7. Discussion

The information obtained through the three main processes undertaken by the Taskforce give valuable insights into the benefits, risks, and outcomes related to the current care provided to Queensland women who live in rural and remote locations. It is recognised that a healthy mother and baby, who are physically, psychologically, and emotionally well, is a fundamental healthcare goal; and continuous improvement in maternity services to provide best practice care is required on an ongoing basis.

Factors that impact upon maternal and neonatal clinical risks are much more prevalent in rural and remote women, particularly among Indigenous women in Queensland. The fact that 80 per cent of the women living four or more hours from a birthing service are Indigenous shows that universal healthcare is not being achieved but instead the inverse care law, where ‘the availability of good medical care tends to vary inversely with the need for it in the population served’ (Hart, 1971), is occurring and those people are given the least accessible opportunities to help shape the health system.

Some risk factors are preventable and antenatal care offers a unique opportunity to provide women with information, support and treatment to prevent poor outcomes. This relies on culturally capable providers networked into a multidisciplinary team with outreach services. Based on reported data it seems that there is room for improvement in rates of women attending the recommended minimum number of antenatal visits with approximately 45 per cent of Indigenous women and approximately 30 per cent of non-Indigenous women across all CSCF categories not attending the recommended number. This suggests that improved access to high quality, culturally appropriate antenatal care is needed. Risk factors such as smoking, overweight and obesity are likely to require targeted interventions at a whole-of-population level. This can include a multipronged approach, e.g. social and health support, access to primary and preventative health programs, access to affordable quality food.

Models of care at the time of birth that are used for high risk births in very rural areas appear to be allowing access to appropriate care, but the travel that this often involves can be difficult and very costly both financially and psychologically for women and their families. It also ignores the desire of Indigenous women to birth on country, and of all women to birth as close to home as possible, which were strongly indicated through the stakeholder analysis and public submission processes.

Workforce and infrastructure availability are important considerations for planning services and determining appropriate models of care, in addition to the service needs and risk levels included in this report. Consideration needs to be given to the potentially protective effect of CSCF level 2 maternity services, i.e. birthing services that do not necessarily include onsite caesarean capability. They can have a protective effect for even the high-risk women in that community. A locally situated midwife can establish and maintain a clinical and therapeutic relationship with the woman, which can include early intervention, stabilisation and efficient transfer when required (Kruske et al., 2015; Schultz et al., 2014).

An area for further investigation is the BBA rate in Queensland. The rate of BBAs has increased in Queensland over the past 10 years and is particularly high for women who live one hour or more and less than two hours away from a maternity service. Further analysis could be done to assess characteristics of pregnancies that result in BBAs, in particular, looking at where and to whom these are occurring. In addition, assessment of service models used in areas with high rates of BBAs is warranted.

Overall, in terms of clinical outcomes, Queensland maternity services are enabling high quality care at the time of birth for women, regardless of rurality. When clinical risk factors that are not related to quality of care at the time of birth are adjusted for, perinatal outcomes are similar for women regardless of how far they live from services. However, this does not change that fact that small but important numbers of women do not have access to local birth services and rates of poor outcomes such as preterm births, stillbirths and neonatal deaths are higher in remote areas where there are less services, which tend to be of a lower CSCF level. This is an important area that requires further investigation to determine how to improve services and reduce modifiable risk factors. There is also a lack of measures of outcome and
quality of service from the user perspective. Patient Reported Outcomes and Experience measures must be part of the quality surveillance of the system. What might be judged as quality services from the current limited data view may actually be delivering something quite different from the end user perspective.

It is clear 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 need reliable adequate support and resources (including for older children and support persons) when they have to travel away from home for several weeks 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.

Consideration needs to be given by HHSs to what services and supports can be provided in rural and remote Queensland to reduce risk factors that increase the risk of perinatal death and to improve attendance at antenatal appointments. These risk factors need to be addressed before a woman is pregnant as well as supporting the woman through her pregnancy, birth and those first few critical weeks and months after the birth. For example, increasing access to continuity of carer services can improve outcomes for women of all “risk” categories.

Infrastructure and system levers, such as policy, planning, reviewing and co-designing services with consumers, funding models, and clinical guidelines should be viewed from a rural and remote perspective to ensure they support and enable the provision of safe, high quality health services in general, and maternity services in particular.
8. Conclusion

The Rural Maternity Taskforce (the Taskforce) was established to explore what steps can be taken to minimise risk for mothers and babies in rural and remote communities, whilst providing services as close as possible to where they live.

This has been realised through consultation with consumers of maternity services, concerned community members, healthcare providers across public and private organisations, health service decision makers, and relevant maternity experts.

An understanding of the issues, concerns and expectations of the rural and remote communities has been achieved through face-to-face consultation at the rural and remote forums, through public submissions, and through the data analysis. This information has enabled the development of an appropriate set of recommendations (page 5) that support and enable the provision of suitable woman-centred care as close as possible to where women live, whilst enabling good outcomes for mothers and babies in rural and remote communities.

Further, a Rural and Remote Maternity Services Planning Framework is in development. This has been informed through the consultation processes and is presented for discussion at the Maternity Summit in June 2019. This Framework will assist HHSs with planning, developing and delivering rural and remote maternity services.

A healthy mother and baby, who are physically, psychologically, spiritually, and emotionally well is a fundamental healthcare goal, and continuous improvement in maternity services to provide best practice care is required on an ongoing basis.