HPPPC | Using existing resources | AHMAC recommends to HWA the investigation of drivers of productivity, performance and retention of the maternity workforce |
| 3.1.2 | AHMAC recommends to HWA that work is undertaken to guide the future development of requirements for education and clinical training for the maternity workforce, and ensure that training places meet this need | HWPC with HPPPC | Using existing resources | AHMAC recommends to HWA that work is undertaken to guide the future development of requirements for education and clinical training for the maternity workforce and ensure that training places meet this need |
| 3.1.3 | NMBA applies the professional requirements for the recognition of eligible midwives | NMBA | Using existing resources of the NMBA | Professional requirements for the recognition of eligible midwives are implemented by the NMBA |

**3.2** Develop and support an Aboriginal and Torres Strait Islander maternity workforce

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 3.2.1 | AHMAC recommends to HWA that strategies are developed to increase access to a range of programs, including Certificate IV Aboriginal Health Worker, midwifery and medical training, which lead to an increase in the number of Aboriginal and Torres Strait Islander people in the maternity workforce | AHMAC through HWPC and HPPPC — Maternity Services Inter-Jurisdictional Committee | Using existing resources | AHMAC recommends to HWA that strategies are developed to increase access to a range of programs that lead to an increase in the number of Aboriginal and Torres Strait Islander people in the maternity workforce |
| 3.2.2 | Australian governments, through Closing the Gap initiatives, continue to provide support to increase the number and capacity of Aboriginal and Torres Strait Islander people in the maternity workforce across all disciplines and qualifications | Australian governments | Funded within jurisdictional budgets | Support to increase the number and capacity of Aboriginal and Torres Strait Islander people in the maternity workforce across all disciplines and qualifications is provided |
| 3.2.3 | The Australian Government provides scholarships (under the Puggy Hunter Memorial Scheme) for the training of Aboriginal and Torres Strait Islander people for the maternity workforce | Australian Government | Funding from the Puggy Hunter Memorial Scholarship Scheme | Scholarships are provided (under the Puggy Hunter Memorial Scheme) for the training of Aboriginal and Torres Strait Islander people for the maternity workforce |

**3.3** Develop and support a rural and remote maternity workforce

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 3.3.1 | The Australian Government continues to provide locum support for the rural and remote maternity workforce<br>The Australian Government considers expanding locum support for the rural and remote maternity workforce | Australian Government | Using existing resources | Locum support continues to be provided |
| 3.3.2 | The Australian Government provides scholarships for training to increase the maternity workforce in rural and remote Australia | Australian Government | Australian Government through the 2009–10 maternity reform budget package | Scholarships for training to increase the maternity workforce in rural and remote Australia are provided |

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 3.3.3 | Australian governments explore options for the flexible delivery of education and training for the rural and remote maternity workforce | Australian governments | Funded within jurisdictional budgets | Options for the flexible delivery of education and training for the rural and remote maternity workforce are explored |

**3.4** Facilitate a culture of interdisciplinary collaboration in maternity care

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 3.4.1 | AHWMC considers the recommendations arising from the Core Competencies and Educational Framework for Primary Maternity Services Final Report (June 2010) | HWA | Using existing resources | AHWMC considers the recommendations arising from the Core Competencies and Educational Framework for Primary Maternity Services Final Report |
| 3.4.2 | The Australian Government, through the NHMRC, develops the National Guidance for Collaborative Maternity Care | Australian Government | Australian Government through the 2009–10 maternity reform budget package | National Guidance for Collaborative Maternity Care is developed |

**4.1** Ensure all maternity care is provided within a safety and quality system

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 4.1.1 | The Australian Government works with the RANZCOG and ACM to inform the development of consultation and referral guidelines for maternity care | Australian Government | Australian Government through the 2009–10 maternity reform budget package | Interdisciplinary consultation and referral guidelines for maternity professionals are under development |
| 4.1.3 | AHMAC develops a national woman-held pregnancy record | HPPPC — Maternity Services Inter-Jurisdictional Committee | Funding provided in 2010–11 AHMAC cost-shared budget | A national woman-held pregnancy record is developed |

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 4.1.4 | The Australian Government, in consultation with key stakeholders, commences planning for the introduction of a PCEHR system | Australian Government | Australian Government through the 2010–11 PCEHR system initiative maternity reform budget package | Consultation with key stakeholders informs planning for the introduction of a PCEHR system |
| 4.1.5 | The Australian Government funds the development of nationally consistent maternal and perinatal data collections | Australian Government | Australian Government through the 2009–10 maternity reform budget package | The development of nationally consistent maternal and perinatal data collections is under way |

**4.2** Ensure maternity service planning, design and implementation is woman-centred

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 4.2.1 | AHMAC examines tools to assist in future planning for maternity care, including in rural and remote communities | HPPPC — Maternity Services Inter-Jurisdictional Committee with the Rural Health Standing Committee | Additional funding from the AHMAC cost-shared budget would be required | Appraisal of tools is completed |
| 4.2.2 | AHMAC develops a National Maternity Services Capability Framework for the provision of maternity care | HPPPC — Maternity Services Inter-Jurisdictional Committee | Funding provided from 2010–11 AHMAC cost-shared budget | National Maternity Services Capability Framework for the provision of maternity care is developed |
| 4.2.3 | Australian governments, through Closing the Gap initiatives, continue to provide supported accommodation and travel options for Aboriginal and Torres Strait Islander women and key family members who travel to access appropriate levels of maternity and neonatal care | Australian governments | Funded within jurisdictional budgets | Supported accommodation and travel options continue to be provided |
| | States and territories review existing accommodation and transport support mechanisms for women and key family members who travel to access appropriate levels of maternity and neonatal care | States and territories | Using existing resources | Existing accommodation and transport support mechanisms are reviewed |

| Action | Initial year action | Responsibility | Funding | Signs of success — end of year 1 |
|---|---|---|---|---|
| 4.2.5 | The Australian Government introduces MBS and PBS subsidies for antenatal, intrapartum (excluding homebirth) and postnatal care provided by eligible midwives | The Australian Government | Australian Government, through the 2009–10 maternity reform budget package | Australian Government introduces MBS and PBS subsidies for antenatal, intrapartum and postnatal care provided by eligible midwives |
| | States and territories use best endeavours to amend the relevant drugs and poisons legislation to enable appropriate prescribing rights for midwives to facilitate access to PBS subsidies for women | States and territories | Funded within jurisdictional budgets | States and territories facilitate the implementation of PBS subsidies for private midwives by amending relevant drugs and poisons legislation to enable appropriate prescribing rights for eligible midwives |

AHIA = Australian Health Insurance Association; ACM = Australian College of Midwives; AHMAC = Australian Health Ministers' Advisory Council; AHMC = Australian Health Ministers' Conference; AHWMC = Australian Health Workforce Ministerial Council; APHDPC = Australian Population Health Development Principal Committee; CALD = culturally and linguistically diverse; HIRMAA = Health Insurance Restricted Membership Association of Australia; HPPPC = Health Policy Priorities Principal Committee; HWA = Health Workforce Australia; HWPC = Health Workforce Principal Committee; MBS = Medicare Benefits Schedule; MSOAP = Medical Specialist Outreach Assistance Program; NHMRC = National Health and Medical Research Council; NMBA = Nursing and Midwifery Board of Australia; PBS = Pharmaceutical Benefits Scheme; PCEHR = personally controlled electronic health record

# Appendixes

# **Appendix A** AHMAC initiatives

In recent years, AHMAC has initiated a range of projects aimed at improving maternity services in Australia. These AHMAC initiatives outline agreed principles for reform and set the context for the action described in the National Maternity Services Plan (the Plan).

## Primary Maternity Services: A Framework for Implementation

The framework, endorsed by AHMAC in 2008, articulates principles for implementing primary maternity services as well as providing examples of best practice maternity service models in Australia. The eight principles identified for primary maternity services are:

- Principle 1: Ensuring services enable women to make informed and timely choices regarding their maternity care, and to feel in control of their birthing experience.
- Principle 2: Ensuring that maternity services and care are provided in a culturally appropriate and responsive manner according to the individual needs of each woman.
- Principle 3: Maximising the potential of midwives, obstetricians, general practitioners and, where appropriate, other health professionals such as paediatricians and Aboriginal health workers with specific knowledge, skills and attributes to provide a collaborative, coordinated interdisciplinary approach to maternity service delivery.
- Principle 4: Offering continuity of care and, wherever possible, continuity of carer as a key element of quality care.
- Principle 5: Ensuring that maternity services are of a high quality, safe, sustainable and provided within an environment of evidence-based care.
- Principle 6: Ensuring continued access to evidence-based maternity services and care at the local level, while recognising that the benefits of local access must be considered within a quality and safety framework.
- Principle 7: Providing the right balance between primary level care and access to appropriate levels of medical expertise as clinically required.
- Principle 8: Working to reduce the health inequalities faced by Aboriginal and Torres Strait Islander mothers and babies, and other disadvantaged populations

## National Evidence-Based Antenatal Care Guidelines

Evidence-based clinical guidelines for antenatal care are being developed by AHMAC under the auspice of the National Health and Medical Research Council. An expert Advisory Committee has been convened to direct the guideline development, and the Maternity Services Inter-Jurisdictional Committee (MSIJC) is now a co-sponsor of this project with the Child Health and Wellbeing Subcommittee of the Australian Population Health Development Principal Committee.

## Core Competencies and Educational Framework for Maternity Services in Australia

Detailed engagement with all maternity services and professions has been undertaken to develop a framework for education and core competencies for maternity professionals. The framework will be program based rather than profession based to promote interprofessional collaboration and evidence-based care by maternity professionals. This project is co-sponsored by the National Health Workforce Taskforce and the MSIJC.

## National Maternal and Perinatal Mortality and Morbidity Reporting project

This project aims to ensure that:

- national databases support the implementation of performance benchmarks
- data definitions enable appropriate and valid data collection
- definitions are consistent across jurisdictions and services
- national data on primary maternity care are provided

The MSIJC is providing advice to AHMAC on the reporting and analysis of maternal and perinatal mortality data, and the potential for these data to inform quality improvement for maternity care.

## The Core Maternity Indicators project

ACSQHC commenced development of the information for the Core Maternity Indicators project, which was transferred to the sponsorship of the MSIJC in 2008.

The MJISC has since convened an Expert Working Group to consider the relevance and currency of the indicators, and to make recommendations to AHMAC for a contemporary set of core national maternity indicators that will inform quality improvement in maternity services.

## The National Woman-Held Pregnancy Record project

The MSIJC is developing a National Woman Held Pregnancy Record (NWHPR) to align with and complement the national electronic health records under development. Benefits of the handheld record include:

- reduction in local variations in service and practice
- improvement of the ability of women to move between different jurisdictions and professionals during their pregnancy as they take their records with them
- elimination of the need for the history-taking process to be repeated with each new health professional
- improvement in data capture about care provided and outcomes using the core dataset facilitated by the NWHPR
- improvement in communication
- improvement in risk management

The project includes an examination of jurisdictional and international handheld records, with recommendations for a national, standardised record due to be completed by July 2011.

## National Maternal and Neonatal Services Capability Framework

The MSIJC is undertaking mapping and analysis of jurisdictional maternity and neonatal service capability frameworks. Recommendations will be delivered to the HPPPC for the potential aligning of jurisdictional frameworks to provide:

- a standard set of capability requirements for most acute health facility services provided by health facilities
- a consistent language for health care providers and planners to use when describing health services and planning service developments

The development of a National Services Capability Framework will enable nationally consistent benchmarking of clinical indicators as well as meaningful comparisons of maternal mortality and morbidity.

This project is due for completion in July 2011.

# **Appendix B** Related Australian Government strategies

The Australian Government has recognised the need for national leadership in health care, including maternity care, to address issues, gaps and priorities affecting Australian communities. The following table outlines a number of relevant, major strategies, and highlights which of the priorities of the National Maternity Services Plan (the Plan) they address.

These strategies include:

**Table B.1** Related Australian Government strategies

| Initiative | Plan priority | | | |
|---|---|---|---|---|
| | Access | Service delivery | Work-force | Infra-structure |
| **National initiatives** | | | | |
| **National Primary Health Care Strategy**<br>▸ On 11 June 2008, the Australian Government announced the development of a National Primary Health Care Strategy to manage the health challenges of the 21st century supported by an External Reference Group of health experts.<br>▸ The 2010 National Primary Health Care Strategy provided a road map to guide future policy and practice in primary health care in Australia. Of its four priority areas, three are directly related to needs identified in the Maternity Services Review:<br>– Key priority area 1: Improving access and reducing inequity<br>– Key priority area 3: Increasing the focus on prevention<br>– Key priority area 4: Improving quality, safety, performance and accountability. | ✓ | ✓ | | |
| **National Preventative Health Strategy**<br>▸ The National Preventative Health Taskforce was established in April 2008 to develop the National Preventative Health Strategy. It initially focused on obesity, tobacco and excessive consumption of alcohol.<br>▸ The Taskforce considered the keys to prevention during pregnancy and the early years of life as:<br>– early identification of family risk and need, starting in the antenatal period<br>– response to needs in pregnancy, early years and through parent support<br>– monitoring of child health, development and wellbeing<br>– service redevelopment and workforce training to meet family and childhood needs.<br>▸ *Australia: The Healthiest Country by 2020: National Preventative Health Strategy*[31] was released in 2009 and focused on a primary prevention agenda reflecting the social determinants of health such as housing, welfare, justice, immigration, employment, agriculture, education, family and community services, Aboriginal and Torres Strait Islander people affairs, and communications.<br>▸ The Strategy included recommendations that directly support the National Maternity Services Plan.<br>▸ The Australian Government's response to the National Preventative Health Strategy was released on 11 May 2010. All the Taskforce's recommendations that related to maternal and child health, enhancing early life, and growth patterns were either supported by the Australian Government or were consistent with current Australian Government initiatives. | ✓ | ✓ | ✓ | ✓ |

| Initiative | Plan priority | | | |
|---|---|---|---|---|
| | Access | Service delivery | Work-force | Infra-structure |
| **National E-Health Agenda**<br>▸ On 12 February 2010, AHMAC affirmed their commitment to advancing an e-health agenda for the Australian health system with a focus on developing electronic health records and accompanying unique health care identifiers for consumers.<br>▸ Other potential elements of e-health initiatives include:<br>– e-discharge summaries that allow the electronic exchange of comprehensive and accurate patient reports between hospitals and primary health care sectors<br>– e-referrals that will facilitate the seamless exchange of significant patient information from one treating health care provider to another.<br>▸ The E-Health agenda will enhance collaboration and communication between maternity professionals and maternity services by facilitating the timely transfer of information between providers of maternity services throughout pregnancy, birth and postpartum care. | | ✓ | | ✓ |
| **National health workforce initiatives**<br>*National Health Workforce Taskforce*<br>▸ In 2006, COAG established the National Health Workforce Taskforce (NHWT) to undertake projects that inform development of practical solutions on workforce innovation. The taskforce reported directly to the Chair of AHMAC's Health Workforce Principal Committee (HWPC). This taskforce has subsequently been subsumed by a new agency, Health Workforce Australia (HWA).<br>*National Health Workforce Planning and Research Collaboration*<br>▸ On 24 November 2009, a consortium comprising the Australian Health Workforce Institute (AHWI) and PricewaterhouseCoopers was selected to undertake the National Health Workforce Planning and Research Collaboration.<br>▸ The collaboration between the NHWT and the consortium have informed the establishment of HWA, which will undertake a substantial program of national health workforce planning and research projects over three years.<br>*Health Workforce Australia*<br>▸ On 12 February 2010, COAG established a new agency, HWA, to manage and oversee major reforms to the Australian health workforce, such as increasing workforce supply and reforming the workforce.<br>▸ HWA is governed by a board that includes a representative of each jurisdiction. | | ✓ | ✓ | |

| Initiative | Plan priority | | | |
|---|---|---|---|---|
| | Access | Service delivery | Work-force | Infra-structure |
| **Early childhood initiatives**<br><br>*National Early Childhood Development Strategy*<br>▸ On 2 July 2009, COAG endorsed the Investing in the Early Years — A National Early Childhood Development Strategy,[64] which reflected the commitment of Australian governments to take a leadership role in early childhood development now and into the future.<br>▸ The strategy seeks to achieve positive early childhood development outcomes, and address concerns about individual children's development early to reduce and minimise the impact of risk factors before problems become entrenched.<br>▸ The strategy aims to improve outcomes for all children and reduce inequalities in outcomes between groups of children. It covers children from the antenatal period to eight years.<br>▸ The strategy proposes six priority areas for reform to be further developed for COAG in 2010, including strengthening universal maternal, child and family health services, and strengthening the early childhood development and family support services workforce.<br>▸ Strategies aligned with the National Maternity Services Plan are the development of the evidence-based clinical guidelines for antenatal care.<br>▸ The strategy also recommended the development of a National Maternity Services Plan (this Plan), drawing on the Maternity Services Review. | ✓ | ✓ | ✓ | ✓ |
| *National Framework for Protecting Australia's Children 2009–2020*<br>▸ The first *National Framework for Protecting Australia's Children 2009–2020* has been endorsed by all Australian governments. It is a long-term, national approach to help protect all Australian children, developed in response to an increasing number of reports of child abuse and neglect.<br>▸ The Framework calls for a paradigm change, from seeing 'protecting children' merely as a response to abuse and neglect to one of promoting the safety and wellbeing of children. It argues that applying a public health model to care and protection will provide better outcomes for children and young people and their families.<br>▸ This Framework is aligned with the Plan as it identifies the role of health professionals in working with child protection services to identify and prevent at-risk children and families. | | | | |
| *Draft National Framework for Universal Child and Family Health Services*<br>▸ Victoria is overseeing this project as part of a steering committee consisting of representatives from South Australia, the Australian Capital Territory, Western Australia, New South Wales and the Department of Health and Ageing. Consultation has occurred with key stakeholders in assessing the *Draft National Framework for Universal Child and Family Health Services*. This project has been conducted on behalf of the Child Health and Wellbeing Subcommittee of the Australian Population Health Development Principal Committee of AHMAC.<br>▸ This 2009 draft national framework includes the vision, objectives, principles and core activities of a universal child and family health service. Its main aim is to promote consistency in child and family health services across Australia.<br>▸ The framework covers children and their families from birth to eight years. It also recognises the antenatal period as being important for children's health and development, and in need of further integration. | | | | |

| Initiative | Plan priority | | | |
|---|---|---|---|---|
| | Access | Service delivery | Work-force | Infra-structure |
| *Healthy Eating and Physical Activity Guidelines for Early Childhood Settings*<br>▸ The *Healthy Eating and Physical Activity Guidelines for Early Childhood Settings*[65] was launched in October 2009. They form part of the Australian Government's plan for tackling obesity in early childhood, with a budget of $4.5 million over five years.<br>▸ The guidelines and resources were developed by a consortium comprising the Murdoch Children's Research Institute Centre for Community Child Health, Early Childhood Australia and the Royal Children's Hospital Melbourne.<br>▸ The Get Up and Grow guidelines and resources provide early childhood education and care settings (centre based care, family day care and pre-schools) and families with children attending these settings with practical information to support and promote healthy eating and physical activity in children under five years of age. | | | | |
| *Review of Infant Feeding Guidelines for Health Workers*<br>▸ The 2003 NHMRC *Infant Feeding Guidelines for Health Workers* (Infant Feeding Guidelines) includes guidance on the establishment and maintenance of breastfeeding, the management of breastfeeding problems and the safe use of infant formula. The revised Infant Feeding Guidelines will complement the revised suite of NHMRC's Australian dietary guidelines. | | | | |
| **National Mental Health Plan 2009–2014**<br>▸ On 13 November 2009, the Australian Health Ministers' Conference launched the Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009–2014.<br>▸ The National Mental Health Plan features national actions to implement targeted prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations.<br>▸ Within the National Mental Health Plan, the National Perinatal Depression Initiative[61] recognises that depression is common in the perinatal period and that maternal wellbeing is critical for early attachment. The National Perinatal Depression Initiative is discussed below. | | ✓ | | |

| Initiative | Plan priority | | | |
|---|---|---|---|---|
| | Access | Service delivery | Work-force | Infra-structure |
| **National Health and Hospitals Reform Commission**<br>▸ The National Health and Hospitals Reform Commission (NHHRC) was established by the Australian Government in February 2008 to report to the Australian Government on long-term health reform.<br>▸ The NHHRC's 2009 report, *A Healthier Future for all Australians: Final Report*[66] presented more than 100 recommendations to transform the Australian health system.<br>▸ This report outlined very specific recommendations that directly support the National Maternity Services Plan. These include:<br>– providing targeted services to help teenage girls at risk of pregnancy<br>– universal child and family health services providing a schedule of core contacts<br>– determining a pathway for targeted care where the universal child and family health services identify a health or developmental issue or support need such as an enhanced schedule of contacts and referral to allied health and specialist services<br>– subsidies to bring the price of fresh food in line with large urban and regional centres, investment in nutrition education and community projects, and food and nutrient supplementation for schoolchildren, infants, and pregnant and breastfeeding women; the strategy would be developed in consultation with Aboriginal and Torres Strait Islander communities building on existing successful initiatives in this area<br>– increased care and support for people living in remote and rural locations. | ✓ | ✓ | ✓ | ✓ |
| **Australian Health Care Agreements**<br>▸ Under the Australian Health Care Agreements (AHCAs), state and territory governments provided free public hospital services to public patients and were responsible for the day-to-day operations of public hospitals. They also determined the major public hospital funding and guidelines on the budget over a five-year period.<br>▸ The primary objective of the AHCAs was to secure access for the Australian community to public hospital services based on three principles that broadly guide the provision of public maternity services:<br>– eligible persons are given the choice to receive free health and emergency services of a kind or kinds that are currently, or were (on 1 July 1998) provided by hospitals as a public patient<br>– access to such services by public patients is on the basis of clinical need and within a clinically appropriate period<br>▸ Arrangements were to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographical location.<br>▸ The AHCA's have now been replaced by the National Healthcare Agreement, and the National Health and Hospitals Network Agreement. | ✓ | | | ✓ |

| Initiative | Plan priority | | | |
|---|---|---|---|---|
| | Access | Service delivery | Work-force | Infra-structure |
| **State of our public hospital reports**<br>▸ Under the AHCAs, the Australian Government was responsible for publishing an annual report on the performance of public hospitals in each state and territory.<br>▸ The *State of our Public Hospitals, June 2009*[67] report described the performance of public and private hospitals in 2007–08 and included chapters on national hospital reform activities, Aboriginal and Torres Strait Islander people in hospitals, maternity services in Australian hospitals and state and territory public hospital performance reporting.<br>▸ This 2009 report identified four important issues for the hospital system. Two of these issues are relevant to the Plan — Aboriginal and Torres Strait Islander Australians in hospital, and improving maternity services.<br>▸ This report was authored at a time when major reforms were being orchestrated by the Australian Government. This reform agenda has resulted in Australian governments agreeing to move towards a more comprehensive framework for the new health agreement, including increased investment. | | | | ✓ |
| **National maternity services initiatives** | | | | |
| **Expanding Medicare support**<br>▸ Establishing new arrangements under Medicare for eligible midwives will expand their role in providing maternity care for Australian mothers and their babies.<br>▸ This initiative, through arrangements for Medicare Benefits Schedule (MBS) rebates (including a range of associated MBS services, such as requesting pathology and diagnostic imaging services) for eligible midwives and access to the Pharmaceutical Benefits Scheme (PBS), for authorised midwives (subject to state and territory legislation enabling midwives to prescribe) will:<br>– reduce family disruption through greater access to services close to home<br>– expand the range of birthing options available to women by supporting them in their choice of practitioner and their preference for continuity of care<br>– ensure Australian women and their babies continue to access maternity services that are safe and high quality, but which will provide greater access to midwives.<br>▸ Recognising midwives as primary maternity care providers under Medicare will improve service delivery by optimising the existing workforce. It will also increase participation and retention rates among midwives.<br>▸ This initiative will reduce the pressure on rural medical practitioners providing maternity services and enable the development of new, more innovative models of care tailored to local needs.<br>▸ This initiative also applies to rural, remote, Aboriginal and Torres Strait Islander and Continuity of Carer programs.<br>▸ $66.6 million over four years. | ✓ | ✓ | ✓ | |

| Initiative | Plan priority | | | |
|---|---|---|---|---|
| | Access | Service delivery | Work-force | Infra-structure |
| **Workforce support**[1]<br>▸ This initiative will provide additional support for GPs and midwives, particularly in rural and remote Australia, to undertake training that will help overcome workforce shortages and increase the availability of maternity services for women and their families.<br>▸ Funding will be provided for:<br>– GPs to undertake additional training to become GP obstetricians or GP anaesthetists<br>– midwives to undertake additional education and training to enable them to provide MBS-subsidised services and prescribe PBS-subsidised medicines.<br>▸ Women, their partners and families will benefit from improved access to a greater range of models of care, particularly in rural and remote areas, and access to maternity care for Aboriginal and Torres Strait Islander mothers and babies.<br>▸ This initiative also applies to rural, remote and Aboriginal and Torres Strait Islander programs.<br>▸ $8 million over four years. | | ✓ | ✓ | |
| **Professional indemnity insurance**<br>▸ From 1 July 2010, all health professionals, including midwives, must be covered by professional indemnity insurance under the National Registration and Accreditation Scheme.<br>▸ Professional indemnity insurance for eligible midwives will underpin the benefits to Australian families of improved choices and access to a range of services and supports for women and their babies during the antenatal, intrapartum and immediate post natal period (with the exception of planned delivery in the home).<br>▸ This initiative also applies to rural, remote, Aboriginal and Torres Strait Islander and Continuity of Carer programs.<br>▸ $25.2 million over four years. | | | ✓ | |
| **Australian National Breastfeeding Strategy 2010–2015**<br>▸ On 22 April 2010, Australian Health Ministers endorsed the 2010 implementation plan for the *Australian National Breastfeeding Strategy 2010–2015*.[37] This followed endorsement of the strategy by Health Ministers on 13 November 2009. The strategy provides a framework for priorities and action for Australian governments at all levels to protect, promote, support and monitor breastfeeding throughout Australia.<br>▸ Implementation of the strategy will be progressed by governments both independently and nationally under AHMAC, with ongoing leadership from the Australian Government and input from community stakeholders. | | ✓ | ✓ | |

| Initiative | Plan priority | | | |
|---|---|---|---|---|
| | Access | Service delivery | Work-force | Infra-structure |
| **Breastfeeding education and training**<br>▸ $1.8 million is being provided over four years (from 2007–08) to support training and educational opportunities for breastfeeding counsellors and health professionals. This includes:<br>– development and delivery of nationally accredited courses in breastfeeding that are recognised under the Australian Quality Training Framework<br>– ensuring volunteer counsellors staffing the national breastfeeding helpline receive comprehensive training (a Certificate IV in Breastfeeding) to equip them to support breastfeeding women and their families<br>– seminars and workshops to support the continuing education of health professionals working with pregnant women and breastfeeding mothers<br>– delivery of four pilot breastfeeding education workshops for Aboriginal health workers. | | | ✓ | |
| **National Perinatal Depression Initiative 2008–09 to 2012–13**<br>▸ On 13 November 2009, Australian Health Ministers agreed on the framework for the National Perinatal Depression Initiative.[61]<br>▸ This strategy specifically addresses the mental health issues surrounding maternal health and establishes a specific framework for addressing perinatal depression between 2008–09 and 2012–13.<br>▸ Following agreement of the national framework, the Australian governments are progressing the initiative as set out in the framework.<br>▸ Key elements of the framework that complement the Plan are:<br>– routine and universal screening for perinatal depression using the Edinburgh postnatal depression scale<br>– follow-up support and care for women assessed as being at risk of or experiencing perinatal depression<br>– workforce training and development for health professionals<br>– community awareness initiatives. | | ✓ | | |
| **Collaborative care**<br>▸ A National Guidance for Collaborative Maternity Care is under development by the NHMRC to support collaborative care arrangements between health care professionals involved in maternity care.<br>▸ Funding for collaborative care is part of expanding Medicare support. | ✓ | ✓ | ✓ | |

| Initiative | Plan priority | | | |
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| **Information for women and their families**<br>▸ Women, their partners and families will be assisted by a special 24-hour-a-day, seven-day-a-week telephone helpline available during their pregnancy and up to 12 months after the birth of the baby.<br>▸ The pregnancy and perinatal support helpline will provide information and support on the services available to women and their families.<br>▸ Up-to-date maternity-related information will be provided through a single online gateway on the web.<br>▸ This initiative also applies to rural, remote, Aboriginal and Torres Strait Islander and Continuity of Carer programs.<br>▸ $9.4 million over four years. | ✓ | | | |
| **National Breastfeeding Helpline**<br>▸ $2.5 million is being provided over five years (from 2007–08) to enable the Australian Breastfeeding Association (ABA) to establish and maintain a toll-free 24-hour telephone helpline providing breastfeeding information and peer support for mothers and their families.<br>▸ The number is 1800 MUM 2 MUM (1800 686 2 686).<br>▸ The helpline is staffed by trained volunteer counsellors. | ✓ | | | |
| **Dietary guidelines**<br>▸ NHMRC, in partnership with the Department of Health and Ageing, is reviewing national nutrition recommendations including those in the *Core Food Groups*[68]; the Australian dietary guidelines for infant, children, adolescents, adults, older Australians and pregnant and breastfeeding women; and in the *Australian Guide to Healthy Eating*[69] publications.<br>▸ The review is expected to be completed by mid-2011 when revised dietary guidelines and appropriate publications for consumers, health professionals and policy makers will be issued by the NHMRC. | ✓ | | | |
| **Growth charts**<br>▸ Research into the use of growth charts with children up to five years of age by key health professionals is expected to be completed by the end of 2010.<br>▸ Outcomes of the research project will inform options and recommendations to progress the adoption of a single national child growth chart and supporting materials in Australia. | ✓ | | | |

| Initiative | Plan priority | | | |
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| **Data collection**<br>▸ Enhanced national data collection, a small program of targeted research and overarching evaluation of the Commonwealth Maternity Reform Budget Package, will ensure ongoing quality and safety for maternity services.<br>▸ This initiative will encourage greater adherence to evidence-based practice.<br>▸ Funding for enhanced data collection is part of Expanding Medicare support. | ✓ | | | ✓ |
| **Australian National Infant Feeding Survey (ANIFS)**<br>▸ The NIFS will collect national baseline data on infant feeding practices, including the prevalence of breastfeeding initiation and duration in Australia.<br>▸ A random sample of mothers of children aged birth to two years from all jurisdictions will be invited to participate in the survey.<br>▸ A pilot survey will commence in July 2010, with the full survey implemented by the end of 2010.<br>▸ Results are expected to be available in mid-2011. | | | | ✓ |
| **Rural initiatives** | | | | |
| **Expansion of the Medical Specialist Outreach Assistance Program (MSOAP)**<br>▸ The MSOAP expansion will introduce outreach maternity service teams (comprising obstetricians and/or registered midwives, registered maternal and child health nurses and allied health professionals) that will contribute to better antenatal and postnatal care, and better health outcomes for women and their babies in rural and remote communities.<br>▸ Expansion of the existing MSOAP program will increase access to services locally and reduce the need for women to travel to access services.<br>▸ This initiative will also improve the capacity of rural and remote communities to recruit and retain the medical services workforce through opportunities for local health professionals to enhance their skills through interaction with the outreach teams.<br>▸ This initiative also applies to rural, remote, Aboriginal and Torres Strait Islander programs.<br>▸ $11.3 million over four years. | ✓ | ✓ | ✓ | |
| **Rural Procedural Grants Program**<br>▸ The Rural Procedural Grants Programs (formerly the Training for Rural and Remote Procedural GPs Program) enables procedural GPs in rural and remote areas to access a grant to attend relevant training, upskilling and skills maintenance activities.<br>▸ This will encourage procedural GPs to maintain important procedural skills and assists in the retention of procedural GPs in rural communities.<br>▸ Procedural GPs provide an invaluable service to rural communities and through this program they are encouraged to maintain their skills to ensure high standards of care for rural communities. | ✓ | ✓ | ✓ | |

| Initiative | Plan priority | | | |
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| **Practice Incentives Program (PIP) Procedural General Practitioner (GP) Payment**<br>▸ The PIP Procedural GP payments aim to encourage rural GPs to provide procedural services in obstetrics, surgery and anaesthetics.<br>▸ The payments are available to practices located in Rural, Remote and Metropolitan Areas (RRMA) 3-7.<br>▸ The PIP Procedural GP payments support procedural GPs in rural and remote areas to develop and maintain their skills and encourage GPs to remain in rural and remote areas for longer. | ✓ | ✓ | ✓ | |
| **Rural maternal services initiatives** | | | | |
| **National Consensus Framework for Rural Maternity Services**<br>▸ The 2008 *National Consensus Framework for Rural Maternity Services*[57] was developed by the Rural Doctors Association of Australia (RDAA), the Australian College of Rural and Remote Medicine (ACRRM), Australian College of Midwives (ACM), the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the National Rural Faculty of the Royal Australian College of General Practitioners (RACGP) and Rural Health Workforce Australia, with funding from the Australian Government Department of Health and Ageing.<br>▸ The framework was developed in response to community and professional concerns about access to birthing services in rural and remote Australia.<br>▸ The purpose of the project was the codification of a set of principles to provide a framework for policy and planning to support quality maternity services in rural Australia.<br>▸ The framework presents a set of agreed principles that encompass quality and safety, access, models of care, infrastructure, workforce and funding, which have been formally endorsed by the boards of each of the participating organisations. | ✓ | ✓ | ✓ | ✓ |
| **Specialist Obstetrician Locum Scheme (SOLS)**<br>▸ SOLS assists rural GPs and specialist obstetricians with accessing a locum. The GP Anaesthetist Locum Scheme (GPALS) provides the same assistance to rural GP anaesthetists. These programs allow existing rural obstetricians and GP anaesthetists to have time to rest, and to undertake ongoing education and training.<br>▸ These programs support the continuity of obstetric services to Australian women in rural communities, and contribute to the retention of medical practitioners in rural communities.<br>▸ $6 million over three years from 2008–09. | ✓ | ✓ | ✓ | |

| Initiative | Plan priority | | | |
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| **Aboriginal and Torres Strait Islander people initiatives** | | | | |
| **Closing the Gap**<br>▸ In 2007, COAG committed to closing the gap in life outcomes and opportunities between Aboriginal and Torres Strait Islander people and non-Aboriginal and non-Torres Strait Islander people.<br>▸ In November 2008, COAG endorsed the National Aboriginal and Torres Strait Islander Reform Agreement (NIRA), which comprises the following six key targets:<br>– Close the life expectancy gap within a generation.<br>– Halve the gap in mortality rates for Aboriginal and Torres Strait Islander children under five years old within a decade.<br>– Halve the gap in employment outcomes between Aboriginal and Torres Strait Islander people and non-Aboriginal and non-Torres Strait Islander people within a decade.<br>– Halve the gap in reading, writing and numeracy achievements within a decade.<br>– Ensure all four year olds in remote communities have access to early childhood education within five years.<br>– At least halve the gap for Aboriginal and Torres Strait Islander students in Year 12 attainment or equivalent attainment rates by 2020.<br>▸ The NIRA also established a number of strategic areas for action or 'Building Blocks', which formed the structure for the Closing the Gap report. The Building Blocks underpinning COAG reforms are Early Childhood, Schooling, Health, Economic Participation, Healthy Homes, Safe Communities and Governance and Leadership.<br>▸ Under National Partnership Agreements, the Australian Government has allocated the following funds across Australia:<br>– $564 million over six years for Aboriginal and Torres Strait Islander Early Childhood Development<br>– $291.2 million over six years for Aboriginal and Torres Strait Islander Remote Service Delivery<br>– up to $228.8 million over five years for Aboriginal and Torres Strait Islander Economic Participation<br>– $5.48 billion over 10 years on Remote Aboriginal and Torres Strait Islander Housing<br>– $1.58 billion over four years on Closing the Gap on Aboriginal and Torres Strait Islander Health Outcomes<br>– $6.967 million over four years on Remote Aboriginal and Torres Strait Islander Public Internet Access.<br>▸ Within Closing the Gap, a number of specific initiatives address issues relating to the provision of maternity care to Aboriginal and Torres Strait Islander women and babies within the scope of the Plan. These initiatives are described below. | ✓ | ✓ | ✓ | ✓ |

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| | Access | Service delivery | Work-force | Infra-structure |
| **Aboriginal and Torres Strait Islander people maternal services initiatives** | | | | |
| **Indigenous Early Childhood Development National Partnership (IECD NP)**<br>▸ The IECD NP has three priority areas:<br>– Element 1 — Integration of early childhood services through the establishment of 35 Children and Family Centres.<br>– Element 2 — Increased access to antenatal care, pre-pregnancy and teenage sexual and reproductive health, which will cost $20 million in the 2010–11 financial year.<br>– Element 3 — Increased access and use of maternal and child health services by Aboriginal and Torres Strait Islander families. This builds on an existing Australian Government election commitment of $90.3 million for New Directions: An Equal Start in Life for Indigenous Children (Mothers and Babies Services program) and includes a complementary state/territory investment of $75 million.<br>▸ Service delivery varies between state and territory governments and is detailed in their individual implementation plans.<br>▸ The Australian Government funds a range of programs for Aboriginal and Torres Strait Islander families that address the needs of their children in their early years, including maternal and child health services and support for breastfeeding. These are the Healthy for Life Program, New Directions Mothers and Babies Services and the Australian Nurse Family Partnership Program. | ✓ | ✓ | | |
| **Healthy for Life Program**<br>▸ This program provides the necessary funding for primary health care services to improve the availability and quality of Aboriginal and Torres Strait Islander child and maternal health, Aboriginal and Torres Strait Islander men's health, and chronic disease services. The program will be supported by up to $38 million in administered funds annually.<br>▸ This program is delivered in a number of metropolitan, rural and remote Aboriginal and Torres Strait Islander communities, and will provide Aboriginal and Torres Strait Islander women with improvements in availability and quality of antenatal and postnatal care.<br>▸ This program will assist to increase the capacity of the Aboriginal and Torres Strait Islander people health workforce through the employment of appropriate health workers as required, and through providing funding to increase the number of health scholarships available to Aboriginal and Torres Strait Islander people through the Puggy Hunter Memorial Scholarship Scheme.<br>▸ This program provides funding for primary health care services to develop better infrastructure and improve data collection to increase capacity in the areas of Aboriginal and Torres Strait Islander child and maternal health services, men's health and chronic disease care.<br>▸ The program began in 2005–06 as a budget measure offering $102.4 million over four years, but has since become an ongoing program supported by up to $38 million in administered funds annually. | ✓ | ✓ | ✓ | ✓ |

| Initiative | Plan priority | | | |
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| | Access | Service delivery | Work-force | Infra-structure |
| **New Directions Mothers and Babies Services**<br>▸ This program directs funding to organisations to provide new or additional Aboriginal and Torres Strait Islander child and maternal health services in areas of high need across Australia. Funding is $90.3 million over five years from 2007–08, including $1.6 million for Puggy Hunter Memorial Scheme scholarships.<br>▸ This program is delivered in a number of metropolitan, rural and remote Aboriginal and Torres Strait Islander communities.<br>▸ This program specifically focuses on providing Aboriginal and Torres Strait Islander children and their mothers with increased access to antenatal care, standard information about baby care, practical advice and assistance with parenting, nutrition and breastfeeding, monitoring of developmental milestones, immunisation status and infections, and health checks and treatment for Aboriginal and Torres Strait Islander children before starting school.<br>▸ This program will also increase the capacity of the Aboriginal and Torres Strait Islander people health workforce through the employment of appropriate health workers as required, and by increasing the number of health scholarships available to Aboriginal and Torres Strait Islander people through the funding of $1.6 million over five years from 2007–08 for the Puggy Hunter Memorial Scholarship Scheme.<br>▸ The New Directions: An equal start to life for Aboriginal and Torres Strait Islander children initiative sits across three Australian Government portfolios: the Department of Families, Housing, Community Services and Aboriginal and Torres Strait Islander Affairs (FaHCSIA), the Department of Education, Employment and Workplace Relations (DEEWR), and the Department of Health and Ageing (DoHA). The three elements that comprise this Closing the Gap initiative are:<br>– child and maternal health services<br>– early development and parenting support<br>– literacy and numeracy in the early years.<br>▸ The child and maternal health services component consists of the New Directions: Mothers and Babies Services program, the rheumatic fever strategy and the Aboriginal and Torres Strait Islander Mother's Accommodation Fund.<br>▸ The child and maternal health element provides $112 million over five years and commenced in 2007–08. | ✓ | ✓ | ✓ | |

| Initiative | Plan priority | | | |
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| | Access | Service delivery | Work-force | Infra-structure |
| **Aboriginal and Torres Strait Islander Mother's Accommodation Fund**<br>▸ The Aboriginal and Torres Strait Islander Mother's Accommodation Fund (IMAF) component of New Directions is an example of an existing initiative that supports combined Australian Government effort across portfolios to improve outcomes for Aboriginal and Torres Strait Islander mothers and babies.<br>▸ FaHCSIA has primary carriage of the provision of housing, parenting programs and child protection and welfare in Aboriginal and Torres Strait Islander communities. IMAF provides $10 million in capital funds over three years (2008–11) for new and expanded accommodation facilities in major cities and regional centres to support Aboriginal and Torres Strait Islander women who need to leave their communities temporarily to have their babies.<br>▸ The implementation of IMAF includes supporting management models that appropriately address the needs of Aboriginal and Torres Strait Islander women, locating facilities in close proximity to child and maternal health services, and ensuring that facilities can support newborn babies and, where possible, other children staying with their mothers. The first site was approved at Cairns in 2009, with plans for a further two sites in Darwin and Port Hedland. | ✓ | ✓ | | |
| **Australian Nurse Family Partnership Program (ANFPP)**<br>▸ The ANFPP aims to support pregnant women with an Aboriginal or Torres Strait Islander baby to improve their own health and the health of their child, through nurse-led sustained home visiting until the child is two years of age. The 2007–08 Budget provided $37.4 million over four years for this program.<br>▸ The ANFPP aims to improve pregnancy outcomes by helping women engage in good preventative health practices, support parents to improve Aboriginal or Torres Strait Islander child health and development, and help parents develop a vision for their own future, including continuing education and finding work. This is a sustained home visiting program providing step-by-step life course guidance and education, rather than clinical services, to mothers pregnant with an Aboriginal or Torres Strait Islander child.<br>▸ This program will also increase the capacity of the Aboriginal and Torres Strait Islander people health workforce through the employment of nurses, Aboriginal and Torres Strait Islander family partnership workers and administrators to deliver the program, and by increasing the number of health scholarships available to Aboriginal and Torres Strait Islander people through the funding of $1.5m over four years from 2007–08 for 30 new Puggy Hunter Memorial Scholarship Scheme scholarships. | ✓ | ✓ | ✓ | |

AHCA = Australian Health Care Agreements; AHMAC = Australian Health Ministers' Advisory Council; COAG = Council of Australian Governments; GP = general practitioner; NHMRC = National Health and Medical Research Council

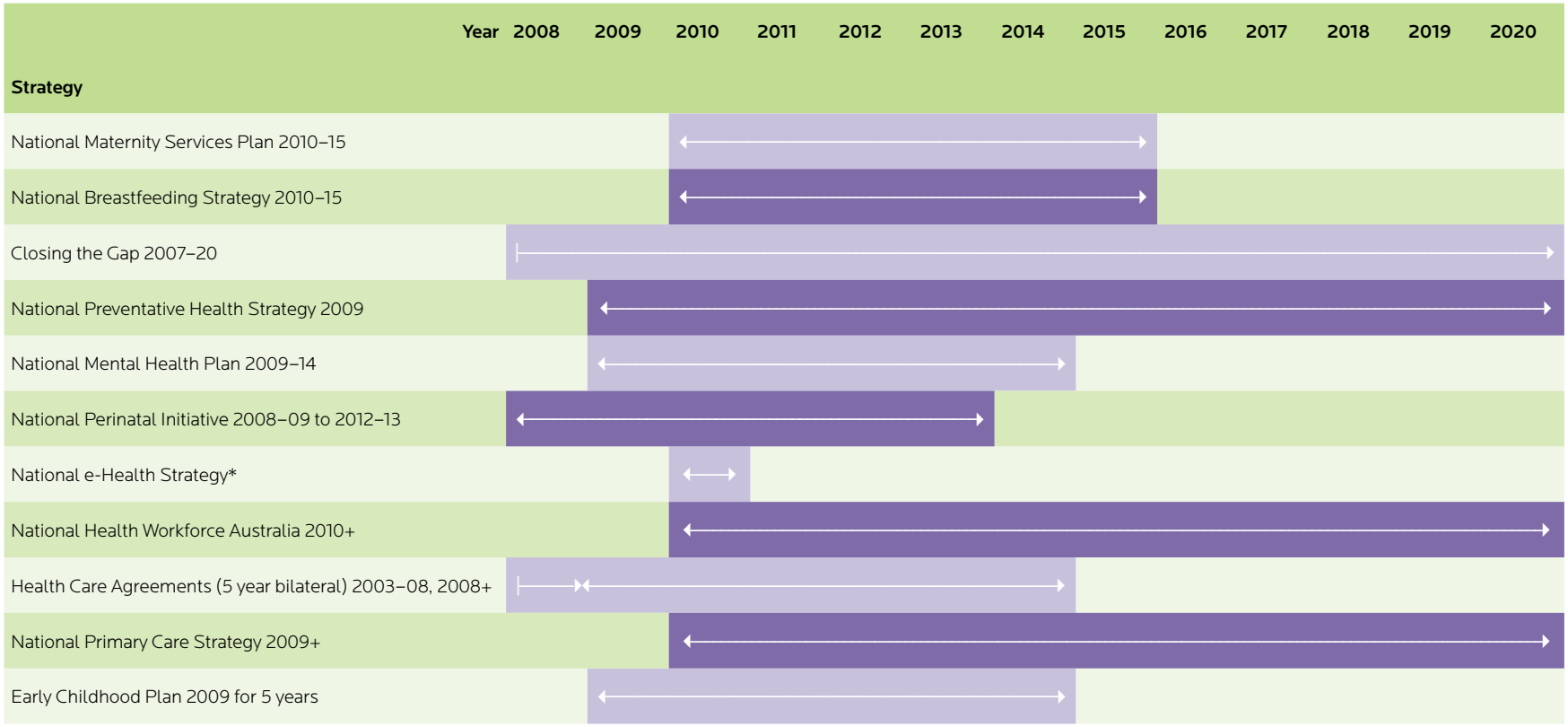
[1] The Commonwealth's workforce initiatives are backed by significant investments to support the health workforce. This includes $1.1 billion as part of the November 2008 COAG agreement to train more doctors, nurses and allied health professionals. This provided: $497 million to expand clinical training places for undergraduate medical, nursing and allied health students; $28 million to help train approximately 18,000 nurse supervisors, 5,000 allied health and VET supervisors, and 7,000 medical supervisors; 212 additional ongoing GP training places per annum — a 35% increase on the limit imposed since 2004; and 73 additional specialist training places in the private sector each year.

To address current workforce shortages and better equip Australia's health system to meet the growing demand for health services into the future, the Australian Government will invest $1.2 billion in training more GPs and specialists, and better supporting nurses working in general practice, aged care and rural areas, and allied health professionals working and training in rural areas over the next four years.

The Australian Government will deliver: 1,375 more GPs practising or in training by 2013, and 5,500 new GPs or GPs undergoing training over the next decade ($345 million); 975 places each year for junior doctors to experience a career in general practice during their postgraduate training period ($150 million); 680 more specialist doctors over the next decade ($145 million); a comprehensive package of measures to deliver greater support to nurses and other workers in the aged care system ($103 million); support for the equivalent of almost 4600 full-time practice nurses in general practice in 2013–14 ($390 million); for the first time, support for up to 7,500 rural nurses and 1,000 rural allied health professionals over the next decade to take leave to access professional development courses to keep their skills up to date ($34 million over four years); and 1,000 extra clinical training scholarships for allied health students over the next decade ($6 million over four years).

Figure B.1 illustrates the intersections between the major strategies and the scope of the Plan in terms of timelines.

**Figure B.1** Timelines of national plans and strategies




*The Healthcare Identifiers Bill 2010 (amends Health Insurance Act)

# **Appendix C** Related state and territory initiatives

Australian Government reviews have been complemented by work conducted by state and territory governments reflecting a unity of focus and common principles across jurisdictions. Priorities identified in planning and strategic documents are supported by extensive action already undertaken by the jurisdictions, making significant inroads to improved maternity service delivery.

An overview of the most recent maternity frameworks or initiatives produced by state and territory governments is given in Table C.1.

**Table C.1** Related state and territory strategies

| Initiative | Plan priority | | | |
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| | Access | Service delivery | Work-force | Infra-structure |
| **New South Wales** | | | | |
| **New South Wales Framework for Maternity Services**<br>This document[38] provides strategic objectives for the development and implementation of future services over a five year period. Strategies supporting this Plan were structured around the following goals:<br>– consumer choice and access to culturally sensitive maternity care<br>– safety and quality<br>– collaboration amongst maternity care professionals<br>– recognition of birth as a normal process<br>– availability of a range of models of care, including continuity of care<br>– a competent and flexible workforce. | ✓ | ✓ | ✓ | ✓ |
| **Maternity — Towards Normal Birth in NSW (June 2010)**<br>This policy directive provides the current maternity services policy. It provides the following ten steps to promote, protect and support normal birth:<br>1. Have a written normal birth policy/guidelines, along with other relevant policies, that are routinely communicated to all health care staff.<br>2. Train all health care staff in skills necessary to implement this policy.<br>3. Provide or facilitate access to midwifery continuity of carer programs in collaboration with GPs and obstetricians for all women with appropriate consultation, referral and transfer guidelines in place.<br>4. Inform all pregnant women about the benefits of normal birth and factors that promote normal birth.<br>5. Have a written policy on pain relief in labour that includes the use of water immersion in labour and birth.<br>6. Have a written post-due-date policy/guideline that is routinely communicated to all health care staff.<br>7. Provide or facilitate access to vaginal birth after caesarean section operation (VBAC) that is supported by a written vaginal birth after caesarean section operation policy/guideline, and provide health care staff with the skills necessary to implement this policy/guideline.<br>8. Provide or facilitate access to external cephalic version.<br>9. Provide one to one care to all women experiencing their first labour or undertaking a VBAC, vaginal breech or vaginal twin birth.<br>10. Provide formal debriefing in the immediate postpartum period for all women requiring primary caesarean section operation or instrumental birth with the opportunity for further discussion and information transfer. | ✓ | ✓ | ✓ | ✓ |

| Initiative | Plan priority | | | |
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| | Access | Service delivery | Work-force | Infra-structure |
| **Maternity and Newborn Capability Framework**<br>▸ This framework guides health services in planning and providing appropriate levels of maternity and newborn care in the community. | ✓ | ✓ | ✓ | ✓ |
| **Funding**<br>▸ Maternity enhancement funding has been provided over four years to 2011–12 in response to the increased birth rate. Maternity services have been requested to reform maternity services including:<br>– increased continuity of carer programs<br>– increased access to VBAC, external cephalic version and vaginal breech birth where appropriate<br>– ensuring maternity health professionals have the skills to implement this policy<br>– increased support for women including the postnatal period ($42.8 million over four years) | ✓ | ✓ | ✓ | ✓ |
| **Policy**<br>▸ Policy directives provide consistent strategic directions for maternity services in NSW.<br>– PD2006_045 Maternity — Public Homebirth Services<br>– PD2006_012 Breastfeeding: Promotion, Protection and Support<br>– PD2007_024 Maternity — Timing of Elective or Pre-Labour Caesarean Section<br>– PD2009_003 Maternity — Clinical Risk Management Program<br>– PD2009_058 Maternity — Early Pregnancy Complications<br>– PD2010_ 019 Maternity — Breastmilk: Safe management<br>– PD2010_022 Maternity — National Midwifery Guidelines for Consultation and Referral<br>– PD2010_040 Maternity — Fetal Heart Rate Monitoring<br>– PD2010_045 Maternity — Towards Normal Birth in NSW.<br>▸ Maternal and Perinatal Health Priority Taskforce provides strategic policy and operational advice to the Department of Health. This Taskforce hosts annual statewide seminars about topical issues. NSW Maternal and Perinatal Committee reviews maternal and perinatal mortality and provides advice to the Department of Health and the Minister for Health ($30,000) | ✓ | ✓ | ✓ | ✓ |

| Initiative | Plan priority | | | |
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| | Access | Service delivery | Work-force | Infra-structure |
| **Models of care**<br>▸ Stand alone midwifery managed programs are linked to nearby maternity services (tertiary in these instances). They have associated specialist obstetricians for consultation and referral. There are three in NSW.<br>▸ Public funded homebirth programs are operated midwifery group practices within mainstream maternity services. There are four publicly-funded homebirth services.<br>▸ A variety of services are provided through birth centres, including caseload care, team midwifery and traditional care. There are at least seven birth centres in NSW.<br>▸ Women with normal, moderate and high risk factors are provided care in continuity models including team midwifery and caseload care. Some of this care is provided through birth centres. | ✓ | ✓ | | |
| **Specialist care**<br>▸ The NSW Government committed $3.6 million over four years to 2011–12 to support high-risk maternity services to further enhance the care provided to women with more complicated pregnancies.<br>▸ In NSW, health services have been offering care to pregnant women with substance use problems for at least 25 years. Some of the services are standalone treatment services, others are merged with maternity or drug and alcohol. $1.5 million has been provided between 2007–08 and 2009–10 for some of these services under the dedicated Drug Budget 3. However, this does not represent total investment in these services.<br>▸ New specialist perinatal mental health teams in three areas will provide specialist assessment and intensive short-term mental health care in-reaching to maternity and across community settings. Mental Health and Drug & Alcohol professionals attend SAFE START multidisciplinary case discussion meetings in maternity settings to assist midwives in care coordination for women with complex antenatal risk factors. A SAFE START Consultation–Liaison position has been funded for each Area Health Service (eight new positions).<br>▸ Neonatal and paediatric Emergency Transport Service (NETS) ($6,739,940) | ✓ | ✓ | | |
| **Early pregnancy care**<br>▸ Major rural referral and some metropolitan hospitals have implemented early pregnancy units in Emergency Departments and Early Pregnancy Assessment Services (EPAS) to expedite the treatment of women experiencing lower abdominal pain or vaginal bleeding in early pregnancy. ($3 million recurrent p.a. from 2008–09). The EPAS are provided on a daily basis (Mon-Fri) as an outpatient service staffed by midwives and obstetricians.<br>▸ The introduction of more public antenatal clinics in over 40 rural towns has increased access to public antenatal care. This includes 1.5 hours for comprehensive first visit, medical and midwifery clinics ($1.3 million recurrent p.a. from 2008–09). The service delivery model for the provision of public antenatal is one of shared pregnancy care where the midwife shares care with the GP/GP obstetrician/obstetrician. | ✓ | ✓ | | |

| Initiative | Plan priority | | | |
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| | Access | Service delivery | Work-force | Infra-structure |
| **Hospital infrastructure**<br>▸ Redevelopment of hospitals (including maternity services) will provide more integrated services and improve relationships, including maternity services:<br>– Orange, Narrabri and Manilla (in construction)<br>– Royal North Shore Hospital (redevelopment).<br>– Funding announced to complete planning and start work on the redevelopment of Tamworth Hospital including planning to relocate women's and children's services.<br>– Funding for redevelopment at Dubbo. | ✓ | | | ✓ |
| **Breastfeeding**<br>▸ The NSW Statewide Breastfeeding and Infant Nutrition Reference Group (RG) meet at NSW Health on a quarterly basis and is chaired by the Nursing and Midwifery Office. The RG was established to support the implementation of NSW Health Policy Directive- PD2006_012 Breastfeeding in NSW: Promotion, Protection and Support and to encourage a collaboration and coordination of effort. It has representation from NSW Health, Area Health Services, Baby Friendly Health Initiative NSW, Midwifery and Neonatal Professional Bodies and the Australian Breastfeeding Association. | ✓ | | | |
| **Aboriginal Maternity and Infant Health Service (AMIHS)**<br>▸ The AMIHS is a maternity service that was first established in 2000 providing continuity of care in the antenatal and postnatal periods for Aboriginal women and babies. It has expanded to over 30 services across NSW. AMIHS has a preferred referrer pathway to the Community Services' early intervention program Brighter Futures ($8.865 million p.a.). AMIHS provides care for around 75% Aboriginal mothers and babies in NSW. It is predominantly rural, but there are four services in metropolitan Sydney.<br>▸ AMIHS suite of resources include a generic brochure, a safe sleeping brochure, and a brighter futures brochure; calling cards, poster and media pack ($24,684). The printing and distribution cost is $10,000. The Healthy Pregnancy for a Healthy Baby is being revised to update the clinical content and provide a generic statewide resource ($100,000).<br>▸ AMIHS data set development and collection ($30,000). | ✓ | ✓ | ✓ | ✓ |
| **Training and Support Unit (TSU) for Aboriginal Mothers and Babies**<br>▸ This is being re-established in the NSW Institute for Clinical Services and Training. Its purpose is to provide training and support for the AMIHS ($2,187,000 p.a.). | ✓ | | ✓ | |

| Initiative | Plan priority | | | |
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| | Access | Service delivery | Work-force | Infra-structure |
| **Aboriginal Mothers and babies**<br>▶ The Indigenous Early Childhood Development National Partnership Agreement Element 2: Increased access to antenatal care, pre-pregnancy and teenage sexual and reproductive health has been funded by the Australian Government for a total of $26.7 million over five years. Element 2 has two components:<br>1. The antenatal component is to provide secondary mental health, and drug and alcohol services to Aboriginal Maternity and Infant Health Services (AMIHS) families, where appropriate. Eight mental health, and eight drug and alcohol services are to be implemented. Funding provides for clinical positions, including Aboriginal Traineeship positions. In addition to these positions, funding provides for training, education, social marketing and workforce development strategies.<br>2. The aim of the sexual and reproductive health component is to increase the proportion of young Aboriginal people (i.e. 12–19 years) accessing sexual and reproductive health programs and services. There will be 10 services implemented as part of this component. Funding is available for positions, education activities, social marketing and workforce development strategies. All the sexual and reproductive health positions are identified as Aboriginal specific positions.<br>▶ A smoking cessation support program called Quit for New Life will be implemented in all AMIHS to support pregnant Aboriginal women and their families to quit smoking and remain smoke-free. The program includes a range of tailored resources and tools. The Quit for New Life program aims to build the skills and capacity of maternal health staff to offer smoking-cessation support. All staff will have access to brief intervention training and resources to assist in the provision of smoking-cessation intervention to their clients. | ✓ | ✓ | ✓ | ✓ |

| Initiative | Plan priority | | | |
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| **NSW Aboriginal Nursing and Midwifery Cadetship**<br>▶ The NSW Government has made a commitment to increase the number of midwifery cadetship positions by 6 annually and nursing cadetship positions by 18 annually. There is also funding for 40 enrolled nursing cadetships annually (Total = $752,000).<br>▶ An international advertising campaign to attract specialist Obstetricians and Gynaecologists to NSW was launched in March 2010. The advertising campaign directs potential applicants to a new recruitment website listing current vacancies in Obstetrics and gynaecology in NSW. To date, this has resulted in positions being viewed by 1,300 potential applicants from 60 countries. The cost of the campaign to date is approximately $122,000.<br>▶ Birthrate Plus® (midwifery workload measurement tool for maternity services) being tested for adoption across all NSW public maternity services ($165,000p.a).<br>▶ Centralised application process for:<br>– new graduate midwives in their first year of registration. 150@$1,000 ($15,000p.a)<br>– postgraduate midwifery students designed to monitor and increase the availability of clinical training places in NSW.<br>▶ Scholarships available:<br>1. Undergraduate midwifery students in Bachelor of Midwifery courses leading to registration as a midwife ($50,000 p.a.)<br>2. Postgraduate midwifery students who are registered nurses undertaking a Graduate Diploma or Masters courses leading to registration as a midwife. 120@$8,000 ($960,000p.a)<br>3. Rural Placement Grants to assist undergraduate and postgraduate midwifery students to undertake a clinical placement in a rural maternity service. 11@$500 ($5,500p.a)<br>4. Rural Clinical Midwifery Consultant Scholarships will provide financial assistance for the four Clinical Midwifery Consultants meetings/ year ($30,000p.a)<br>5. Rural Midwifery Scholarships to fund a number of external courses taken out to approximately 630 midwives in rural NSW including Advanced Life Support in Obstetrics (ALSO, Active Birth and Family Partnerships Training ($150,000 p.a.)<br>6. Clinical Supervision to provide training scholarships for midwives to undertake Clinical Supervision training in the four rural Area Health Services ($200,000)<br>7. Aboriginal Post Graduate Scholarship Program — Up to $500,000 over the next three years is available for Aboriginal nurses and midwives for postgraduate scholarships, particularly focusing on maternity, early childhood, paediatrics, drug and alcohol and mental health.<br>▶ Funded the update into CD version and the distribution of a Midwifery Refresher Package for currently practicing or returning to practice midwives employed by NSW Health ($20,000).<br>▶ Midwifery Connect is a supported return to practice program. To date, 36 (26 rural and 10 metro) midwives have been employed through the program ($120,000). | | | ✓ | ✓ |

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| **NSW Aboriginal Nursing and Midwifery Cadetship** *continued*<br>▸ Masterclass vacuum extraction – the NSW Department of Health will fund four masterclasses targeting senior clinicians to standardise and increase the uptake of vacuum extraction. Some clinicians will then become trainers across the State to ensure sustainability ($13,500).<br>▸ Under Caring Together: The NSW Health Action Plan a new specialist obstetrician/gynaecologist position has been funded in western Sydney at a cost of $177 000 p.a. for four years. | | | | |
| **Training**<br>▸ Fetal welfare Obstetric emergency and Neonatal resuscitation Training (FONT) provides statewide consistency for the management of these emergency situations. Online education about the interpretation of fetal heart-rate patterns is provided for all clinicians ($110,000).<br>▸ The Maternity Support Network (MSN) is being established with 5.0 FTE Clinical Midwifery Consultants, as a prevention and early intervention maternity support service, to provide advice to the Department of Health, and to support maternity services and clinicians statewide for the implementation of policies, education and clinical advice. The MSN is also responsible for the FONT program and supports the Perinatal Advice Line (PAL). ($700,000 pa). To assist with local, ongoing education and training, simulation equipment has been purchased for access across the State for the FONT and Vacuum extraction training (training resources $41,000).<br>▸ Undergraduate direct-entry midwifery programs have been established in two universities and a third is planned to commence in 2011.<br>▸ Online training — SAFE START Perinatal psychosocial assessment and depression screening for all Maternity Service Staff.<br>▸ Project Officer — Rural Midwifery Education to support and conduct midwifery education in the rural maternity services ($110,000 p.a.) | | | ✓ | |
| **Role delineation**<br>▸ NSW categorises health services by the Guide to the role delineation of Health Services (2002) which identifies a service level from 1 to 6. This identifies the level of complexity that can be supported by the health facility.<br>▸ NHMRC research partnership to assess impact of role delineation on clinical services ($200,000). | | | ✓ | |

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| **Information**<br>▸ NSW collects centralised data through the Midwives Data Collection and provides data to the National Perinatal Statistics Unit. Perinatal outcome data for public and private maternity services is published in the annual NSW Mothers and Babies Report, a Public Health Bulletin. Maternity services with ObstetriX (maternity information system) are able to run local reports to examine trends in outcomes and for risk management purposes. Electronic data collections are being expanded through the provision of hardware and Year 1 set-up costs to implement the maternity information system, ObstetriX ($96,706).<br>▸ Implementing an electronic system to notify births in NSW public hospitals in accordance with NSW Registry of Births, Deaths & Marriages policy.<br>▸ The Clinical Excellence Commission publishes a biannual safety report on the incidence, trends and actions in response to reporting to the Incident Information Management System (IIMS).<br>▸ Print resources: *Having a Baby* is provided to every pregnant woman who books into a public maternity service. It provides an introduction to the many and varied subject areas across maternity care and organisation, directing women and their families to more comprehensive information and help ($200,000 p.a.). This publication has been translated in full into five community languages ($130,000). It is available free of charge on the internet.<br>▸ Early Pregnancy Care project:<br>– Thinking of having a baby — planning a pregnancy and becoming pregnant: Provides factual, simple information for women to prepare for pregnancy and tips on keeping healthy while pregnant<br>– Early pregnancy — when things go wrong: A booklet for women experiencing complications in early pregnancy, including information on what to do if you are having a miscarriage, types of miscarriage and support services available These resources are in the process of being translated into 10 languages ($50,000)<br>▸ An information brochure has been developed for women and families experiencing a stillbirth about the post-mortem examination of a stillborn baby.<br>▸ The distribution of major publications is automated so as to ensure just-in-time provision and a guaranteed supply.<br>▸ SIDS and Kids NSW are conducting 10 Early Pregnancy Loss Workshops across NSW (six in rural areas and four in metropolitan Sydney) over 2010–11. The project aims to increase the awareness of grief and loss associated with miscarriage and early pregnancy loss up to 19–22 weeks (including still birth) ($28,240).<br>▸ Pregnancy and Newborn Services Network (including the Perinatal Advice Line) (PSN) ($0.975 million). | ✓ | | | |

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| **Victoria** | | | | |
| **Future Directions for Victoria's Maternity Services**<br>▸ This plan[39] documents a framework for gradual but strategic change that will guide developments over the next five to ten years.<br>▸ The policy focus is to provide primary maternity services within local settings, provide women with greater control of their birthing experience and establish maternity service models that promote continuity of care. It comprises four key principles:<br>– Women have informed choice, continuity and safety in their pregnancy, birthing and postnatal experiences.<br>– Primary maternity care is the most appropriate model of care for the normal life events of pregnancy and birthing.<br>– Access to appropriate specialised care when required is integral to providing safe, high-quality maternity care.<br>– A collaborative, interdisciplinary team approach to the provision of maternity care requires education, training and development. | ✓ | ✓ | ✓ | ✓ |
| **Maternity and Newborn Capability Framework**<br>▸ This framework guides health services in planning and providing appropriate levels of maternity and newborn care in the community. | ✓ | ✓ | ✓ | ✓ |
| **Maternity and Newborn Clinical Network (MNCN)**<br>▸ Maternity services are active participants in the network, supporting consistency in practice, collaboration and partnerships.<br>▸ Specific MNCN projects include a statewide standard for induction of labour, vaginal birth after caesarean section (VBAC) and a Special Care Nursery project to keep mothers and babies together. | | ✓ | | |
| **Rural Maternity Initiative (RMI)**<br>▸ $9.6 million has been allocated from 2003–11 through RMI to support sustainable rural maternity services including developing new service models, collaborative alliances, quality and safety initiatives and workforce training and development.<br>▸ RMI has funded the implementation of continuity of midwifery care models, service reviews, model-of-care redesign, upskilling of clinicians, collaborative partnerships, and quality and safety initiatives to support sustainable rural maternity services. | ✓ | ✓ | ✓ | ✓ |
| **Maternity Emergency Education Program (MEEP) and Pregnancy Care Program (PCP)**<br>▸ State funding supports regular, collaborative, team-based training, education and professional development to facilitate optimal maternity care team functioning. | | | ✓ | |

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| **Models of care**<br>▷ Since the introduction of Future Directions in 2004, Victorian women have more maternity care options available to them, including publicly funded homebirth as well as caseload and team midwifery. These models are increasingly available in metropolitan, rural and regional areas and promote continuity of midwifery care for low-risk women.<br>▷ Ongoing work is under way to provide all women with access to appropriate levels of maternity care and equitable access to primary models of maternity care where clinically appropriate.<br>▷ Smaller rural facilities are able to provide antenatal, postnatal and support services in partnership with larger subregional and regional services that provide birthing options.<br>▷ Health services facilitate consultation and referral processes from primary to secondary and tertiary models of care to enable women to move seamlessly through the levels of care they require. | ✓ | ✓ | | |
| **E-health**<br>▷ The Victorian Maternity Record (a handheld record) is being implemented across the state. | ✓ | ✓ | | |
| **Workforce**<br>▷ Maternity workforce funding promotes recruitment and retention and optimal use of workforce skill mix.<br>▷ 2009–10 funded projects included changes to maternity care models, maternity skill development and training, development of workforce skill mix across maternity and neonatal care, support for regional workforce collaboration, development of a midwifery common assessment tool and a midwifery fellowship model of employment. | | | ✓ | |
| **Victorian Maternity Services performance indicators**<br>▷ Health services review their performance and benchmark their maternity care through the Maternity Services Performance Indicators.<br>▷ These services also seek support for education, training and skill development where performance can be improved, such as areas with high intervention rates. | | | ✓ | |
| **Funding**<br>▷ Since 2007–08, $45.85 million has been committed to increase maternity and neonatal bed capacity and maternity service provision across Victoria.<br>▷ In 2008–09, $30.5 million in capital funding was allocated to accommodate an additional 2800 births per year. | ✓ | ✓ | ✓ | ✓ |

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| **Queensland** | | | | |
| **Maternity and Newborn Services in Queensland Work Plan**<br>▶ Queensland Health is implementing this plan[56] to address the priorities for maternity reform.<br>▶ A dedicated Maternity Unit and a statewide Maternity and Neonatal Clinical Network have been established to guide the reform agenda.<br>▶ Under the leadership of the clinical network, Queensland is:<br>– developing clinical indicators to monitor maternity and neonatal clinical outcomes such as caesarean section and induction rates<br>– undertaking service improvements in relation to midwifery-led discharge<br>– developing statewide maternity and neonatal clinical guidelines<br>– developing a handheld pregnancy health record. | ✓ | ✓ | ✓ | ✓ |
| **Universal Postnatal Contact Services Initiative**<br>▶ Queensland has invested almost $30 million over four years to ensure all Queensland mothers receive follow-up from a health professional after the birth of their baby.<br>▶ The initiative has:<br>– supported the establishment of community-based Newborn and Family Drop-in Services in around 20 communities<br>– supported the expansion, upgrading and integration of the Child Health Line with 13HEALTH<br>– supported the universal antenatal screening for tobacco, drug and alcohol use, psychosocial wellbeing, domestic violence and depression<br>– improved community partnerships and service networks to ensure appropriate referral for families identified at risk. | ✓ | ✓ | | |
| **Maternity Services Enhancement Program**<br>▶ Queensland has invested $9 million over four years from 2008–09 for this program.<br>▶ It includes the Rural Maternity Initiative, which aims to develop or enhance continuity models of maternity care to increase the range of options for women in rural Queensland and provide services closer to where they live.<br>▶ In 2009–10, $1 million from this program was allocated for the development of new or expanded services providing more midwifery continuity of care in nine communities. | ✓ | ✓ | | |

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| **Queensland Centre for Mothers and Babies**<br>▶ Queensland has allocated $7 million over four years to provide evidence-based information and resources for consumers and maternity carers.<br>▶ The centre is conducting an annual survey of women's experiences of maternity care.<br>▶ Ongoing stakeholder and consumer consultation and collaboration are being undertaken via a Maternity Care Collaborative forum. | ✓ | | | |
| **Maternity services**<br>▶ In 2009–10, the Queensland Government committed $42.7 million over three years for maternity and child health care.<br>▶ The program includes nine new drop-in clinics, the rural maternity initiative, $25 million to expand the neonatal intensive care unit at the Townsville Hospital and an additional $9 million to provide advanced care for premature newborns and others with respiratory problems in north Queensland.<br>▶ Queensland Health has birth centres operating in Townsville, Mackay, Brisbane and the Gold Coast. An additional $1 million capital funding was provided in 2009–10 for a new birth centre in Toowoomba. | ✓ | ✓ | | ✓ |
| **Queensland's Clinical Services Capability Framework**<br>▶ From 2010–11, this framework will assign maternity services a level from 1 to 6 according to their capacity to provide care, from antenatal and postnatal care only, to primary midwifery-led low-risk birthing care, to tertiary and super-specialty services. | | | | |
| **Indigenous Early Childhood Development National Partnership Agreement**<br>▶ Under this agreement Queensland is investing in a range of new and enhanced services for Aboriginal and Torres Strait Islander mothers and babies. | ✓ | ✓ | | |
| **Flying Obstetrics and Gynaecological Service (FOGS)**<br>▶ This service provides outreach to women in remote North and Western Queensland. | ✓ | | | |
| **Models of care**<br>▶ Queensland Health has developed an Implementation Guide for Midwifery Models of Care and has expanded the scope of midwifery practice to include the ordering of routine medications for maternity clients.<br>▶ Some rural Queensland Health facilities are investigating reopening sustainable birthing services through midwifery-led and shared care models. | | ✓ | | |

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| **Workforce**<br>▸ Queensland undertakes workforce surveys and is trialling improved and flexible working conditions to foster the retention of the maternity workforce.<br>▸ Direct-entry midwifery courses have been established at two universities and Queensland is funding a range of scholarships for student midwives and those wishing to return to practice.<br>▸ Queensland has developed a rural GP specialty, with equivalent remuneration to other medical specialities, to promote a rural GP workforce, including GP obstetricians.<br>▸ Queensland targets rural school leavers showing a propensity towards a career in the medical workforce. A screening tool has been developed to identify propensity to remain in rural Australia, as well as scholarships, mentoring and rural clinical placements to provide a pathway to rural practice.<br>▸ A doula program in far north Queensland has been developed, which focuses on educating female Aboriginal and Torres Strait Islander elders to encourage and support young Aboriginal and Torres Strait Islander women with their maternity care. | ✓ | ✓ | ✓ | |
| **South Australia** | | | | |
| **South Australia's Health Care Plan 2007–2016**<br>▸ The plan[70] has been developed to meet future challenges in health care. It outlines the government's investment in the New Royal Adelaide Hospital, a new hospital in metropolitan Adelaide, as well as other major hospitals. It also focuses on health promotion and illness prevention, providing community services and keeping people out of hospitals.<br>▸ South Australia is seeking to consolidate maternity services into larger and more modern sites that are better equipped to care for mothers and babies. There are moves to expand shared care models with GPs in metropolitan areas, and to give women the choice of midwifery-led care.<br>▸ Obstetric services at four country general hospitals will be maintained with support from the state's Maternal and Neonatal Clinical Network. | ✓ | ✓ | ✓ | ✓ |
| **Maternity services**<br>▸ The establishment of a maternal and neonatal statewide clinical network.<br>▸ South Australian regional and rural health services are being supported to ensure they are equipped to provide planned delivery for low-risk births. | ✓ | | ✓ | |

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| **Models of care**<br>▶ South Australia has a focus on expanding GP-shared care models throughout the state, as well as providing options to women for midwifery-led models of care.<br>▶ South Australia offers universal home visits for the first post natal visit as a standard of care.<br>▶ South Australia is developing GP Plus health centres with the capacity to provide antenatal and postnatal care in the community.<br>▶ South Australia has established midwife clinics in local shopping centres to facilitate easy engagement with young and teenage mothers.<br>▶ Birthing centres are associated with major public hospitals and are in high demand.<br>▶ A public homebirth program has been established. | ✓ | ✓ | | |
| **A universal home visiting program**<br>▶ This program offers a home visit by a community nurse to every newborn baby, and a Family Home Visiting Program offering extra support for families who need it during the first two years of life. | ✓ | ✓ | | |
| **E-health**<br>▶ South Australia has developed new IT systems, including handheld obstetric records, to enable consistent access to patient records. | | ✓ | | |
| **Workforce**<br>▶ South Australia has developed direct-entry midwifery courses. | | | ✓ | |
| **Standards of care**<br>▶ South Australia implements the Robson audit which is a tool for auditing interventions against clinical indicators.<br>▶ South Australia has developed complete perinatal practice guidelines. | | ✓ | | |

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| **Western Australia** | | | | |
| **Improving Maternity Services: Working together across Western Australia**<br>▶ This plan[41] is the result of a comprehensive statewide consultation process, which will guide the development of maternity services over a five-year period.<br>▶ The policy framework incorporates seven main goals, each supported by objectives and strategies. These goals are to improve:<br>– health outcomes for Aboriginal and Torres Strait Islander women and babies<br>– health and wellbeing of women and their unborn babies through better preconception and early pregnancy care<br>– women's experience of pregnancy<br>– women's experience of childbirth<br>– health and development of infants and address the needs of new parents<br>– safety and accountability in all maternity services<br>– sustainability of the maternity care workforce and promote clinical leadership and collaboration. | ✓ | ✓ | ✓ | ✓ |
| **Models of Maternity Care: A Review of the Evidence (2007)**<br>▶ Western Australia has invested in research, including a review[71] investigating the various outcomes and cost-effectiveness of a range of models of maternity care, and advocated for an increased range of models of maternity care and increased midwifery-led maternity care. | | | | ✓ |
| **The Women's and Newborn's Health Network**<br>▶ Collaborate with Telethon Institute of Child Health Research to undertake research into maternity service provision in Western Australia<br>▶ Developed consumer information website<br>▶ Developed statewide guideline for the management of co-sleeping<br>▶ Developed statewide guideline for the use of water for labour / birth<br>▶ Developed statewide policy and guideline for breastfeeding in hospital and health services with maternity inpatient facilities including promotional and educational package. | ✓ | ✓ | | |
| **Postnatal Depression Service**<br>▶ Western Australia has invested $2 million to expand the statewide service to provide integrated mental health and maternity units at the King Edward Memorial Hospital, as well as an Aboriginal and Torres Strait Islander perinatal mental health model providing outreach from Carnarvon to central Western Australia. | ✓ | ✓ | | |

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| **Perinatal Mental Health Unit**<br>▶ A comprehensive state service targets culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander communities and rural and remote communities. | ✓ | ✓ | | |
| **Models of care**<br>▶ There is one birthing centre co-located on the tertiary hospital site that is in constant high demand.<br>▶ Public homebirth program established and being expanded within metropolitan area. Similar model being considered to the South West region.<br>▶ Western Australia is reviewing referrals to its tertiary hospital to redirect low-risk women to secondary centres to enable birthing closer to home.<br>▶ A significant proportion of antenatal and postnatal care is provided by Area Health Services through hospital-based midwives and some community-based midwives.<br>▶ Western Australia has conducted research into the cost-effectiveness of a range of models of care, concluding that sustainable and cost-effective midwifery-led models of care can be provided to low-risk women.<br>▶ Birth rates in many of the birthing services in Western Australia are too low to sustain a full-time obstetrics specialist. GP Obstetricians play an important role in providing maternity care outside Perth.<br>▶ Visiting medical staff also play a critical role in providing maternity care to women in Western Australia.<br>▶ Approximately 90% of all families have contact with a child health nurse within 10 days of hospital discharge.<br>▶ King Edward Memorial Hospital (Perth) reviewing models of care provision, with plans to introduce Group Practice continuity of midwifery care models. | ✓ | ✓ | | |
| **Specialised care**<br>▶ There are statewide specialised clinics available for women with diabetes mellitus, maternal fetal medicine complications, teenage pregnancy, women with substance misuse and women with complex mental health problems.<br>▶ Statewide coordination of neonatal beds is currently under way.<br>▶ A Next Birth after Caesarean clinic established at King Edward Memorial Hospital (Perth), being developed in some secondary services. | ✓ | ✓ | | |
| **E-health**<br>▶ Western Australia has made significant progress with the development of e-records with unique patient identifiers already assigned to a large proportion of the population.<br>▶ Statewide roll out of STORK (perinatal database). | | ✓ | | |

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| **Workforce**<br>▸ The number of GPs trained in obstetrics in Western Australia is increasing.<br>▸ A GP Obstetrics mentoring scheme has been successful in bridging the gulf between completion of the Diploma of Royal Australian and New Zealand College of Obstetricians and Gynaecologists (DRANZCOG) and providing new GP obstetricians with the confidence to practice autonomously.<br>▸ A diploma for nonproceduralist GPs in women's health, which includes a maternity care module, has been introduced in Western Australia.<br>▸ Direct- entry midwifery courses have been established.<br>▸ The King Edward Memorial Hospital (Perth) in Western Australia provides educational videoconferencing to most maternity services in the state.<br>▸ Maternity workforce leadership is provided through the statewide Obstetric Support Unit and the Women's and Newborn's Health Network.<br>▸ The Medical Specialist Outreach Assistance Program funds education programs to rural areas, although this is limited by short-term funding.<br>▸ Double degree commenced in 2010.<br>▸ Statewide e-learning packages developed by SOSU and WNHN (BFHI, Perinatal Loss, Neuraxial Blockade).<br>▸ Implementation of statewide education program – K2. | ✓ | ✓ | ✓ | |
| **Statewide Obstetric Support Unit**<br>▸ In collaboration with WNHN, developed MANSMap database of workforce and service provision for all Western Australia maternity service providers<br>▸ Developed outreach education committee to determine the education needs of all service providers.<br>▸ In collaboration with WNHN, developed e-Learning packages for Perinatal Loss Service, Neuraxial Blockade, BFHI.<br>▸ Implemented statewide roll out of K2 on-line fetal monitoring education package. | | | ✓ | |

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| **Indigenous maternity services**<br>▸ Aboriginal women receive care through clinics for Aboriginal women, either within Aboriginal Medical Services/Aboriginal Controlled Community Health Organisation, or in mainstream services and birthing at local regional or secondary hospitals.<br>▸ Midwives at Derby Hospital provide excellent culturally supportive care for women.<br>▸ The Aboriginal Maternity group practice in Carnarvon has an excellent program in perinatal mental health.<br>▸ Good linkage and established relationships with Indigenous stakeholders supports culturally appropriate and safe maternity care programs. Armadale Health Service provides the Boodjari Yorgas Program in collaboration with Derbarl Yerrigan Health Service, and is a caseload model of maternity care.<br>▸ Aboriginal Maternity Services Support Unit is being established at King Edward Memorial Hospital (Perth), under COAG's Closing the Gap initiative, in collaboration with Aboriginal Maternity Group Practice models of care under the same initiative.<br>▸ The Aboriginal Health Council of Western Australia (AHCWA) have undertaken a Strength & Needs Analysis of all Maternal and Child Health Services within the Aboriginal Community Controlled Health Sector (ACCHS). This analysis has resulted in 29 recommendations, which provide direction to the development of appropriate models of care for local regions.<br>*True Care True Culture Program*<br>This program has been implemented through Closing the Gap, but is limited by short-term funding.<br>*National Partnership Agreement on Indigenous Early Childhood Development*<br>This agreement supports improved antenatal, pre-pregnancy health for Aboriginal women, especially teenagers, and increased access and use of child and parent health services by Aboriginal families.<br>*Strong Women, Strong Babies, Strong Culture Program*<br>This program works with senior Aboriginal women in participating communities to provide and direct support to pregnant women and their families. | ✓ | ✓ | | |
| **Information**<br>▸ Western Australia categorises health services by the Clinical Services Capability Framework, which assigns services a level from 1 to 6 according to their capacity to provide care.<br>▸ Western Australia Country Health Service has recently completed an audit and analysed data sources that have informed services of safety, quality and governance priorities by region.<br>▸ MANSmap (Maternity and Newborn Services map) data collection system including information related to workforce, models of care, education requirements collected and updated annually by SOSU in collaboration with WNHN. | ✓ | | | |

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| **Tasmania** | | | | |
| **Tasmania's Health Plan**<br>▶ This plan[72] is a blueprint for Tasmania's health services reform into the future. It comprises the Primary Health Services Plan, focusing on health services provided in the community, and the Clinical Services Plan, focusing on services provided in the major hospitals and by the ambulance service.<br>▶ This plan does not make detailed reference to maternity services, but it does articulate relevant issues and principles of care.<br>▶ The key principles for Tasmania's health services are for it to be:<br>– accessible and as close as possible to where people live, providing services can be provided safely, effectively and at an acceptable cost<br>– appropriate to community needs<br>– client and family focused<br>– integrated through effective service coordination and partnerships between providers<br>– designed for sustainability. | ✓ | ✓ | ✓ | ✓ |
| **Models of care**<br>▶ Birthing centres are associated with major public hospitals and are in high demand.<br>▶ A tertiary centre in Tasmania provides monthly outreach antenatal clinics to three regions within a 30 km radius of the service.<br>▶ Hospitals in Tasmania provide specific clinics for teenage mothers and their families or nominated support to provide education and antenatal care in a group setting.<br>▶ Clinical networks are under development. | ✓ | ✓ | | |
| **E-health**<br>▶ Handheld obstetric records have been developed in Tasmania. | ✓ | | | |

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| **Northern Territory** | | | | |
| **The Maternity Services Review in the Northern Territory**<br>▶ This review led to the development of a framework for services required to optimise the accessibility, safety, effectiveness and efficiency of maternity services for Territorians. The *Integrated Maternity Service Framework*[42] continues the evolution and service development of a range of new initiatives aimed at improving services and the health and wellbeing of mothers and babies.<br>▶ Key elements of this framework include:<br>– the new leadership model to develop the way forward<br>– defined referral pathways and protocols for care whether women are low or high-risk<br>– continuity of carer through a designated team<br>– electronic shared care record and/or handheld record<br>– a skilled and supported workforce<br>– consumers and professionals working together<br>– Aboriginal community-controlled organisations as lead providers of culturally appropriate maternity care<br>– recognition of private options as a component of the framework. | ✓ | ✓ | ✓ | ✓ |
| **Advanced Life Support in Obstetrics**<br>▶ The Northern Territory contributes $30,000 per annum to support obstetricians to undertake training in advanced obstetric care. | | | ✓ | |

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| **Models of care**<br>▸ Establishment of a range of new models of care, including:<br>– a community midwifery program in Darwin<br>– a birthing centre at the Royal Darwin Hospital<br>– homebirth services in Darwin and Alice Springs<br>– a maternal and child health strategy<br>– the introduction of a midwifery group practice for remote women who come into town for birth under the Closing the Gap initiative.<br>▸ Remote area nurse/midwives and Aboriginal health workers also provide antenatal care in community settings, including outreach.<br>▸ The Northern Territory successfully reinstated and has retained maternity services at Gove District Hospital through the recruitment of three GP obstetricians.<br>▸ Alice Springs and Darwin Hospitals provide outreach at considerable distances to remote communities.<br>▸ The Northern Territory Integrated Maternity Services Framework identifies defined referral pathways and protocols for care of low and high-risk women.<br>▸ There are Aboriginal Community Controlled Primary Health organisations such as Congress Alukura in Alice Springs, which features a Grandmothers Advisory Committee.<br>▸ Provision of care through midwifery group practices working with Aboriginal health workers from Darwin and Alice Springs.<br>▸ The development of remote area midwife positions with the potential to provide outreach maternity care, including education, antenatal and postnatal care, and provision for homebirth and birthing on land for Aboriginal and Torres Strait Islander women. | ✓ | ✓ | | |
| **Standards of care**<br>▸ The Northern Territory uses the South Australian perinatal clinical practice guidelines in acute settings and the Women's Business Manual in remote settings.<br>▸ Midwives use the Australian College of Midwives' National Midwifery Guidelines for Consultation and Referral. | | ✓ | | |
| **Workforce**<br>▸ The Northern Territory Department of Health and Families, and Congress Alukura (Aboriginal Community Controlled Organisation) are supporting the education of five Aboriginal women undertaking a Direct Entry Midwifery Program. | | | ✓ | |

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| **Australian Capital Territory** | | | | |
| **A Pregnant Pause: The Future for Maternity Services in the Australian Capital Territory**<br>▶ In 2003, the Australian Capital Territory (ACT) Standing Committee on Health undertook an inquiry into maternity services.[55] The report made some 20 recommendations to improve the maternity service system, including fundamental infrastructure changes to the operation of areas of the ACT public hospital system and the provision of community midwifery.<br>▶ The ACT Government's response to this review indicated support for some, but not all, recommendations. | ✓ | ✓ | ✓ | ✓ |
| **ACT Maternity Shared Care Guidelines**<br>▶ These guidelines[73] provide the framework for public maternity care in the ACT. They enable the territory to apply a consistent approach to maternity care from the confirmation of a pregnancy with a GP, through to maternity care and referral processes within the ACT.<br>▶ The primary health shared care arrangements are suitable for a healthy woman with an uncomplicated singleton pregnancy. Women requiring additional care from an obstetrician or a fetal medicine unit specialist are referred through to the secondary and tertiary services within the ACT. | ✓ | ✓ | ✓ | ✓ |
| **IMPACT Program (Integrated Multi-Agencies for Parents and Children Together)**<br>▶ This innovative program is a partnership between ACT Health and The Office for Children, Youth and Family Support, general practice and community pharmacy to provide intensive and coordinated care for vulnerable families.<br>▶ The aim of the IMPACT Program is to improve outcomes for pregnant women or those with children up to two years of age who have been identified with a significant mental health issue or who are receiving opioid replacement therapy by providing a coordinated cross-agency system response to the needs of families. | ✓ | ✓ | | |
| **ACT Breastfeeding Strategic Framework**<br>▶ The ACT has allocated $250,000 over three years to develop and implement this framework. | | ✓ | | |
| **Aboriginal Midwifery Access Program**<br>▶ The ACT provides culturally appropriate care to Aboriginal and Torres Strait Islander women through the program, which is delivered by the Winnunga Nimmityjah Aboriginal Health Service.<br>▶ The new tertiary referral Women's and Children's Hospital will facilitate the move to a new model of care. | ✓ | ✓ | | |

| Initiative | Plan priority | | | |
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| | Access | Service delivery | Work-force | Infra-structure |
| **Maternity services**<br>▸ There are three maternity facilities in the ACT: the Canberra Hospital, Calvary Public Hospital and Calvary Health Care. The Canberra Hospital maternity unit is the largest public maternity unit in the region, and provides general and specialist care to a population of over 500,000 from the ACT and the surrounding region. The maternity unit provides a comprehensive range of services, including midwifery-led care, obstetrician-led care, fetal medicine services and the Canberra Midwifery Program.<br>▸ Development of a new Women's and Children's Hospital on the Canberra Hospital Campus is under way with construction expected to be completed in late 2012. The hospital will co-locate maternity, gynaecology, neonatal intensive care and paediatric services. This tertiary referral centre will provide additional midwifery-led models of care and increased neonatal services, expansion of maternal–fetal medicine facilities and establish a Maternity Assessment Unit. A new model of care has been developed with the following key principles included<br>– family-centred care<br>– developmental care frameworks<br>– continuity of care and carer<br>– integrated and multidisciplinary care and treatment<br>– provision of research and information resources for clinicians, primary care providers, patients and their carers.<br>▸ ACT Health has a Service Funding Agreement with the Canberra Mothercraft Society to manage the Queen Elizabeth 11 (QE11) Family Centre. The QE11 Centre provides residential primary health care and parenting programs for families with young children who are experiencing complex health and behavioural difficulties in the first three years of an infant's life. QE11 provides assistance with complex lactation and other feeding problems, failure to thrive, unsettled babies, postnatal depression, children at risk or with special needs, and parent and grandparent support.<br>▸ ACT Health and the Greater Southern Area Health Service have established a medical retrieval service for critically ill newborns. The service is a satellite unit of the New South Wales Neonatal Emergency Transfer Service(NETS) established at the Canberra Hospital (NETS-ACT).<br>▸ The capacity of maternal–fetal medicine services has been expanded through re-accreditation as a training site for the maternal–fetal medicine subspeciality and increased scanning capacity by enhancing the sonographer workforce.<br>▸ The Canberra Hospital has received Baby Friendly Hospital Initiative accreditation for the fourth time.<br>▸ The newborn screening program has now been extended to include all infants born in the ACT. | ✓ | ✓ | | |

| Initiative | Plan priority | | | |
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| **Models of care**<br>▶ The ACT Government is committed to providing women in the ACT with continuity of care in a range of birthing options.<br>▶ Specific models of care have been developed to meet the needs of adolescent women, women from culturally diverse backgrounds, and women who have additional risk due to social, drug and alcohol use, mental health or economic factors.<br>▶ The Maternity Unit has expanded its services to provide more antenatal care to women in the local community setting providing a valuable link to the community following the birth of their babies.<br>▶ The popularity of the Canberra Midwifery Program has led to the Maternity Unit exploring other models of midwifery care that will meet the demand for continuity of care and complement the services provided in the new Women's and Children's Hospital.<br>▶ Maternal and child health nurses offer a universal home visiting service to families residing in the ACT.<br>▶ The Canberra College Cares program is a partnership between ACT Health and the ACT Department of Education and Training to provide education, support and antenatal care to pregnant teenagers and young parents on campus. | ✓ | ✓ | | |
| **Specialist care**<br>▶ Planning is in progress for the commencement of specialist antenatal clinics for obese pregnant women, the expansion of diabetes in pregnancy services and dedicated medical disorders in pregnancy clinics.<br>▶ The establishment of a perinatal loss coordinator/high-risk midwifery position will improve services for women and families who experience perinatal loss.<br>▶ The establishment of a vaginal birth after caesarean (VBAC) clinical pathway has shown a direct benefit in increasing the rate of VBAC. | ✓ | ✓ | | |
| **Workforce**<br>▶ Direct-entry midwifery courses have been established in the ACT.<br>▶ Workforce planning across all disciplines has been a key component in the development of the new Women's and Children's Hospital. | | | ✓ | |

# Glossary

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| access | The ability to obtain services. |
| antenatal | The period between conception and the onset of established labour. |
| Australian Government | The Australian Federal Government. |
| Australian governments | A collective term for the federal, state and territory governments. |
| baby | A child under the age of one year. Also referred to as an infant. |
| birth-centre care | Team midwifery care within a separate section of a hospital where midwives provide antenatal, intrapartum and postpartum care. |
| clinical guidelines | Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. |
| continuity of care | The practice of ensuring that a woman knows her maternity care provider(s) and receives care from the same provider, or small group of providers, throughout pregnancy, labour, birth and the postpartum period. |
| culturally competent care | 'Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations (Cross et al 1989, cited in Eisenbruch 2004a). Cultural competence is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services.<br><br>To become more culturally competent, a system needs to:<br>▷ value diversity<br>▷ have the capacity for cultural self-assessment<br>▷ be conscious of the dynamics that occur when cultures interact<br>▷ institutionalise cultural knowledge<br>▷ adapt service delivery so that it reflects an understanding of the diversity between and within cultures (RACP 2004).'<br><br>Source: www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/hp19.pdf |
| early childhood | Birth to five years of age, including neonates. See also baby, infant and young child |
| eligible midwife | See www.nursingmidwiferyboard.gov.au |
| evidence-based best practice care | A practice or methodology that, through experience and research, has proven to reliably lead to a desired result. |

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| health inequalities | Differences in health status or in the distribution of health determinants between different population groups (e.g. differences in infant mortality rates between women from different socioeconomic backgrounds). |
| health outcome | A change in the health status of an individual, group or population that is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status. |
| health professional | A person who provides proper health care in a systematic way professionally to any individual in need of health care services, including midwives, obstetricians, general practitioners, paediatricians, Aboriginal health workers, nurses and Allied Health professionals. |
| infant | A child under the age of one year. Also referred to as a baby. |
| informed choice | The right to make informed decisions regarding one's health care, based on available information and options. |
| intrapartum | The time from the onset of true labour until the delivery of the infant and placenta during childbirth. |
| midwifery-led care | Maternity care provided in a range of settings by a team of professionals that is led by a midwife or a team of midwives. |
| national | Comprising the Australian Government, and all state and territory governments. |
| perinatal | The time around birth, up to 28 days post-delivery. |
| postnatal | The period after the delivery of the baby, usually defined as the six weeks after birth. |
| primary maternity services | The first contact point with the maternity care system, primary maternity care includes the clinical care provided by a midwife or general practitioner for a low-risk woman not experiencing any pregnancy complications. |
| private maternity care | Private patients of a midwife, obstetrician or GP obstetrician attending private rooms for antenatal care, or receiving care in the home, and are attended by the same maternity professional for labour and postnatal care. |
| referrals | The process whereby a health professional directs a patient to the services of another health professional. |
| secondary maternity services | A clinical service provided by specialists who generally do not have first contact with patients; for example, obstetricians. |
| shared maternity care | Formal arrangements between a public hospital and a local practitioner (GP, obstetrician, midwife), in which the majority of care is provided by a local practitioner, with visits to the hospital at the beginning and latter stages of pregnancy. |

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| strategic plan | A comprehensive plan for accomplishment in relation to stated goals and objectives. Ideally, a plan will cover multiple years, include targets for expected accomplishments, and propose specific performance measures used to evaluate progress towards those targets. |
| Strong Women Workers | A 'Strong Women, Strong Babies, Strong Culture' Program Worker is an Aboriginal woman who has been chosen by her community as an appropriate person for passing on knowledge about pregnancy, birth, childcare and women's health to the young girls and young women in their community. The women use a bi-cultural approach using both traditional knowledge and cultural ceremonies as well as evidence-based western health knowledge. |
| tertiary maternity services | Specialised consultative maternity care, usually on referral from a primary or secondary health professional, by specialists working in a centre that has personnel and facilities for special investigation and treatment. |
| young child | A child between one and five years of age. |

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