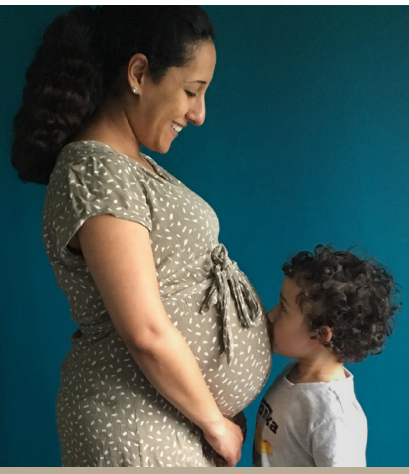
Rural Maternity Services
16 March 2021
Reality Check



RURAL DOCTORS ASSOCIATION OF AUSTRALIA

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

A "Low risk" birth can quickly turn into a complicated obstetric emergency. Doctors & midwives need the skills to manage this with telehealth back up. In reality rural maternity services are ALL RISK services.

Birthing Service Closures

CLOSED

- In real numbers 255 maternity units were closed from 1992-2011 (41% reduction)
- Same period 47% increase in babies born before arrival *(Kildea, McGHie, Gao 2015)*

Trend Continues, since 2016 rural birthing services that have closed

- Kyabram Vic
- Kyneton Vic
- Yarrawonga Vic
- Mersey Hospital Latrobe Tas
- Theodore Qld
- Tanunda SA

Birthing Services still closing or under pressure

- Chinchilla Qld – bypass for over 3 years/closure by stealth
- Cohuna Vic – service may close 1 June 2021
- Ceduna SA – intermittent extended bypass periods
- Castlemaine Vic – service under review, currently not in use
- Temora NSW
- Waikerie SA – suspended until March 2021

What happens when a maternity service closes?

- GP Obstetricians & midwives will de-skill
- GP Obstetricians & midwives will leave for new jobs where they can use all their skills
- Operating theatre service reduction
- Antenatal, postnatal and paediatric services reduced

Excuses for closure?

- Can't recruit GP obstetricians
- Can't recruit midwives
- Too expensive
- Not safe
- Not enough babies being born
- Insufficient numbers of operating theatre staff

What a closure means to Mum & Family

- If no local access to a birthing service medical advice is generally to relocate up to 4 weeks prior to due date (with significant additional financial and social costs to families)
- Reduced access to antenatal and postnatal care, including midwifery and allied health services
- Interrupted continuity of care for mothers
- Increased risk of roadside delivery

Safety Data

- Research shows – In Australia, lower hospital volume is not associated with adverse outcomes for low risk women *(Tracy, Sullivan, Dahlen, Black, Wang & Tracy 2006)*

The Future...

Rural Birthing Services CAN be re-established

- Beaudesert Qld
- Cooktown Qld
- Ingham Qld
- Weipa (in process)

What does it take?

- Political imperative
- Effort
- Commitment
- Rural Generalist Training Program
- Midwife and Nurse Upskilling programs
- Skills maintenance programs for all clinical staff
- Continued efforts of recruitment & retention of medical, midwifery & operating theatre staff
- Maintain a high standard of hospital infrastructure

Ideal workforce model (provides Caesarean level 3 maternity service)

- GP obstetricians / Rural Generalist Obstetricians min 3-5 headcount
- GP Anaesthetists / Rural Generalist Anaesthetists min 3-5 headcount
- Midwives min 3-5 headcount

(Why a min of 3-5 of each? Manage the overnight oncall, the bigger and busier the service the more you will need.)

- Operating theatre staff (ACORN Standards require min 4 headcount in attendance)
- Visiting consultant specialists or onsite consultant specialists (workforce can be combined with GP Obstetrician for headcount)
- Supported by allied health services such as Physiotherapists

Is there a point where it is reasonable to close a rural maternity service?

Yes – but the following must be considered...

- Current birth numbers – low birth numbers will increase recruitment challenges
- Number of women leaving town to birth (there is evidence that a new updated maternity wing can reverse a downward trend of birth numbers)
- How far from the nearest alternate maternity service?
- Management must be willing to have transparent discussions with key stakeholder groups to explore solutions/alternate models & most importantly with the community

Examples of Consolidated Services:

- Riverland Hospital SA – Berri, Loxton & Renmark
- Forbes & Parkes NSW

More information?

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