Executive summary

“When you’ve seen one rural maternity service…You’ve seen one rural maternity service”
(Rural Maternity Clinician)

The provision of health services in rural and remote communities is very different from that in regional and metropolitan areas. Geography and scale create unique challenges and the workforce tends to be generalist rather than specialist. The many support services present in cities and towns are usually absent in rural and remote areas with the rural hospital often being the provider of primary, community and aged care services. The small scale creates major challenges in the provision of safe work hours and sustainable work-life balance for clinicians. The loss of one staff member can mean the loss of critical services. Isolation can create major challenges for maintenance of skills and opportunities to upskill. An advantage of small scale is that clinicians can develop a more meaningful and holistic relationship with patients and have a broader understanding of their health concerns and the external factors that impact upon them. The models of care that are provided in rural and remote areas can depend on the skill mix of the available clinicians, but in many small communities continuity of carer is achieved by default.

The Queensland Rural Maternity Taskforce (the Taskforce) was established in August 2018, at the request of the Minister for Health and Ambulance Services in response to concerns raised by the media and consumer groups regarding the provision of safe and accessible maternity services in rural and remote areas. The Taskforce was asked by the Minister to advise on the safety of current rural maternity services in Queensland and explore what steps can be taken to minimise risks for mothers and babies in rural and remote communities, whilst providing services as close as possible to where they live. Membership of the Taskforce includes consumers, front-line clinicians, Aboriginal and Torres Strait Islander consumers and organisations, professional organisations and union representatives, researchers, policy makers, and health service leaders. The Taskforce had two key deliverables: a report on the safety of current rural maternity services in Queensland, and the development of a decision-support guide, known as the Rural and Remote Maternity Services Planning Framework that will support Hospital and Health Services in decision making on rural and remote maternity service provision.

The report consists of three key sections. The data analysis section provides information on geographical access to maternity services, clinical outcomes, and risk factors for rural women and their babies. The data analysis is complemented by the stakeholder engagement and public submission sections. These provide the perspectives and opinions of the consumers, clinicians, community members and health service leaders who have the lived experience of accessing, working within, and managing and planning maternity services in rural and remote communities, and the views of the wider population of Queensland.

Of the 40 public maternity services that currently provide birthing, antenatal and postnatal services in Queensland, 32 are located in regional, remote and very remote areas. The majority of these services are CSCF level 3, which can provide planned births for a healthy woman with a pregnancy of 37 weeks gestation or greater and who is not expected to have complications in labour or birth. The data analysis found that approximately 96% of women who give birth live within a one-hour drive of a public maternity service. Of the remaining 4% who live an hour or more from that service, a third are Indigenous. For women living four or more hours from a maternity service this increases to 80% who are Indigenous.

The closure of maternity services has not been a slow steady progression over a few decades as suggested by the media. While a number of services closed between 1996 and 2005, service numbers have remained relatively stable since then. From 2011 to 2017 six services closed and five opened. However, the loss of rural birthing services, and a preference by some clinicians and administrators to keep the concentration of maternity services within major towns and cities is having unintended
consequences. These include loss of skills base from rural hospitals; health, social and economic consequences for women and families; and introduction of new risks to the safety of the mother and baby, which may outweigh any intended safety benefits.

The analysis showed that perinatal and neonatal mortality rates were a maximum of 1.7 times higher for women in very remote areas compared to women in regional areas. This increased rate was found to be partly explained by maternal health factors that can be modified by good access to social and health support before and during pregnancy. The main conclusion from this is that more work needs to be done to support better general health of women in rural and remote areas, including improved access to primary and preventive health services and better social care services.

The rate of babies being born before arrival at hospital (BBA) was found to be increasing and has more than doubled since 2000. The BBA rate is highest for women who live between one and two hours from maternity services. This suggests that the centralisation of rural maternity services may be contributing to more unintended home births or births by the roadside due to the longer distances women have to travel to birth. Whilst there are fewer BBAs in very remote areas, this is possibly because women are relocated closer to a birthing service many weeks prior to the estimated birth date, which has its own risks and challenges for the women, their babies, and families.

The stakeholder engagement and submission processes found that some clinicians believe women take unnecessary risks for themselves and their babies or are willing to accept higher risk rates than clinicians are comfortable with. Clinicians may only be considering clinical risks for the mother and baby, and professional risks for themselves. They may not fully appreciate the complex interaction between clinical, social, cultural, spiritual, and financial aspects of safety and risk that the woman considers when choosing what she believes is best for herself and her baby. In an attempt to reduce clinical and professional risks, decisions made by clinicians and health services create other risks that are transferred to the mother and baby.

Women want to be informed about all their maternity options, not just the ones that are locally available. They want continuity of carer within welcoming, comfortable, culturally appropriate services as close to home as possible. They want adequate support and resources when they have to travel away from home to access maternity services. Community members and clinicians want to be involved in, not just consulted on, the development and review of maternity services. They want transparency in how decisions are made and for more than just clinical safety to be considered.

Aboriginal women in some communities told the Taskforce they want more welcoming environments within which to give birth, and to see more Indigenous women in maternity workforce roles. Aboriginal and Torres Strait Islander consumers would like to be consulted separately from other consumers, as well as participating in the broader consumer engagement process.

Clinicians want to be supported by the health service to provide continuity of carer in a safe, collaborative environment. They want adequate support and resources to maintain their professional skills and work to their full scope of practice. They want good peer networks and mutually respectful relationships with the higher-level services they refer to. Clinicians and women want good communication and clear processes in place for when women are transferred between services.

Rural and remote maternity is the barometer for the health of all rural services and a keystone for rural and remote communities. Appropriate governance, whole-of-system planning, and funding models are required to support and sustain rural hospitals, and reduce reliance on centralisation based on economies of scale.
Recommendations

In the light of the findings in the data analysis section and information obtained from the written submissions and five rural visits, the following recommendations are made:

1. **Queensland Health establish clear whole-of-system governance and strategy for rural and remote health services.**

   Rationale – The current health system funding and performance management model is geared to urban based specialist hospital services, operating efficiently at scale, with a focus on performance measures of emergency department, specialist outpatient and elective surgery waiting lists. Given the very different circumstances of small hospitals, with a generalist medical workforce, limited access to support services, and need for 24/7 operations with a small multi-skilled workforce, specific system governance is required to ensure that the needs of rural communities and providers are carefully considered. A clear whole-of-system governance and strategy for rural health service delivery in Queensland is required that brings together: education and training; workforce; planning, funding and performance management; sustainability; and safety and quality. Ring-fenced funding allocation specifically for rural and remote maternity services should be considered in the health budget.

2. **Queensland Health undertake comprehensive system-wide planning of rural maternity service provision.** The broad aim should be to strengthen the case for bringing rural maternity services closer to home; strengthen and improve existing CSCF level 2 and 3 services, and carefully plan for re-establishment of key level 2 and 3 maternity services in collaboration with local communities.

   Rationale – The increasing rates of babies born before arrival (BBA) at hospital, and the relatively high rate of BBA amongst women who live between one and two hours’ drive from a maternity service that has caesarean section capability, prompts the need to carefully plan the re-establishment or strengthening of existing level 2 and 3 services. Providing maternity services close to where women live improves outcomes for both the mother and baby; and clinical, social, cultural, spiritual, and financial risks for women, their babies, and their families are reduced. Planning should include consideration of the risks for woman and their families that arise when women travel long distances for maternity services and spend extended periods of time away from their community, usually at a substantial cost to the woman and her family. Clinical risks may be reduced from the health system perspective, but other risks are increased for the woman and her baby.

3. **HHSs invest in and promote improved rural maternity service collaborative culture and teamwork as a core to ensure best outcomes for women and babies.**

   Rationale – Acknowledging the evidence demonstrating the widespread benefits associated with continuity of care, the development of a culture of collaboration, trust and teamwork between doctors, midwives, Aboriginal and Torres Strait Islander health workers and nurses is especially critical in rural settings where emergency specialist support is often hours away. This does not happen by accident. It requires investment in relationships, joint training and education, and shared quality and case reviews, across the network of services including the specialist service; and additional support for inexperienced clinicians. Careful selection, development, and support of medical and midwifery leaders to create this culture is critical to safe outcomes for women, their babies, and the staff providing care. Collaboration with consumers and the community when developing and reviewing services is just as critical for ensuring the service is sustainable and meets the needs of the community.
4. Each HHS (localised for each maternity service) develop an easy-to-understand guide for women, which summarises their local maternity model options. Queensland Health to co-design a template with consumers and service providers.

Rationale – Women universally indicated that they are not provided with information on models of care choices available to them locally or at a referral service; differences in risk with maternal and neonatal factors or service factors; and importantly, what the protocol is if an unforeseen emergency occurs during labour or if service provision changes. Rural maternity services should consider all aspects of maternity care in service delivery, including post-natal care which receives much less attention than it should.

5. Queensland Health mandate HHSs to follow evidence-based framework for decision-makers in assessing and configuring rural maternity services.

Rationale – There is currently little formal guidance for HHS decision makers on how to assess, review and configure rural and remote maternity services. Assessments of safety and risk seem to be narrow, lack transparency and whilst well intentioned, may overstate the risk for women and babies, especially if they are risk screened only for clinical factors. A Rural and Remote Maternity Services Planning Framework is being developed by the Taskforce to support a more evidence based and transparent approach to rural maternity service delivery, taking into account the key issues, criteria, and processes. This framework has been developed by the Taskforce to assist HHSs in planning, evaluating, improving and re-configuring rural and remote maternity services. The framework includes essential steps in engaging with consumers and the local community using a co-design approach. The System Manager should mandate the use of this guide as part of its assurance system.

6. Queensland Health identify and coordinate local and state-wide actions to improve maternal health in rural and remote communities. Remote Indigenous communities should be a priority.

Rationale – The data analysis identified poorer outcomes, i.e. stillbirth, neonatal death, or pre-term birth for Aboriginal and Torres Strait Islander families and women living in remote communities.

The taskforce recognises the added challenges of providing services in these communities and that strategies are needed to reduce the prevalence of modifiable risk factors and to improve services. Maternity services must address the psychosocial determinants of health working with a primary healthcare approach that includes overarching Indigenous governance to ensure that women feel culturally safe. Strategies will need to be developed to ensure appropriate representation of Aboriginal, Torres Strait Islander, and culturally and linguistically diverse people in the maternity service workforce.
Fast facts and findings

- The definition of ‘safety’, ‘risk’, and ‘a good outcome’ mean different things to consumers, clinicians, and the executives who plan and manage the services provided in the Hospital and Health Services (HHSs).

- Women want to be provided with information about their maternity options (antenatal, birth and postnatal) both locally and elsewhere, and want to be supported to access their preferred maternity options.

- Many women want access to maternity services as close to home as possible, with continuity of carer the preferred option.

- Women who need to travel away from home to access care want improvements in subsidy and reimbursement schemes, transport and accommodation (including for older children and support persons) to lessen some of the impacts of travel on them and their families.

- Aboriginal and Torres Strait Islander women want more welcoming environments within which to give birth and to see more Indigenous women in maternity workforce roles.

- All consumers and community representatives, including Aboriginal and Torres Strait Islander people, want to be engaged from the beginning of maternity services planning processes and on an ongoing basis throughout design and review.

- The psychological safety of clinicians needs to be supported. Many clinicians reported they do not regularly participate in structured or facilitated reflective practice where they continue to be supported in their role on an ongoing basis, and where psychological distress can continue to be monitored for and worked on.

- Clinicians in rural and remote communities reported difficulties in accessing training and skills development and maintenance that included: not enough pregnant women for all maternity providers in the community (doctors, midwives, nurses) to maintain their skills in their respective disciplines, being unable to be released from work due to work-force shortages, lack of funding and support, and lack of on-site training.

- Incentives for midwives, nurses and allied health clinicians to work in rural and remote communities were significantly less than those for doctors, e.g. employment contracts and options including preferential housing, pay and conditions such as on-call payment, professional development and Right-Of-Private-Practice arrangements, which may contribute to recruitment and retention issues.

- Communication and information sharing between services and with the women could be improved, especially when a woman is transferred to a higher-level service or returns to her community.

- No pregnancy is risk-free but there needs to be a balance between what consumers, clinicians, health services, and the government consider to be acceptable risks and how to address them.

- 32 of the 40 facilities in Queensland that provide birthing (along with antenatal and postnatal services) are located in regional, remote and very remote areas (CSCF levels 2 to 6).

- 20 of those facilities are in outer regional, remote and very remote regions of Queensland.

- There is only one CSCF level 2 maternity service in Queensland and few women have access to birth centres.

- 78 regional, rural and remote facilities identify as a CSCF level 1 facility that provides antenatal and postnatal services on-site.
• 96 per cent of mothers who gave birth between 2013 and 2017 lived within a one-hour drive of a Queensland Health facility that provides birthing (CSCF level 2 to 6).

• The remaining four per cent accounts for 9,257 mothers who lived an hour or more from a public birthing facility during the five-year period; 3,066 (33 per cent) of these women are Indigenous.

• Of the women living four or more hours from a maternity service 80 per cent are Indigenous women.

• 35 per cent of all women and 46 per cent of Indigenous women are not attending the minimum recommended number of antenatal visits.

• Smoking during pregnancy and maternal obesity, irrespective of where a mother lives, are risk factors that increase the chances of a baby dying during pregnancy or within 28 days after birth. However, rates of smoking and obesity are higher in rural and remote locations.

• Women who live four or more hours from a maternity service have higher rates of all risk factors and higher rates of preterm birth, stillbirth and neonatal death than women who live close to services.

• In very remote areas, the rate of perinatal death is of the order of 1.6–1.7 times the rate of the inner and outer regional areas.

• When risk factors that are not associated with quality of care at the time of birth were included in statistical models calculating the chance of neonatal mortality, stillbirths and preterm births occurring, the rate of these outcomes occurring was not found to be higher in rural and remote areas than in urban areas. This suggests that it is important to focus on reducing the higher rates of risk factors present in the population residing in rural and remote areas in order to reduce the higher rate of adverse outcomes observed.

• The rates of babies born before arrival (BBA) at hospital are increasing in Queensland and are highest among women who live between one and two hours from a maternity service with caesarean section capability. This area requires further investigation.

• The findings of this report highlight the importance of ensuring women in rural and remote areas have access to appropriate, culturally safe services that meet their needs. This has important implications for service planning and targeting of prevention initiatives.