SA Post Election Maternal Health Brief 2022

A pre-election brief was sent to MPs, Candidates and Senators prior to the election to inform politicians of poor quality, expensive public maternity services and make recommendations for change. In response, ALP promised increased access to continuity of midwifery care in SA. We request that this is implemented by the following dates to ensure a safe and smooth transition; 25% by 2023, 50% by 2024, 75% by 2025. We expect 100% access to continuity of midwifery care by 2023 for Indigenous women to almost close the gap.

Recommendations for Change

1. An expansion of access to **Continuity of Midwifery Carer models** from 12% to 75% across South Australian public hospitals to improve outcomes, reduce over servicing and save $5208/birth.

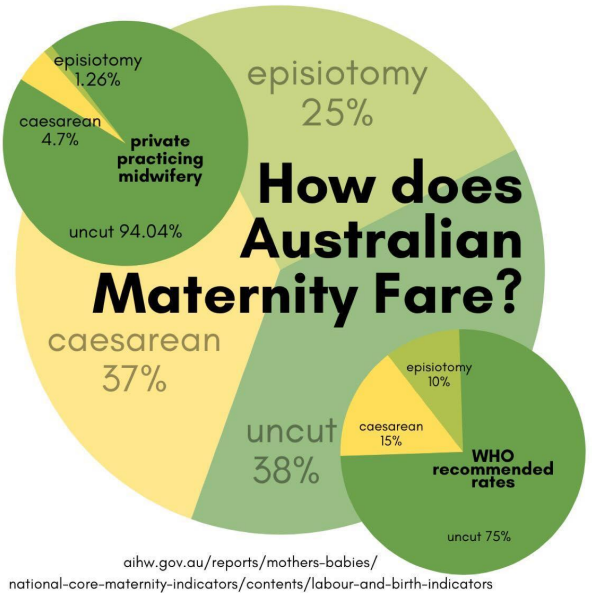
0. Roll out **Publicly Funded Home Birth** programs in remaining 8 local health networks in South Australia (currently only offered at Women's and Children's Hospital [WCHN] and Lyell McEwin Hospital [NALHN]) and increase accessibility to save $10,000/birth+ and reduce rising unassisted (freebirth) birth rates.

0. Increase **Birthing on Country** programs especially in rural South Australia for First Nation women. Roll out of Indigenous led midwifery carer services close to home such as the already successful Aboriginal Family Birthing Unit at the Women's and Children's Hospital in North Adelaide [2] and the Anangu Bibi Birthing Program at Port Augusta Hospital [3] across each Health District.

0. Creation of a **Chief Midwifery Officer** role in SA Health to focus on implementing these recommendations and reporting directly to the deputy chief executive. This is warranted as maternity is the largest service user group and biggest spender for the department. It has the most consumer complaints, insurance claims, least evidence-based guidelines and unwarranted variances compared to any other area of health.

Our Organisation

Our organisation, Maternity Choices Australia (MCA), is an unfunded volunteer run non-for-profit peak advocacy organisation that aims to improve women's outcomes and experiences for the last 35 years. We are deeply concerned about reduction in choice, coercion, unconsented procedures and unwarranted variances inflicted on vulnerable pregnant women in public hospitals. ACSQHC 3rd atlas reports a 12-fold variance in caesarean section rates [4].



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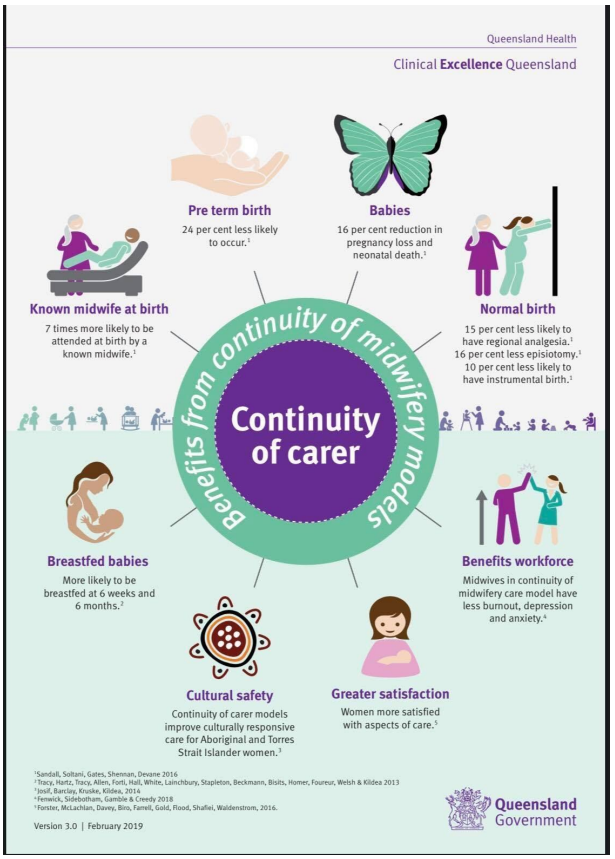
International Picture

Last year on World Patient Safety Day, WHO launched a campaign focusing on 'Safe and Respectful Maternity care' given high levels of 'abuse and mistreatment' especially in high income countries like Australia [5]. In 2019, the UN Special Rapporteur coined the term Obstetric Violence and called Australia out as a particularly poor performer [6]. Almost all pregnant women in New Zealand have access to all models of care and all places of birth [7]. 94% choose a known midwife and 40% choose out of hospital birth. During covid, hospitals in LA launched 'pop up birth centres' in hotels in the first month of the pandemic to reduce virus transmission, protect the workforce, reduce costs and improve outcomes. If a public hospital in the UK is unable to facilitate homebirth the government pays the cost of a private midwife (in Australia it would be $4,000 to pay the out of pocket costs for 20x 60 min pre and postnatal appointments and the two midwives to attend the birth compared to public hospitals average of $25,000). The British government has created a Chief Midwife position and has tasked the incumbent with rolling out a known midwife to 75% of women and 100% access for Black and Minority Ethnicities [8].

Continuity of Midwifery carer

Commonly known as Midwife Group practice (MGP) or caseload midwifery, this care model supports women through a primary and back-up midwife through all stages of pregnancy, birth and postpartum. The latest statistics in SA show that only 11.8% of women accessed MGP care models publicly [9]. Level 1 evidence proves that it is the physically and emotionally safest and most cost-effective care model for women and thus, should be made readily available to all expecting mothers [10].



Cost Benefits of MGP and out of hospital birth

Not only does MGP benefit pregnancy, birth and postnatal outcomes for the mother and their baby, if universally available to SA women, it would save $88,556,832. MGP model of care costs 22% less ($5208) than other models of care. In addition, midwives report higher levels of job satisfaction and lower levels of occupational burnout when participating in a well-supported MGP care model [11].

Qld data from Callander (2021) Covid Opportunity Cost paper shows increased access to Public Birth Centres and Publicly Funded Homebirth (PFHB) saves 348,625 in postnatal bed days by using virtual beds and the same research team is extrapolating at the moment and it looks like $10,000+ will be saved per low risk birth. [12]

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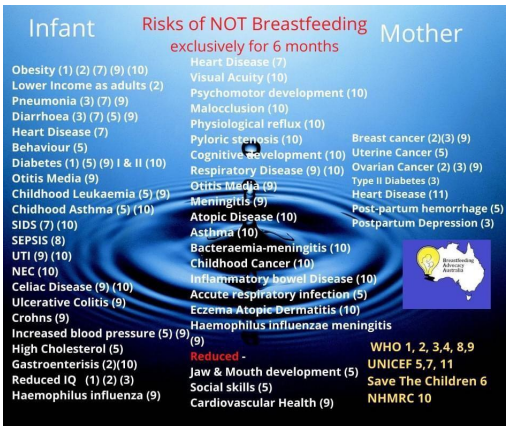
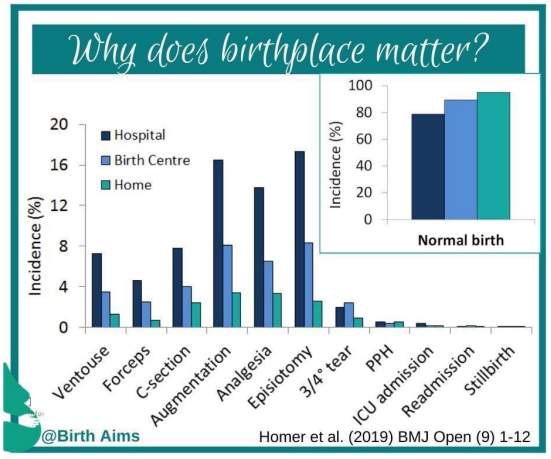
Breastfeeding and MGP

97% of women want to breastfeed but only 15% are at 6 months. MGP increases the likelihood of breastfeeding through additional time for education and continued relationship-based support postnatally. Breastfeeding reduces the likelihood of death, illness, chronic diseases such as allergies, obesity, diabetes and cancer for BOTH mother and baby [13].



Publicly Funded Home Birth

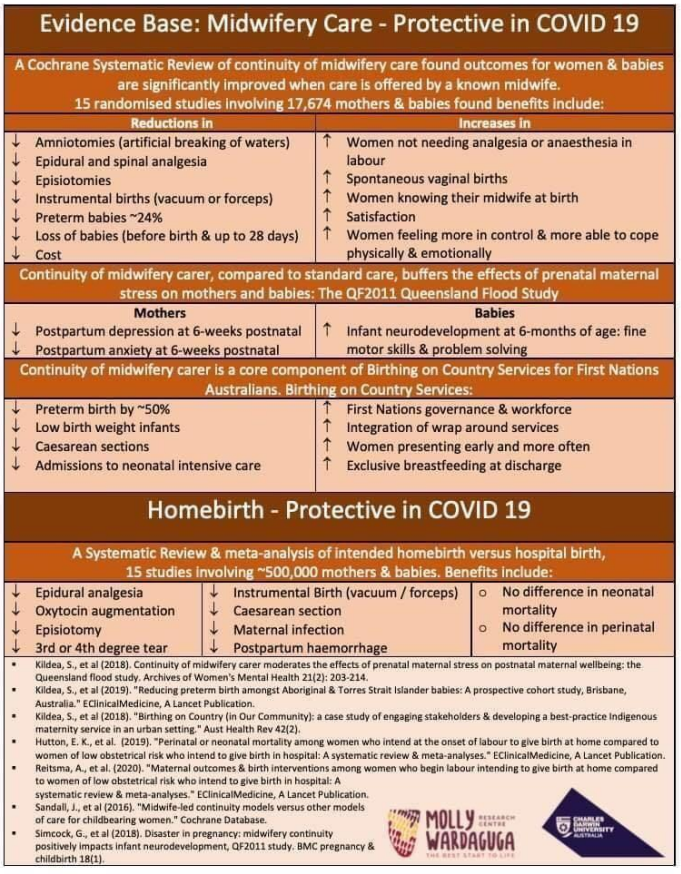
Planned home birth with registered midwives is the physically safest way for all risk categories of women to give birth. For low risk mothers, planned hospital birth significantly increases the physical and emotional risks of poor outcomes for themselves and their babies. High risk mothers have improved outcomes when planning a homebirth but their babies have slightly worse outcomes. Only 2 health districts have PFHB programs out of 10 in SA and the unplanned and planned unassisted birth rates are rising due to non-evidence-based care, abuse and mistreatment experienced in public hospitals [14].



First Nation Women

Indigenous women (3.8%) are unfortunately 2-3 times more likely to experience adverse maternal and perinatal outcomes than non-indigenous women [15]. The national average data shows that indigenous child mortality was 22.7 per 1000 births compared to non-indigenous rate of 7.5 per 1000 births [15]. It is reported that the main cause of indigenous child deaths was perinatal conditions such as complications during pregnancy and birth [16]. In addition, first nations women are 50% more likely to have children born with low birth weight and preterm labour [17] when restricted to standard fragmented maternity care.

However, most of these complications can be avoided under more culturally appropriate care models such as the 'Birthing in our Country' Indigenous-led



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birthing programs. These statistics show that Birthing on Country care programs will assist in meeting the nations targets in the Closing the Gap Report on infant mortality [18]. Midwife led birth units in rural areas across Australia are called level 2 facilities and with appropriate transfer pathways, show exceptional outcomes. Most women want to birth close to home and begin labour in home with their known care provider.

We are eager to engage in a meeting with the new Health Minister to discuss their commitments.

Supporting Organisations:

Australian College of Midwives

South Australia Branch

Homebirth Australia

MATERNITY CONSUMER NETWORK

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