3. Maternity within the broader healthcare and societal context.

Health includes the dimensions of physical, mental and social well-being and is affected by social, economic, political, cultural and environmental factors. Environmental factors include the healthcare provider’s approach and the birth environment6.

Empowering women to have healthy pregnancies and safe births helps to achieve social and economic gains beyond the health sector (Singh et al., 2009). It sets the foundation for lifelong good health and wellbeing. It is well known that poor quality maternity care can result in maternal or perinatal mortality. However, it can also contribute to acute and chronic physical and psychological morbidity for women. This can have lasting effects on the physical and psychosocial health and wellbeing of the woman and baby (Renfrew et al., 2014), which in turn impacts on the family and community.

Within rural and remote communities, the presence or absence of a maternity service has repercussions for the broader community and the health services provided. Improving access to quality maternity and newborn care has a substantial, measurable impact on the health of women and families and can have an economic effect on communities (Singh et al., 2009, Kildea et al., 2016). Reducing the incidence of obesity, smoking and hypertension in parents has been shown to reduce the incidence in their children, grandchildren and future generations (Marmot et al., 2012). Children who experience a positive start in life are likely to do well at school, attain better paid employment and enjoy better physical and mental health in adulthood (Marmot et al., 2012). Maternity and newborn care are lynchpins for sustainable communities, medically, socially, and economically (Hoang et al., 2014).

3.1. Classifying rural and remote services

Several different classification systems have been developed to define remoteness and rurality in Australia (AIHW, 2017). These tend to define in terms of the size of a community, distance from population centres, and access to services. The analysis in this report will focus on the time it takes to travel by road to various levels of services to provide an indication of remoteness in terms of individual women and services.

It can be difficult to assess the implications of remoteness for health due to:

- the interactions between remoteness, low socio-economic position and the higher proportion of Indigenous Australians in many of these areas compared with major cities
- the variability in the distribution of disadvantage and of Indigenous Australians across all areas—for example, levels of disadvantage on the fringe of major cities can be more akin to those in rural/remote areas than to inner-city areas
- gaps in the availability and coverage of health data in rural and remote areas, and in information available at the local area level.

It is also difficult to measure whether there is adequate supply of medical services because of the influence of factors such as varying health-seeking behaviours, professional scope of practice, and health system efficiency across remoteness areas.


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6 The International Childbirth Initiative (ICI): 12 steps to Safe and Respectful MotherBaby-Family Maternity Care' was developed in 2018 to improve respectful maternity care to improve the safety, privacy and dignity of women whereby the woman is the final decision maker in her care. (ICI 2018)
3.2. Clinical Services Capability Framework – Maternity

The Clinical Services Capability Framework (CSCF) is a Queensland Health tool that outlines the minimum service and workforce requirements, as well as specific risk considerations required in both public and private health facilities to ensure safe and appropriately supported clinical services (Queensland Health, 2018). Categorisation is based on the hospital’s self-assessment and rating of their maternity service into CSCF levels ranging from level 1 (lowest) to level 6 (highest).

The CSCF is intended for a broad audience including clinical staff, managers and health service planners. It is not intended to replace clinical judgment or service-specific patient safety policies and procedures, but to complement and support the planning and/or provision of acute and sub-acute health services.

CSCF levels 1 to 3 maternity services are provided in rural and remote public health services.

Table 1 provides an overview of the services provided for each level. Figure 1 shows the location of all facilities with a maternity service of a CSCF level 2 or above.

Information on Queensland birth rates and CSCF levels by year is provided in:

- Appendix C: Births by year and CSCF level 2–6 facilities.
- Appendix D: Births by year and CSCF level 1 and ‘No level’.

Table 1. Clinical Services Capability Framework level of service description (abbreviated)

<table>
<thead>
<tr>
<th>Clinical Services Capability Framework</th>
<th>Service description</th>
</tr>
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</table>
| 1                                     | Provides community antenatal and postnatal care only.  
|                                       | There are no planned births or maternity inpatient services. |
| 2                                     | Provides access to antenatal care and inpatient postnatal stay as well as planned births for women of 37 weeks or greater gestation and with no identified risk factors, however, epidurals are not available to labouring women.  
|                                       | Access to functional operating theatre (not necessarily on-site) where birthing services are provided.  
|                                       | If operating theatre on site, may perform elective caesarean section for women at or beyond 39 weeks gestation who have experienced uncomplicated pregnancy. |
| 3                                     | Provides community and inpatient care for antenatal and postnatal women without identified risk factors, and planned birth care for healthy women with pregnancy of 37 weeks gestation or greater and not expected to have labour or birth complications.  
|                                       | May offer women with relatively low-risk pregnancy and favourable Bishop (cervical assessment) score at term, an induction of labour locally.  
|                                       | May manage women who present in preterm labour at 35 weeks gestation or greater, with otherwise uncomplicated pregnancy, after consulting with higher level maternity and neonatal service.  
|                                       | Can perform elective caesarean section on women at or beyond 39 weeks who have experienced uncomplicated pregnancy. |
| 4                                     | Provides maternity care for low- and moderate-risk women, but cannot care for women with complex, high-risk conditions.  
|                                       | May provide high risk antenatal clinics as satellite or outreach from higher level service.  
|                                       | Can care for pregnant women at 32 weeks gestation or greater if a continuous positive airway pressure (CPAP) device is accessible on-site for the baby, and the baby is expected to have a birth weight of 1,500 grams or more with no additional risk factors.  
|                                       | If a CPAP device not accessible on-site, the service can plan and deliver care for pregnant women at 34 weeks gestation or greater. |
| 5                                     | Can provide planned care for women at 29 weeks gestation or greater with babies expected to have a birth weight of 1,000 grams or more, as well as providing a multidisciplinary service with capacity to manage all unexpected pregnancy and neonatal emergency presentations. |
| 6                                     | Provides all levels of care, including the highest level of complex care for women with serious obstetric and fetal conditions requiring high-level multidisciplinary care. |
Figure 1. Hospital and Health Services, Queensland Health with recognised Public Hospitals and Primary Health Centres with Maternity Services CSCF level 2 – 6 highlighted
Figure 1 continued.

Note: map includes all HHS facilities, including those that do not provide any maternity services. Those facilities noted with a CSCF level 2 to 6 provide full maternity services including birthing. Other facilities that provide antenatal and postnatal services (CSCF level 1) are listed in Appendix B: Facility CSCF levels 2012–2019.
3.3. Supporting services

Maternity care does not occur in isolation and a range of support services, including considerations of caring for a well or unexpectedly sick newborn baby or mother, are required to be able to provide care in rural and remote services. Table 2 shows the minimum support service CSCF level requirements for CSCF level 1 to 3 maternity services, as detailed in the CSCF Maternity Services module.

Table 2. Support service CSCF level requirements for CSCF level 1–3 maternity services

<table>
<thead>
<tr>
<th>Support services</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>On-site</td>
<td>Accessible</td>
<td>On-site</td>
</tr>
<tr>
<td>Anaesthetic</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Intensive care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical imaging</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Neonatal</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Pathology</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Perioperative (operating suite)</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

On-site means staff, services and/or resources located within the health facility or adjacent campus including third party providers. Accessible means ability to utilise a service (either located on-site or off-site) or skills of a suitably qualified person (who may be either on-site or off-site)—without difficulty or delay—via various communication mediums including but not limited to face-to-face, telehealth, telepharmacy, and/or outreach.


Where a woman’s pregnancy or birth becomes complex and a higher level of maternity service is required, it is vital that efficient and safe mechanisms are in place within the existing level of service to facilitate consultation or referral to a higher level service. Retrieval Services Queensland and the Royal Flying Doctor Service (RFDS) work closely with rural and remote and regional services to facilitate the timely transfer of mothers and newborn babies who require services beyond the capability of rural and remote facilities.

3.3.1. Queensland Flying Obstetric and Gynaecology (FOG) Service

The FOG as part of the Flying Specialist Service, is a Queensland Health initiative that commenced on 4 July 1988. It provides specialist obstetrics and gynaecology services to women living in rural and remote areas of Queensland. The facilities currently visited by the FOG are: Roma, Charleville, Cunnamulla, St George, Goondiwindi, Longreach, Barcaldine, Stanthorpe, Dalby, Kingaroy, and Chinchilla

In Barcaldine and Cunnamulla, the FOG provides a consultative service. An elective operative service in addition to consultations is provided in the other facilities. The FOG provides a 24/7 emergency service for acute obstetric and gynaecological emergencies to the facilities routinely visited. A dedicated aircraft is available for the service at all times. It flies to different facilities four days a week.

The FOG Service has made a very significant impact on the delivery of specialist services to the women of outback Queensland, and also provides continuing education opportunities and professional support for remotely placed rural medical, nursing and midwifery staff.

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3.3.2. Far North Regional Obstetric and Gynaecological Service

The Far North Regional Obstetric and Gynaecological Service (FROGS) is a cost-effective outreach service which provides equitable access to specialist care for people living in remote communities and aims to address many of the significant problems of women’s healthcare in far north Queensland.

3.3.3. Telehealth Emergency Management Support Unit

The Telehealth Emergency Management Support Unit (TEMSU) acts as a video conference support service that is able to access and connect rural and remote facilities to nursing, senior medical officers and specialty services, such as obstetrics and midwifery.

To achieve the right fit, the TEMSU team works closely with staff in each HHS to define how the TEMSU model can support their local pathways, clinicians and patients.

3.4. Maternity workforce

Maternity care may be provided by a diverse range of clinicians (health practitioners) who provide maternity care within their scope of practice and are registered to legally practise by their associated professional national board.

3.4.1. Workforce roles

Good maternity care requires strong collaboration between the following clinicians:

- **Midwives** – a midwife has the requisite qualifications to be registered with the Nursing and Midwifery Board of Australia (NMBA) to legally practise midwifery. Midwives are educated and skilled to provide comprehensive care and advice to women pre-conception, during pregnancy, labour and the postpartum period, and care for the baby. Midwives are educated, competent and required to identify complications, consult or refer care as per the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral and to institute emergency measures for a mother or her baby. A midwife may practise in the home, hospitals, clinics, community health units, or in any other service. Midwives work collaboratively with doctors and other members of the healthcare team as appropriate where there are identified risk factors for the woman and/or baby (NMBA, 2018). Some midwives hold additional qualifications and are endorsed to prescribe medications or have other varied advanced skills. For example, midwives employed by Queensland Health may also be endorsed and recognised as a participating midwife with Right of Private Practice. Under the COAG Section 19(2) exemption: Billing for rural hospitals, they are able to utilise their Medicare provider number to order diagnostic tests such as ultrasound and pathology, and bulk bill for ambulatory services as own source revenue.

- **Private Practising Midwives** – midwives who work as sole practitioners, in partnership or in self-employed models, and are working in the private sector consistent with the NMBA quality and safety standards (NMBA 2017). They provide private midwifery services to women in a range of settings including the woman’s home, the hospital, and other settings outside a hospital. They have collaborative arrangements in place with a doctor or health service and may apply to a hospital to be credentialled to admit clients and provide inpatient services. They can apply for a

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9 Which are endorsed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
Medicare provider number, which enables eligible women to claim Medicare rebates for services provided for which they have paid the midwife directly.

- General Practitioner Obstetricians (GP Obstetrician) – a GP with additional training in obstetrics, which may be formal such as the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Advanced Diploma or informal such as additional hospital-based training or experience in practice (RACGP, 2018). GP Obstetricians can manage normal pregnancy and birth and some levels of complicated cases. They can perform operative vaginal births and caesarean sections in appropriate cases. Not all GP obstetricians are Rural Generalists, but those who satisfy the definition of a Rural Generalist doctor outlined below are.

- Private Practising GP Obstetricians – a GP with additional training in obstetrics who offers the same services as a GP Obstetrician, as defined above, in the private sector using private health insurance and patient contribution as the funding model. They may also work part-time in a public hospital as a Visiting Medical Officer (VMO).

- Obstetricians – a medical officer with specialist education, training and experience in all areas of women’s health and is a fellow of RANZCOG. In their full scope of practice as an obstetrician-gynaecologist they can look after women’s reproductive needs from childhood through adolescence and adulthood, during pregnancy and birth as well as aging to menopause and beyond. An obstetrician is specifically trained to look after women in the pre-pregnancy, antenatal, intrapartum and postnatal periods. They are generally able to deal with all aspects of pregnancy, birth, and beyond in normal and complicated cases. They work collaboratively with midwives and other members of the healthcare team. They generally practise in secondary, tertiary and private hospitals, but can also practise in primary care settings.

- Private Practising Obstetricians – specialist medical officers with training in all areas of women’s health. They offer the same services as an obstetrician, as defined above, in the private sector using private health insurance and patient contribution as the funding model. They may also work part-time in a public hospital as a VMO.

Other healthcare professionals who may be involved or consulted during pregnancy, labour, birth and the newborn period include, but are not limited to:

- Neonatologists – a paediatrician with a sub-specialisation in the medical care of newborn infants, especially the ill or premature newborn. They are a fellow of the Royal Australian College of Physicians and the Royal Australian College of Paediatrics and Child Health.

- Maternal-Fetal-Medicine specialists – an obstetrician with advanced knowledge and training in medical, surgical, obstetric, fetal, or genetic complications in pregnancy. They may perform prenatal tests, provide treatments for the mother or baby, or perform surgeries.

- Rural Generalists (RGs) – provide the following: comprehensive primary care for individuals, families and communities; hospital in-patient and/or related secondary medical care in the institutional, home or ambulatory setting; emergency care; extended and evolving service in one or more areas of focused cognitive and/or procedural practice as required to sustain needed health services locally among a network of colleagues; a population health approach that is relevant to the community; working as part of a multi-professional and multi-disciplinary team of colleagues. Not all rural doctors are RGs but all RGs work in rural locations by definition. Rural maternity units commonly employ RG obstetricians and RG anaesthetists.

- Allied health practitioners – trained professionals who are not doctors, midwives or nurses. They have specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses. They often work within a multidisciplinary health team to provide specialised support for different patient needs. They include (but are not limited to) Aboriginal and Torres Strait Islander
health practitioners, audiologists, dieticians, genetic counsellors, occupational therapists, physiotherapists, psychologists, social workers, and speech pathologists.

- Child health nurses or midwives with child and family health certificate – a registered nurse or midwife with additional training in child health and who can provide information on breastfeeding, child health and development, and parenting skills.

### 3.4.2. Workforce requirements

Regardless of the model of care, all care must be woman-centred, collaborative, and cooperative. Appendix E: Models of maternity care identifies the different types of maternity models of care that are provided within Queensland.

Women may receive maternity care within their home, a community setting or hospital, and may be categorised by one or more health professionals and defined as:

- low risk: requiring primary care from a midwife\(^\text{10}\), registered medical practitioner (general practitioner) or obstetrician
- moderate risk: requiring secondary care from a registered medical practitioner (general practitioner) or specialist obstetrician
- high risk: requiring tertiary care from a multidisciplinary maternity team within a specialised service, under the supervision of and in consultation with a specialist obstetrician.

It should be noted that a woman’s level of risk, or complications during pregnancy does not define who can provide continuity of care to her during the pregnancy and birth. Where women have complications that require care in addition to that of her primary maternity care, there must be collaboration with other professional groups, with appropriate consultation and referral according to the woman’s needs and wishes, with reference to the ACM National Midwifery Guidelines for Consultation and Referral.

Workforce requirements for each level of service are included in the CSCF. Specific workforce requirements of rural and remote services are included in Appendix F: Workforce requirements of CSCF level 1–3 maternity services.

In addition, other workforce requirements are noted by the CSCF Maternity Services Module overview to include:

- relevant staff in non-birthing facilities must attend education on imminent birth, preferably conducted by a midwife or obstetrician
- where birthing services are offered, multidisciplinary maternity staff have access to training including:
  - electronic fetal monitoring (e.g. RANZCOG fetal surveillance education program or similar) at least every 12 to 18 months
  - maternity emergency training (e.g. Practical Obstetric Multi-Professional Training (PROMPT) or Advanced Life Support in Obstetrics) at least three yearly, where possible
  - neonatal stabilisation and resuscitation program or similar with a refresher at least two yearly
- other on-site annual multidisciplinary team training inclusive of child safety training, education on normal birth, and breastfeeding competency
- consideration of non-midwifery staff employed in isolated and remote settings to attend the Maternity Emergency Care Course and midwives employed in similar settings to attend the

\(^{10}\) As registered with NMBA
Midwifery UpSkilling Course (MIDUS), both conducted by CRANApplus and designed for remote and isolated settings

- nursing staff in maternity services may work in a supportive role under the supervision of a registered midwife or obstetrician.

### 3.4.3. Supporting rural and remote health workforce

To support the education and training of clinicians in rural and remote communities, and maintain a sustainable and stable workforce, linkages are established between heath service providers, such as Queensland Health and HHSs, and educational and training organisations such as regional training organisations and hubs, colleges (e.g. Australian College of Rural and Remote Medicine), and universities.

Within Queensland Health the Rural and Remote Clinical Support Unit supports safe and quality rural and remote healthcare through the production of clinical resources such as the Primary Clinical Care Manual, training, credentialing, medical advisory support, and primary healthcare information system services. Collaborations between networks such as the Statewide Maternity and Neonatal Clinical Network and the Statewide Rural and Remote Clinical Network have led to the development of training and educational resources such as imminent birth and neonatal resuscitation and stabilisation training programs.

Queensland Health through the Statewide Rural and Remote Clinical Network has developed a rural and remote health workforce strategy for Queensland – ‘Advancing rural and remote service delivery through workforce: A strategy for Queensland 2017–2020’ (Queensland Health, 2017). The strategy sets out the overarching priorities and strategies for building the future rural and remote health workforce for Queensland. It offers a strategic pathway for building the system necessary to support, strengthen, and enable our workforce to deliver sustainable, consumer-centred healthcare into the future (Queensland Health, 2017).

In addition to education links, professional and clinical links are important in supporting the rural and remote health workforce. Public health services work in collaboration with local non-government organisations and private health service providers, such as general practitioners, primary healthcare networks, and Aboriginal and Torres Strait Islander Community Controlled Health Services.
3.5. Defining safety and risk in maternity

The person who lives the experience of safety within childbirth is the mother. It is her body, and her baby. Healthcare systems set up the parameters in which her experience is enacted (Smith et al., 2009). Health professionals are there to assess, to measure, to determine, to deem and to act (or not). All seek to be safe, yet the woman does not always feel safe. (Safety is an interpretive act (Smythe, 2010))

How individuals interpret and define ‘safety’ and ‘risk’ depends on their role, experiences and to some extent their location, within the maternity context. Even within the three main groups of stakeholders, women, clinicians and health service managers, there are sub-groups with their own interpretations.

Although maternity services in Australia are designed to offer women and their babies the best care, they largely reflect modern western medical values and perceptions of health, risk and safety (Kildea et al., 2016). Health service managers tend to make service planning decisions based on clinical, operational, financial, political and legal risks. They and medical practitioners are often concerned that providing birthing in small rural and remote communities, especially where emergency surgical services are not available, would increase the clinical risk for women and babies (Barclay et al., 2016). Clinicians may consider it clinically safer to transfer a woman to a regional centre at 36 to 38 weeks of pregnancy to await the birth of her child.

Women’s perceptions

“I had no concerns in regards to safety while birthing in [rural town]. The midwives and doctors are confident and committed to the role they play. I was a low risks case but had a traumatic first birth so they made sure I was happy and cared about my fears and worries. My first born was birthed in [regional city] and I was made to feel like a number. In [rural town] I had a one on one relationship with my midwife and I was comfortable and felt safe” (consumer – public submission).

The decisions made by clinicians and health service providers based on their perceptions of safety and risk have implications for the clinical, social, cultural, spiritual, and financial risks for women, their babies, and their families.

Aboriginal and Torres Strait Islander people’s definition of health incorporates not just physical wellbeing, but also the social, emotional and cultural wellbeing of individuals and the whole community. (Kildea et al., 2016). Cultural risks include the belief that not being born on their land breaks the links between strong culture, strong health, and the land, a link that is strengthened during birth (Kildea et al., 2016).

For all women, having to travel long distances for general maternity care and being away from their community and family while waiting for the birth of their child can increase a woman’s stress, anxiety and depression, and adds significantly to the financial costs they incur (Gryzbowski et al., 2011). Clinical and medical risks can also be increased if the woman travels on country roads (potentially unsafe, long distance, variable phone service coverage, and risk of hitting animals), does not access antenatal care, or presents late in labour, to avoid the pressure to leave their community for birth (Kildea et al., 2016; Barclay et al., 2016).

Clinicians’ perceptions

“Risk adverse obstetrician’s need psychological support post adverse events outside of their control instead of increasing risk aversity and consequentially increasing caesarean rate.”
(partner/support person – public submission)

In addition to considering the clinical safety of the women, clinicians need to consider their own psychological safety. For midwives and obstetricians to provide a safe and supportive service to women they need to feel safe and supported too. High levels of fear in a clinician, often induced by the
organisational culture, can impact on their professional practice such as reduced confidence to advise women about their birth options, and when caring for women in labour (Toohill et al., 2019). A psychologically safe work environment improves health and wellbeing, job commitment and satisfaction, and improves outcomes for the organisation as well as the women being cared for (Eales, 2018; Harvie et al., 2019). When clinicians feel safe, they are better able to support women to feel safe about having a voice regarding their choices and find ways to give women a sense of control within their maternity care encounters (Ebert et al., 2014).

As noted in this section, perceptions of clinical risk tend to be privileged over social risk in decisions about rural and remote maternity service planning (Barclay et al., 2016). Barclay et al., (2016) proposes a comprehensive risk model that should be considered in the planning and provision of rural and remote maternity services. The comprehensive risk model distinguishes between the concepts of risk described by women (social, cultural, emotional and personal finances) and those described by health service representatives (clinical, operational (including organisational culture), legal, health system financial, and political).

“Fear based care was used to leverage my partner towards the obstetricians preferred choice of birth, elective caesarean. Midwives used inference and threats to state that the child’s welfare was more important than the Mothers choice.

Group threat is used to humiliate [the] mother if her choice is contrary to medical perspective. There is not respect of mother’s choice. There is no advocacy, there is no alignment to policy or procedure even when it states their wishes should be respected.”

(partner/support person – public submission)
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