SECOND SESSION OF THE THIRTY-SIXTH PARLIAMENT

REPORT OF THE

STANDING COMMITTEE ON ENVIRONMENT AND PUBLIC AFFAIRS

IN RELATION TO

A PETITION ON PRIMARY MIDWIFERY CARE

Presented by Hon Christine Sharp MLC (Chairman)

Report 13
November 2004

STANDING COMMITTEE ON ENVIRONMENT AND PUBLIC AFFAIRS

Date first appointed:

May 24 2001

Terms of Reference:

The following is an extract from Schedule 1 of the Legislative Council Standing Orders:

"**3. Environment and Public Affairs Committee**

3.1 An Environment and Public Affairs Committee is established.

3.2 The Committee consists of 7 members.

3.3 The functions of the Committee are to inquire into and report on -

(a) any public or private policy, practice, scheme, arrangement, or project whose implementation, or intended implementation, within the limits of the State is affecting, or may affect, the environment;

(b) any bill referred by the House;

(c) petitions.

3.4 The Committee, where relevant and appropriate, is to assess the merit of matters or issues arising from an inquiry in accordance with the principles of ecological sustainable development and the minimisation of harm to the environment.

3.5 The Committee may refer a petition to another committee where the subject matter of the petition is within the competence of that committee.

3.6 In this order **"environment"** has the meaning assigned to it under section 3(1), (2) of the *Environmental Protection Act 1986*."

Members as at the time of this inquiry:

Hon Christine Sharp MLC (Chairman)
Hon Kate Doust MLC (Deputy Chairman)
Hon Robyn McSweeney MLC
Hon Jim Scott MLC
Hon Bruce Donaldson MLC
Hon Frank Hough MLC
Hon Louise Pratt MLC

Staff as at the time of this inquiry:

Stefanie Dobro, Advisory Officer (General)
Mark Warner, Committee Clerk

Address:
Parliament House, Perth WA 6000, Telephone (08) 9222 7222
Website: http://www.parliament.wa.gov.au

ISBN 1 9208 8627 3

Government Response

This Report is subject to Standing Order 337:

> *After tabling, the Clerk shall send a copy of a report recommending action by, or seeking a response from, the Government to the responsible Minister. The Leader of the Government or the Minister (if a Member of the Council) shall report the Government's response within 4 months.*

The four-month period commences on the date of tabling.

CONTENTS

List of Acronyms and Glossary

ACMI	Australian College of Midwives Incorporated
ACT	Australian Capital Territory
AHWAC	Australian Health Workforce Advisory Committee
AMWAC	Australian Medical Workforce Advisory Committee
Cohen Review	Harry Cohen, *Western Australian Statewide Obstetrics Services Review: Report of the Project Working Group 'an integrated maternity service, a new way forward'*, Discussion Paper, Department of Health, Western Australia, April 2003
FBC	Family Birth Centre
FTE	Full Time Equivalent
GP	General Practitioner
KEMH	King Edward Maternity Hospital for Women
LMC	Lead Maternity Carer
Maternity Coalition	The Maternity Coalition Inc.
MBS	Medicare Benefits Schedule
Minister	Minister for Health
multiparous	having borne more than one child
NMAP	The Maternity Coalition Inc. *et al*., *The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban and Regional Australia*, September 2002
NZ	New Zealand
primiparous	a woman who is bearing a child for the first time
WA	Western Australia
WHO	World Health Organization

EXECUTIVE SUMMARY AND RECOMMENDATIONS FOR THE

REPORT OF THE STANDING COMMITTEE ON ENVIRONMENT AND PUBLIC AFFAIRS

IN RELATION TO

A PETITION ON PRIMARY MIDWIFERY CARE

EXECUTIVE SUMMARY

1 On December 11 2003, Hon Giz Watson MLC tabled a petition in the Legislative Council requesting that the Council:

(a) Inquire into the preservation and expansion of primary midwifery programs in Western Australia.

(b) Ensure measures are taken to make primary midwifery care a choice available to all pregnant women in Western Australia.

2 In accordance with Legislative Council Standing Order 134(f)(i), the petition stood referred to the Environment and Public Affairs Committee.

3 The Committee has conducted preliminary inquiries into the content of this petition and resolved to report to the House in this stand-alone report. The Committee draws the attention of the House to the important issues raised in the submissions received from key stakeholders in relation to the inadequacy of publicly funded primary midwifery services available to Western Australian women. The report provides a summary of the key benefits associated with primary midwifery services and the continuity of care approach to maternity services.

4 The Committee has not had the opportunity to conduct a comprehensive inquiry. In particular, the Committee is not able to report on the benefits of other models of maternity care. Time-constraints have prevented the Committee from conducting a full-scale inquiry into the contents of the petition, including calling for public submissions.

5 The Committee notes that there are three types of midwifery-led maternity care available in WA (team midwifery at KEMH, the Family Birth Centre at KEMH and the Community Midwifery Program). However, these programs are only available to a very limited number of women who are delivering their babies in the metropolitan area. (Paragraphs 4.7 to 4.21.)

6 Intervention rates in childbirth in Western Australia are reported to be amongst the highest in Australia. In 2002, in Western Australia, 20 percent of women giving birth were induced; 51.1 percent of women had an epidural and 29.4 percent of women had a caesarean delivery. (See paragraphs 6.12 to 6.18.)

7 There are a range of benefits associated with primary midwifery care including continuity of care, lower intervention rates, breastfeeding benefits, lower rates of postnatal depression and benefits for women 'at risk' and Indigenous women. (See paragraphs 6.1 to 6.55.)

8 Continuity of care is a key characteristic of the primary midwifery model of maternity care. (See paragraph 6.3 to 6.9.)

9 The Committee acknowledges that primary midwifery care can only be an option for healthy women with low-risk pregnancies.

10 The Committee is concerned about the adequacy of access to primary midwifery programs, particularly given the information which supports the view that there are a range of important benefits to be gained by expanding primary midwifery programs. There are both health and emotional benefits to be gained by the mother and her family. There are significant cost-benefits and more effective use of scarce obstetric resources to be accessed by expanding primary midwifery services in Western Australia.

11 The Committee notes the very high levels of satisfaction with the Community Midwifery Program. (See paragraph 6.52 and 6.53.)

12 The Committee notes the rapid uptake in New Zealand of primary midwifery services (70 percent of women) as a result of legislative and funding changes that officially recognise midwives as midwifery professionals. (See paragraph 8.10.) The Committee notes a reported consequence of the shift to primary midwifery care in New Zealand is a decrease in the maternity budget. (Paragraph 6.40.)

13 The Committee notes *The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia* and its call for State and Federal Governments to facilitate substantial change to the way in which maternity services are provided in Australia. The Committee also notes that Western Australia's Community Midwifery Program, "*with its emphasis on community management and one-to-one continuity of midwifery care, is the recommended template for community midwifery programs in all other States and Territories*."[1] (Paragraph 9.3.)

[1] The Maternity Coalition Inc. *et al., The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia*, September 2002, p7.

14 The Committee acknowledges that there have been a number of obstetric service reviews in WA. (See paragraphs 5.2 and 5.3.) The Committee notes that the Community Midwifery Program "*has not been able to secure a long term funding commitment from the Government or an increase in funding since 1999, despite there being a significant unmet demand for the service, despite the service's proven record in providing high quality care, and despite repeated submissions over the past 5 years for additional funding made to the Department of Health by the contract organisation, Community Midwifery WA.*" (See paragraph 7.22.)

15 The Committee acknowledges the Minister's support for choice in maternity services and his statement that "[a]*ny expansion of the community based midwifery program is difficult at this time, given the current demands on the health system.*"[2] (See paragraph 7.17.)

16 The Committee notes that, while the task of calculating the cost of primary midwifery care in comparison to standard hospital care is complex, there are a number of studies that support the view that primary midwifery care is a cost-effective mutually beneficial model for maternity service delivery. (See paragraphs 6.28 and 6.32.)

17 The Committee is of the view that with government funding of the Community Midwifery Program extending to only 150 women, it is difficult to argue, in a population of 25,000 women giving birth each year, that there is sufficient access to this service. (See paragraphs 7.10 to 7.18.)

18 There is considerable evidence in support of the request to expand access to primary midwifery care, currently only available to less than one percent of women birthing in Western Australia.

RECOMMENDATIONS

Page 33

Recommendation 1: The Committee recommends that the Minister for Health significantly expand the number of funded places in the Community Midwifery Program to meet community demand in the 2005-06 State Budget.

Page 34

Recommendation 2: The Committee recommends that the Government develop a response to The Maternity Coalition *et al.*'s *The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia* within a holistic review of maternity services in Western Australia.

[2] Letter from Hon Jim McGinty MLA, Minister for Health, Western Australia, April 6 2004, p2.

Page 34

Recommendation 3: The Committee recommends that the Government provide secure long-term funding for the Community Midwifery Program.

Page 34

Recommendation 4: The Committee recommends that the Government ensure the provision antenatally of a greater level of educational information relating to available models of care and their respective benefits.

Page 34

Recommendation 5: The Committee recommends that the Government ensure that primary midwifery services are available in regional areas.

REPORT OF THE STANDING COMMITTEE ON ENVIRONMENT AND PUBLIC AFFAIRS

IN RELATION TO

A PETITION ON PRIMARY MIDWIFERY CARE

1 PETITION

1.1 On December 11 2003, Hon Giz Watson MLC tabled a petition in the Legislative Council requesting that the Council:

(a) Inquire into the preservation and expansion of primary midwifery programs in Western Australia.

(b) Ensure measures are taken to make primary midwifery care a choice available to all pregnant women in Western Australia.

1.2 In accordance with Legislative Council Standing Order 134(f)(i), the petition stood referred to the Environment and Public Affairs Committee (**Committee**).

2 INQUIRY

2.1 Submissions and information were sought and received from selected stakeholders, that is, from the principal petitioner, the tabling member, the Director General of the Department of Health, the Minister for Health (**Minister**), the Maternity Coalition Inc, the Manager of the Community Midwifery Program and the Australian College of Midwives Incorporated (**ACMI**).

2.2 The Committee has conducted preliminary inquiries into the content of this petition and resolved to report to the House in this stand-alone report. The Committee draws the attention of the House to the important issues raised in the submissions received from key stakeholders in relation to the inadequacy of publicly funded primary midwifery services available to Western Australian women. The report provides a summary of the key benefits associated with primary midwifery services and the continuity of care approach to maternity services.

2.3 The Committee has not had the opportunity to conduct a comprehensive inquiry. In particular, the Committee is not able to report on the benefits of other models of maternity care. Time-constraints have prevented the Committee from conducting a full-scale inquiry into the contents of the petition, including calling for public submissions.

3 PRIMARY MIDWIFERY CARE

3.1 **Primary midwifery** maternity care (also known as community midwifery or caseload midwifery) has a midwife as the **lead maternity carer** (**LMC**) throughout a woman's pregnancy, labour, childbirth, and for the first four to six weeks in the postnatal period. In primary midwifery maternity care, midwives, working in the community, "*take on responsibility for the care of a caseload of women and work flexible hours in providing that care to those women*."[3]

3.2 Midwives provide supervision, advice and care to a woman prior to and during pregnancy, labour, childbirth and postnatally. This care includes:[4]

- providing women with antenatal care;
- being on call and attending the labour and birth; and
- providing immediate and subsequent postnatal care to the mother and baby for up to six weeks.

3.3 The ACMI explained primary midwifery care as follows:[5]

> *The key of such midwifery care is for the woman to be able to receive care from one primary midwife (with backup from a midwife colleague and from doctors as needed) on an ongoing basis right throughout her pregnancy, during her labour and birth, and during the early weeks of parenting.*

3.4 Midwives' responsibilities also include:

- detecting complications in the mother and baby; and
- procuring medical assistance where necessary.

3.5 Midwives also have the important role of health counselling and education, not just with their patients but also within the family and the community.

3.6 Over time the role of the midwife has expanded. In some jurisdictions, such as New Zealand, midwives have the ability to initiate and administer certain pharmacological substances associated with pregnancy, labour and the postnatal period as well as to

---

3 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p2.

4 Ibid, p3.

5 Ibid, p3.

order and interpret routine tests such as ultra-sounds. This is not the case in Western Australia (**WA**) where legislation does not yet provide midwives with such powers.[6]

3.7 The primary midwifery model is about providing a continuity of care approach to maternity services.

3.8 While primary midwifery has often been associated with homebirths, the primary midwifery model can provide women with the choice of birthing at home, in a birth centre or in hospital, with the primary midwife having the ability to refer patients to appropriate specialist backup services as required. Midwives generally obtain accreditation with birthing facilities and hospitals and are provided with access to the same in order to be able to offer their clients continuity of care during the pregnancy, labour, childbirth and postnatal periods.[7]

3.9 Primary midwifery care for normal healthy women with low risk pregnancies is recommended by the World Health Organization (**WHO**).[8]

4 MATERNITY SERVICES IN WESTERN AUSTRALIA

4.1 Six main models of maternity care were recently identified as operating in public practice in WA:[9]

- "*Traditional hospital based Specialist Obstetrician led care*";
- "*Midwife-led care (e.g. Family Birth Centre; Midwifery Community Program*" which is an example of **Primary Midwifery Care**);
- "*Low risk patient antenatal clinics (e.g General Practitioner Obstetrician/midwife clinics.)*" (**Standard Hospital Care**);

---

6 The Committee notes the *Interim Report of the Reference Committee to Review Recommendations from the NHMRC 1998 Report "Review of Services Offered by Midwives", Enhanced Role Midwife Project*, November 2001, which developed an *"operation framework for the implementation of the enhanced role midwife"*. Executive Summary. The recommendations of this report have not yet been implemented. See also Harry Cohen, *Western Australian Statewide Obstetrics Services Review: Report of the Project Working Group 'an integrated maternity service, a new way forward'*, Discussion Paper, Department of Health, Western Australia, April 2003, Recommendation 8, p7 and p38.

7 The Community Midwifery Program (Western Australia), *Evaluation November 1997 – December 2001* notes that "*As at June 2002, the only formal agreement for Program midwives to remain as their client's primary midwifery on transfer to hospital was with Woodside Hospital. Repeated approaches for midwives' visiting privileges to other units have been made since 1998; however, the response has always been negative."* C Thorogood, B Thiele and K Hyde, *The Community Midwifery Program (Western Australia) Evaluation November 1997 – December 2001*, March 2003, p6.

8 World Health Organization, *Care in Normal Birth: report of a technical working group*, November 1997, Chapter One, http://www.who.int/reproductive-health/publications/MSM_96_24/MSM_96_24_Chapter1.en.html, accessed on November 4 2004.

9 Harry Cohen, *Western Australian Statewide Obstetrics Services Review: Report of the Project Working Group 'an integrated maternity service, a new way forward'*, Discussion Paper, Department of Health, Western Australia, April 2003, p19.

- "*Visiting medical officer (fee for service) model, where the antenatal care occurs outside the hospital, usually in the obstetrician's practice*"; and

- "*Shared care involving GPs or midwives*".

4.2 The standard hospital care and primary midwifery care models are discussed below.

Standard Hospital Care Model

4.3 The standard hospital care model is the dominant government-funded model of maternity services to which all women in WA have the right to access free of charge. It is the standard approach to maternity services not just in WA, but throughout Australia**.**

4.4 Under the standard hospital care model, women attend public hospital antenatal clinics and deliver their babies in a hospital with the assistance of midwives and medical practitioners.

4.5 The standard hospital care model reflects predominant practice in both public and private hospitals, with the main difference being that the woman under private care is more likely to know and have developed a relationship with her doctor, should medical procedures be required.[10] Pregnant women can engage the services of a specialist obstetrician or GP obstetrician and be delivered at a public hospital; however, they must pay for this service.

4.6 The average length of stay for women delivering their babies in hospitals in WA is two to three days for vaginal births and five days or more for women delivering by caesarean section.[11] Postnatally, women delivering their babies under the standard hospital care model traditionally do not receive midwife assistance in their own home subsequent to hospital discharge. The Committee is aware of Early Discharge Programs operating in some metropolitan hospitals that offer a postnatal home visiting service to some clients, for example King Edward Memorial Hospital (**KEMH**), Osborne Park Hospital, Swan District Hospital and Armadale-Kelmscott Memorial Hospital.

Models of Midwifery Care

4.7 Mr Mike Daube, Director General of Health, advised the Committee that there are three options for midwifery care in WA:[12]

---

10 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p2.

11 Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, March 31 2004, p3.

12 Ibid, pp1-2.

- Team Midwifery;
- Family Birth Centre; and
- The Community Midwifery Program.

4.8 Each of these options for midwifery care is described below.

Team Midwifery - Hospital based midwifery care

4.9 One metropolitan hospital offers hospital-based midwifery care that aims to provide greater continuity in care for the mother than standard hospital care. KEMH offers Team Midwifery, where teams of seven midwives work in conjunction with medical practitioners providing continuity of care with women from the clinics to the delivery suite.[13]

4.10 The ACMI submitted to the Committee that team midwifery operating at KEMH is "*directed at specific target groups, such as teenage mothers*" and note that the large number of midwives in each team means that the potential for fragmented care is high.[14]

4.11 Informal advice provided to the Committee's Advisory Officer indicates that the Team Midwifery program at KEMH is available to any low to medium risk woman attending KEMH. The Committee's Advisory Officer was also advised that KEMH offers a separate Adolescent Clinic to cater to the needs of adolescent pregnancies.[15]

Family Birth Centres

4.12 Family Birth Centres (**FBCs**) provide midwife-led maternity services for healthy women who have no major health or pregnancy complications. FBCs do not provide one-to-one midwifery care but do provide a smaller team approach using four midwives per team.[16] Pregnancy, labour and postnatal care is provided with a postnatal stay of up to 24 hours.[17]

---

13 Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, March 31 2004, p2.

14 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p4.

15 Telephone advice received from Ms Sheila Lyons, Acting Midwifery and Nursing Director, Obstetrics and Gynaecology Clinical Care Unit, King Edward Memorial Hospital, November 4 2004.

16 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p4.

17 See the Women's and Children's Health Service Western Australia website: http://wchs.health.wa.gov.au/development/manuals/csd/detail.php?deptid=18&clin_ord=Y, accessed on October 13 2004.

4.13 There is only one FBC in WA.[18] Located adjacent to KEMH, the FBC services women in the metropolitan area with low risk, uncomplicated pregnancies who wish to have birth in a more home-like environment with the facility to transfer to a major tertiary hospital if complications arise.

4.14 Shared antenatal care is available to women who wish to maintain current care with their GP and/or wish to reduce the number of times they need to travel to KEMH. Their care will be shared between their GP and the FBC midwives.[19]

4.15 Six hundred and sixty six women booked to give birth at the FBC in 2003-04, approximately 3.6 percent of the birthing population.[20]

4.16 The Committee notes the findings of the *Western Australian Statewide Obstetrics Services Discussion Paper,* April 2003, (**Cohen Review**) which stated that:[21]

> *Consumer interest for women to have a choice of giving birth in an ambient homely non-clinical environment is high. The environment described as a Birth Centre is one where partners, children and families can have involvement and access. These centres are for low risk planned births and can be safely conducted by midwives, with on site access to medical and specialist emergency backup.*

The Community Midwifery Program

4.17 The Community Midwifery Program is a successful example of primary midwifery care in Australia.[22] The Community Midwifery Program's philosophy is based on the concept that childbirth is, in the majority of cases, a normal life event which, left to nature, will proceed to an uncomplicated outcome.

4.18 The Community Midwifery Program was established in 1996 when the WA Government, with federal grant funding, established a pilot program, providing 70 women with federal government-funded homebirth under the care of a community midwife. In 1999, subsequent to positive reviews, the Community Midwifery Program was expanded through the addition of state government funding (to complement the federal government funding) to provide access for a total of 150

---

18 The Committee notes that the Family Birth Centres previously established at Mandurah and Swan Districts Hospital have closed.

19 See the Women's and Children's Health Service Western Australia website at http://wchs.health.wa.gov.au/development/manuals/csd/detail.php?deptid=18&clin_ord=Y, accessed on October 13 2004.

20 Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, March 31 2004, p2.

21 Harry Cohen, *Western Australian Statewide Obstetrics Services Review: Report of the Project Working Group 'an integrated maternity service, a new way forward'*, Discussion Paper, Department of Health, Western Australia, April 2003, p19.

22 The Maternity Coalition Inc. *et al., The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia,* September 2002, p22.

women to the Community Midwifery Program.[23] Several metropolitan hospitals provide accreditation and access to their facilities for registered and accredited midwives. (See footnote 6.)

4.19 In addition to providing maternity care services for up to 150 women and their families in the Perth metropolitan area, the Community Midwifery Program also provides a range of other important associated services, including:[24]

- Running a series of antenatal education classes at four sites, which offer birthing information.
- Operating four part-time Pregnancy and Childbirth Information and Resource Centres in the metropolitan area, which provide midwifery advice, as well as books and videos for loan.
- Holding postnatal groups to provide support to new mothers.
- Providing placements for nursing and midwifery students and a mentoring program for a qualified midwife to enable the midwife to gain skills in homebirth and seek accreditation with the ACMI.

4.20 The Community Midwifery Program is unique in Western Australia for providing women with one-to-one support and expertise from a known midwife throughout the pregnancy, during labour and birth at home (if she wishes), and the important early days and weeks of breastfeeding and parenting.[25]

Primary Midwifery Care in Non-Metropolitan Areas

4.21 The Committee notes that there are no community midwifery or primary midwifery programs operating outside the metropolitan area. However, the Committee is aware of a shared care model operating in Denmark and a Homebirth Program previously available in the Denmark region.

Denmark Midwifery

4.22 The Committee wrote to the Director General of Health seeking information on the Denmark Program. The Director General's response included a copy of the Denmark Health Service's *Midwifery and Obstetrics Services Review* dated June 2002.

---

[23] See Community Midwifery Program website at http://www.communitymidwifery.iinet.net.au/history.html, accessed on November 10 2004.

[24] Submission No 3 from Community Midwifery Program, April 22 2004, p3.

[25] Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p4.

4.23 Denmark is a town located 450km from Perth. In response to community demand, health professionals joined together to create the Denmark Program to ensure a safe and supportive birthing option for women living in the Denmark Region.[26]

4.24 Distance from a regional hospital is an issue for women living in the country. Women want to birth in Denmark, rather than travelling 45 minutes to Albany, the nearest regional hospital, because their family and friends can visit.[27]

4.25 The Denmark facility "*consists of a birth room fully equipped with all the medications, medical supplies and equipment*".[28] There is a maternity ward with three beds. Babies room with their mothers at all times. The Denmark Program, like the Community Midwifery Program, is only available to women who are deemed to be "*low risk*".[29] Caesarean section and epidural procedures are not available in Denmark.[30]

4.26 The Denmark Health Service conducted a review of midwifery and obstetrics services and reported in June 2002. The report notes that there is considerable cooperation between midwives and general practitioners and that they are supported by their colleagues at Albany Regional Hospital. Arrangements also exist for on-going professional development including two week placements biannually for each midwife at a larger hospital.[31]

4.27 In a letter to the Committee in relation to the Denmark Program, the Director General, Department of Health stated:[32]

> *The model would only be suitable where there is a population in a location lending itself to sustainable retention of the necessary staff skill base. It is also essential that there are GPs prepared to provide this type of service in partnership with midwives. There are few other towns within Western Australia where this model could be implemented if there was sustainable staffing and professional medical support.*

---

26 Denmark Health Service, 'Midwifery and Obstetrics Services Review', June 2002, p7.

27 Ibid.

28 Ibid, p8.

29 Ibid, p11.

30 Ibid.

31 Ibid, p8.

32 Letter from Mike Daube, Director General, Department of Health, Western Australia, June 18 2004, p1.

5 REVIEWS OF MATERNITY SERVICES

5.1 Childbirth, and particularly intervention in childbirth, has been an area of inquiry at both the state and national levels for sometime.

5.2 The numerous state and federal government reports over the past fifteen years have repeatedly urged governments to shift to a shared care model of maternity services with an emphasis on increasing birthing choice for women and providing continuity of care. The same reports have highlighted the disconcerting trend of ever-increasing levels of intervention in childbirth.[33] The predominant view put forward in these reports is that there are health benefits – both physical and emotional – as well as cost benefits to shifting to midwife-based models of maternity care.

5.3 Attached as Appendix 1 is a list of some of the key reports produced over the past 15 years on these issues.[34]

Motion in the Legislative Council

5.4 Hon Barbara Scott MLC moved a motion in the Legislative Council on April 7 2004 in relation to increasing funding to the Community Midwifery Program as follows: [35]

> *That the House urge the Government to increase funding to the Community Midwifery Program Western Australia and recommend that a thorough investigation be conducted into the cost-effectiveness of the Community Midwifery Program Western Australia and its benefits to families, in particular to mothers and babies.*

5.5 The Committee notes that Members from both sides of the House supported the Community Midwifery Program.

6 THE BENEFITS OF PRIMARY MIDWIFERY CARE

6.1 The primary midwifery model is presented as providing many benefits to both the woman and the community. The Committee wrote to several key stakeholders seeking submissions in relation to the petition. Each of the four submissions received emphasised the benefits of primary midwifery care. These include:

---

33 See for example Western Australia, Legislative Assembly, Select Committee on Intervention in Childbirth, *Report of the Select Committee on Intervention in Childbirth,* September 1995 and Commonwealth of Australia, Senate, Community Affairs References Committee, *Rocking the Cradle: A Report into Childbirth Procedures,* December 1999.

34 For a complete list of Commonwealth and State/Territory Government report and policy documents directly relating to maternity service provision see The Maternity Coalition Inc. *et al., The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia*, September 2002, Appendix A, p32.

35 Hon Barbara Scott MLC, Western Australia, Legislative Council, *Parliamentary Debates (Hansard)*, April 7 2004, pp1841-1853. Debate was interrupted and resumed on May 5 2004. Western Australia, Legislative Council, *Parliamentary Debates (Hansard)*, pp2260-2274.

- Continuity of Care (development of a relationship of trust between the pregnant woman and midwife over a seven month period; improved rates of mother/baby bonding, improved rates of long-term breastfeeding and reduced rates of postnatal depression and benefits to particular socio-economic groups, including Indigenous populations and women 'at risk')[36];

- Choice (choice of midwife, choice of birthplace);

- Health Benefits (including reduced levels of medical intervention, positive benefits for breastfeeding and postnatal depression benefits);

- Cost Benefits (associated with lower intervention rates and reduced stay in hospital); and

- Efficient use of scarce resources (scarce high level obstetrics facilities and practitioners; benefits to midwifery professionals allowing them to practise their skills and be able to get to know and assist their client by providing care that is appropriate to the individual).

6.2 These benefits are discussed below.

Continuity of Care

6.3 Submissions received by the Committee emphasise continuity of care as a significant benefit of primary midwifery care. Continuity of care, under the primary midwifery model, revolves around the concept that a woman is able to be assisted by one health professional (generally a midwife of her choice) throughout the 'birth continuum', that is, from her pregnancy, through her labour, during childbirth and in the postnatal period. Under primary midwifery, where each midwife has a caseload of clients, that midwife has total responsibility for the care of the client. In reality this means that the pregnant woman is able to develop a relationship of trust with the person who will monitor her throughout her pregnancy, be by her side through labour and childbirth and assist her in the postnatal period with both the health of the woman and the baby, as well as with the transition to parenthood.

6.4 The development of a relationship over many months may assist the woman to feel at ease asking questions and, equally importantly, affords the midwife the opportunity to get to know the needs, circumstances and desires of the woman she is assisting.[37]

6.5 The ACMI submitted to the Committee that the continuity of care afforded by primary midwifery care contrasts with the standard hospital care model which can be seen to

---

36 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p12.

37 The Maternity Coalition Inc. *et al., The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia,* September 2002, p13.

deliver maternity services in a fragmented manner.[38] Women see a number of different health professionals (midwives, GPs and obstetricians) during their pregnancy and are cared for by a number of different caregivers during labour, birth and in the postnatal period.

6.6 Under the standard hospital care model of maternity care, midwives working in hospitals generally work on a rostered shift basis and care is separated into antenatal, labour, childbirth and postnatal wards. The nature of rostered shiftwork and staffing ratios associated with the standard hospital care model mean that a midwife may not be able to stay with the labouring woman throughout her labour as the shift may end or the midwife may be required to assist with other women in labour at the same time.[39]

6.7 A woman therefore may present at the hospital in labour and be assisted during the course of her labour and childbirth by a midwife or several different midwives that she has never met before and who are not aware of her personal needs and feelings.

6.8 In correspondence to the Committee, the Minister for Health states:[40]

> *Continuity of midwifery care is accepted as having benefit for women and birth outcomes. However, continuity can be provided in a variety of forms; only one of which is community based.*

Recommended by the World Health Organization

6.9 Continuity of care is recommended by the WHO and is a significant benefit of the primary midwifery model of maternity care.[41]

Committee Comment

6.10 The Committee notes that continuity of care is a significant benefit of primary midwifery and also acknowledges that primary midwifery is not the only method of delivering continuity of care.

Health Benefits

6.11 A healthy outcome for mother and baby is the ultimate objective of every labour. Proponents of primary midwifery highlight that there are significant health benefits – both physical and emotional – to be gained by adopting primary midwifery as the

38 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, pp2-3.

39 Ibid, pp1-2.

40 Letter from Hon Jim McGinty MLA, Minister for Health, Western Australia, April 6 2004, p1.

41 World Health Organization, *Care in Normal Birth: report of a technical working group*, Chapter 1, p5-6, website at www.who.int/reproductive-health/publications/MSM_96_24/MSM_96_24_Chapter1.en. html, accessed on October 11 2004.

leading model of maternity care. Health benefits associated with the primary midwifery model of care include: lower rates of medical intervention, breastfeeding benefits and postnatal depression benefits.[42]

Lower rates of Intervention in Childbirth

6.12 The medicalisation of labour and childbirth associated with the predominant model of standard hospital care is a recurring theme in the literature on maternity services in Australia. Concern exists that increasingly individuals are equating specialist obstetricians and medical intervention with safety in relation to childbirth.[43]

6.13 The vast majority of the 25,000 babies born each year in WA are delivered in a hospital, with more than 25 percent of those babies being delivered by caesarean section.[44] *Perinatal Statistics in Western Australia, 2002: Twentieth Annual Report of the Midwives' Notification System* notes:[45]

> *The rate of caesarean section in 2002 was 29.4%. This figure has risen from 16.9% in 1988, and represents one of the most striking features of modern obstetrics.*

6.14 The report also notes that WA had the second highest rate of caesarean sections in Australia in 2000.[46]

6.15 In its submission to the Committee, the ACMI commented on the fragmented nature and under utilisation of midwifery in the hospital environment and the medicalisation of childbirth in WA:[47]

> *The main services to which women have access are thus standard care services that offer women little or no continuity of care by a midwife or midwives. These services also tend to provide limited scope for midwifery expertise to be fully utilised to support healthy women to proceed to an uncomplicated birth. Rather midwives are commonly obliged to provide care in a system that predominantly views childbirth as a medical event and which relies increasingly*

---

42 See for example CSE Homer *et al.,* 'Collaboration in maternity care: a randomised controlled trial comparing community-based continuity of care with standard hospital care', *British Journal of Obstetrics and Gynaecology*, January 2001, Vol 108, p16.

43 The Maternity Coalition Inc. *et al,. The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia*, September 2002, pp10-11.

44 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p2.

45 Department of Health, Western Australia, *Perinatal Statistics in Western Australia, 2002: Twentieth Annual Report of the Midwives' Notification System,* February 2004, p2, at www.health.wa.gov.au/publications/documents/2002%20PN%20Report%20for%20Web.pdf, accessed on November 4 2004.

46 Ibid.

47 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p2.

> *upon routine use of medical procedures such as induction, augmentation, epidural, and instrumental delivery even for the care of women who are healthy and have uncomplicated pregnancy. For example, in 2002, only 51.4% of WA women went into labour spontaneously, and of these more than half (25.9%) then had their labours augmented, 51.1% had epidural anaesthesia, and 29.4% gave birth by caesarean section.*

6.16 The Department of Health's *Perinatal Statistics in Western Australia* also notes "[l]*ess than a quarter of births occurred without intervention to the processes of labour or delivery.*"[48]

6.17 In relation to the increase in rates of intervention, the ACMI submission notes that:[49]

> *all of these rates have increased markedly compared with 10 years earlier without any associated decrease in maternal or perinatal mortality.*

6.18 The WHO's recommended national caesarean section rate is fifteen percent.[50] At between twenty-five and thirty percent[51], WA women are well above the internationally regarded appropriate level of medically indicated caesarean sections.

Breastfeeding and Postnatal Benefits

6.19 The ACMI submission notes additional longer term associated health benefits that accrue from the one-to-one continuity of care primary midwifery model of maternity services: [52]

> *Other benefits to both mothers and babies found to arise from continuity of midwifery care include improved rates of mother/baby*

---

48 Department of Health, Western Australia, *Perinatal Statistics in Western Australia, 2002: Twentieth Annual Report of the Midwives' Notification System*, February 2004, p2, at http://www.health.wa.gov.au /publications/documents/2002%20PN%20Report%20for%20Web.pdf, accessed on November 4 2004.

49 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p2.

50 Australian Institute of Health and Welfare, *Australia's mothers and babies 2000*, National Perinatal Statistics Unit, Perinatal Statistics Series, Number 12, Sydney, 2003, p16.

51 Australian Institute of Health and Welfare, *Australia's mothers and babies 2000*, National Perinatal Statistics Unit, Perinatal Statistics Series, Number 12, Sydney, 2003, p16. Compare with higher rates (29.4%) contained in the more recent *Perinatal Statistics in Western Australia, 2002: Twentieth Annual Report of the Midwives' Notification System*, February 2004, p2, at http://www.health.wa.gov.au/ publications/documents/2002%20PN%20Report%20for%20Web.pdf, accessed on November 4 2004. The AIHW report notes that one third of mothers with private status in hospital in Western Australia had their babies by caesarean. Australian Institute of Health and Welfare, *Australia's mothers and babies 2000*, National Perinatal Statistics Unit, Perinatal Statistics Series, Number 12, Sydney, 2003, p18.

52 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p12. There are numerous footnotes to journal articles and studies supporting the statements contained in the paragraph.

> *attachment or bonding, improved rates of long-term breastfeeding and reduced rates of postnatal depression*.

6.20 The Denmark Program also reports breastfeeding benefits, with a survey conducted in 1999 reporting that 85 percent of women were still breastfeeding after six months.[53]

Benefits for particular socio-economic and Indigenous groups

6.21 In addition to the benefits that primary midwifery is seen to provide to women, it is submitted that primary midwifery is associated with providing additional benefits to women 'at risk'. The ACMI submission states that:[54]

> *There is also mounting clinical evidence that one-to-one continuous midwifery care can improve outcomes for socio-economically disadvantaged women, including Indigenous women, teenage mothers, single mother and mothers experiencing drug or alcohol problems.*

6.22 The ACMI submission also notes the potential benefits for Australian Aboriginal women and their babies:[55]

> *international evidence on the benefits of one-to-one midwifery care for Indigenous women in other countries, particularly where it is provided to women within their own communities, suggests that community midwifery care of pregnant women has the potential to significantly improve maternal and infant outcomes for Australian Aboriginal women and their babies.*

Cost-effectiveness

6.23 In Australia, maternity service costs are shared between the Commonwealth and the State. The Commonwealth funds, in accordance with the Medicare Benefits Schedule (**MBS**), episodes of care that occur outside the public hospital environment, while care within a public hospital as a public patient is a State responsibility.

6.24 In addition to the well-documented potential for physical and emotional health benefits to both the mother and child, proponents of primary midwifery highlight that there are potential cost-savings to be made by moving away from standard hospital care for low risk, uncomplicated pregnancies and providing additional funding for primary midwifery maternity services.

---

53 Denmark Health Service, 'Midwifery and Obstetrics Services Review', June 2002, p7.

54 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p13.

55 Ibid.

6.25 It was submitted to the Committee that:[56]

> *Childbirth already accounts for a significant proportion of the nation's health budget, as it is "the single most important reason for hospitalisation and accounts for the highest number of occupied bed days."*

Comparative Costs

6.26 The Committee sought information from the Department of Health in relation to the assertion that primary midwifery care is cheaper than the cost of birth under conventional medical practices. Mr Mike Daube, Director General, Department of Health stated that:[57]

> *Comparison of the cost of primary midwifery care with the cost of birth under conventional medical practices is a complex matter because of differences in the risk of pregnancy among those choosing the different modes of care and difficulties in separating out the cost of individual deliveries in a hospital setting.*

6.27 More importantly, the Director General stated: [58]

> *Such formal economic analysis has not been carried out in WA.*[59]
>
> *It has been estimated that the cost of such a study would range from $20,000 to $70,000.*

6.28 However, in more recent correspondence, the Director General, with reference to *The National Maternity Action Plan*'s Appendix B, which provides an overview of evidence on the cost of medical maternity services in comparative perspective,

---

56 Ibid, p8, quoting from Commonwealth of Australia, Senate Community Affairs Reference Committee, *Rocking the Cradle: a report of childbirth procedures*, Canberra, 1999. Available at http://www.aph.gov.au/netate/committee/ clac_ctte/index.htm.

57 Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, March 31 2004, p2. See also Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, October 20 2004, p1.

58 Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, October 20 2004, p2. See also The Maternity Coalition Inc. *et al.*, *The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia*, September 2002, Appendix B (pp34-39).

59 Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, March 31 2004, p2. See also Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, October 20 2004, p2.

conceded that "*studies reviewed showed that community based midwifery care was less costly.*"[60]

6.29 The Director General confirmed that the Community Midwifery Program remunerated midwives at the rate of $2,370[61] per birth in the 2002-03 financial year (which includes antenatal care, labour, birth and postnatal care up to six weeks) but did not comment on the relative value-for-money of this figure.[62]

6.30 The Committee sought further information from the Director General in relation to the costs of birth under "*conventional medical practices*" (standard hospital care) and under primary midwifery care. The Director General stated that:[63]

> *The average cost of all births at KEMH excluding those admitted and discharged from the Family Birth Centre is $4,098. This includes both complicated and non-complicated births (vaginal and caesarean births).*
>
> *The average cost per patient admitted and discharged from the Family Birth Centre is $2,170. However, this cost includes all appointments i.e. antenatal, postnatal and education as these costs are currently not separately identified.*

6.31 While acknowledging that the assessment of cost issues in maternity services is a complex matter, the ACMI submission noted that there is a "*lack of transparency and accountability in maternity funding across Australia, and the complexities of Commonwealth and State contributions to maternity care have not been publicly analyzed*."[64]

6.32 The ACMI submission also asserted that it is possible to compare the cost effectiveness of midwifery care with standard hospital care. The submission pointed

---

60 Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, October 20 2004, p2. See also The Maternity Coalition *et al., The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia*, September 2002, Appendix B (pp34-39).

61 Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, March 31 2004, p2.

62 The ACMI Submission notes that "*Other States and Territories that have developed public caseload midwifery services in the past few years (including the ACT, NSW and South Australia, with Victoria moving ahead in this area too), have developed annualised salary agreements for the midwives, which pay a loading for the on-call nature of the work and extended annual leave and may also provide a more cost-effective arrangement.*" Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p7.

63 Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, October 20 2004, p1.

64 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p5.

to a number of recent studies published in "*reputable medical and health journals*" which address this issue.[65]

6.33 For instance, a randomised controlled trial conducted at a major Sydney hospital reported that continuity in midwifery care resulted in savings of around $1,000 per woman compared to standard hospital antenatal clinic care.[66]

6.34 The ACMI submission also stated that it would be possible to undertake a comparative cost analysis in WA:[67]

> *It would be possible for the Department to undertake some analysis of costs using unpublished state data on interventions rates and birth numbers at each maternity facility collected annually by* [Department of Health] *matched with at least the* [Medicare Benefits Schedule] [Diagnosis-Related Group] *scheduled fees. This would not cover state budget costs for salaries and administration of maternity facilities but would give a preliminary set of data about the relative per birth costs of different maternity units in the State.*

6.35 The ACMI submission also addresses the issue of the closure of smaller maternity facilities such as Woodside Maternity Hospital and Kalamunda Hospital because of lack of obstetric backup. The submission states:[68]

> *Implementation of the Cohen Review of State-wide Obstetric Services and Reid Review recommendations regarding rationalising of obstetric services need not involve closing maternity services in local settings such as Kalamunda. Rather WA could adopt the approach now being taken in states like NSW where a small maternity unit at Ryde (around 500 births per year) was facing closing because of the same pressures to achieve economies of scale in obstetric services and benefits from concentration of obstetric skill. Instead of closing down the Ryde maternity unit, the service has been innovatively changed to a caseload midwifery service with no on-site obstetric or anaesthetic cover. Women needing medical care are transferred during pregnancy or labour to a neighbouring tertiary facility.*

6.36 The ACMI notes that the value of this approach is that:[69]

---

65 Ibid, pp5-6. See CSE Homer *et al*, 'Collaboration in maternity care: a randomised controlled trial comparing community-based continuity of care with standard hospital care', *British Journal of Obstetrics and Gynaecology*, January 2001, Vol 108, pp16-22.

66 CS Homer *et al*, 'Community-based continuity of midwifery care versus standard hospital care: a cost analysis", *Australian Health Review*, Vol 24, No 1, 2001, p85.

67 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p6.

68 Ibid, p7.

> *by establishing caseload midwifery services in smaller hospitals within an appropriate range for transfer to an obstetric facility, there could be significant cost savings from avoiding duplication of obstetric rosters (at $3,000 per day) while maintaining safe maternity services for local communities.*

Medical Intervention as a source of rising costs

6.37 Authors of the study 'Costing the cascade: estimating the cost of increased obstetric intervention in childbirth using population data' found that intervention increases the cost of birth significantly:[70]

> *The relative cost of birth increases by up to 50% for low risk primiparous*[71] *women and up to 35% for low risk multiparous women as labour interventions accumulated. An epidural was associated with a sharp increase in cost of up to 32% for some primiparous low risk women and up to 36% for some multiparous low risk women.*

6.38 The average caesarean section costs the health system approximately $5,000, a figure that does not include antenatal care.[72] In addition to the higher costs associated with caesarean sections, there is an associated need for postnatal beds for women recovering from surgery. Lower caesarean section rates would result in reduced costs in terms of procedural costs and postnatal recovery costs.

6.39 It was submitted to the Committee that the increasing rate of medical intervention in standard hospital care is placing additional unnecessary financial strain on the health budget, and increasing the likelihood of intervention for healthy, low risk pregnant women.[73] Primary midwifery is put forward as a potential response to these issues:[74]

> *Increased opportunity for women to have information about birthing choices, the risks and impacts of medical intervention when unnecessary, and non-medical model pre-natal education, are effective strategies to enable less intervention in low risk births.*

---

69 Ibid.

70 SK Tracy and MB Tracy, 'Costing the cascade: estimating the cost of increased obstetric intervention in childbirth using population data', *British Journal of Obstetrics and Gynaecology*, August 2003, Vol 110, p717 (see also pp717-724).

71 "Primiparous" is defined as "*a woman who is bearing a child for the first time*". "Multiparous" is defined as "*having borne more than one child*". *The Oxford Encyclopedic English Dictionary*, Clarendon Press, Oxford, 1991, pp1149 and 953.

72 Submission No.4 from Australian College of Midwives Incorporated, May 18 2004, p6.

73 Ibid, p8.

74 Submission No 3 from Community Midwifery Program, April 22 2004, p3.

6.40 In New Zealand, with more than 70 percent of births carried out by community-based midwifery, the maternity budget is now showing a downward trend.[75]

Effective Use of Scarce Resources

6.41 Western Australia, Australia, and the world more generally, is facing a shortage of obstetricians, GP obstetricians and midwives.[76] Long serving professionals are leaving the field with no one lining up to replace them. The high cost of medical indemnity insurance combined with the fear of litigation and lifestyle issues, mean that it is becoming increasingly difficult to attract students to obstetrics. Fewer specialists to share the burden discourages students from enrolling in obstetrics while limited capacity to practise primary midwifery and fully utilise their skills discourages students from training as midwives. The resulting shortage of maternity professionals in turn puts greater pressure on those practising.

6.42 The Community Midwifery Program Manager submitted to the Committee that the expansion of primary midwifery represents an effective use of scarce health and obstetric resources:[77]

> *Expansion of midwifery-led models in birthing for the majority of women, with appropriate obstetric specialist services when medically indicated, would be a more effective and potentially less costly means to address future shortages in specialist obstetricians. This would lead to greater alignment with the New Zealand model.*

6.43 In its submission to the Committee, The Maternity Coalition Inc. (**Maternity Coalition**) noted that one way to address the shortage of midwives and obstetricians is to provide them with the ability to practise their skills:[78]

> *Maternity services need drastic reform to ensure the professional expertise of midwives as lead maternity carers is available for the majority of women. This will encourage midwives back into the public*

---

75 The Maternity Coalition Inc. *et al.*, *The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia*, September 2002, p27, viewed at http://www.maternitycoalition.org.au/nmap_execsummary.html, accessed on November 2 2004.

76 The Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee have prepared reports that discuss the shortages in the obstetric workforce. Australian Medical Workforce Advisory Committee, *The Specialist Obstetrics and Gynaecology Workforces, An update: 2003 to 2013*, AMWAC Report 2004.2, April 2004, at http://www.healthworkforce. health.nsw.gov.au/amwac/amwac /pdf/obs_gyn_20042.pdf , accessed on November 8 2004. See also Australian Health Workforce Advisory Committee, *The Midwifery Workforce in Australia 2002-2012*, AHWAC Report 2002.2, December 2002, at http://www.healthworkforce.health.nsw.gov.au/amwac/pdf/midwifery_20022.pdf, accessed on November 8 2004.

77 Submission No 3 from Community Midwifery Program, April 22 2004, p3.

78 Submission No 1 from The Maternity Coalition Inc, December 30 2003, p1.

> *health system and support specialist obstetricians to maintain vital specialist skills for the minority of women who need them.*

6.44 Similarly, the WHO's report *Care in Normal Birth* concludes that "*the midwife appears to be the most appropriate and cost effective type of health care provider to be assigned to the care of normal pregnancy and normal birth, including risk assessment and the recognition of complications*."[79]

6.45 The standard caseload for a full time primary or caseload midwife is approximately 40 women.

6.46 The ACMI submitted to the Committee that midwives working in the community midwifery area are currently being under-employed because of insufficient funding despite the demand for their services.[80]

> *The* [Community Midwifery Program] *has an inbuilt capacity to expand its numbers of births with existing staff, since the midwives are underemployed (average annual caseload of 19, when 35 to 40 women per midwife per year is FTE) and most would prefer a full caseload*.[81]

Quality of Experience, Client Satisfaction

6.47 While it is useful to look at the financial benefits of primary midwifery, it is submitted that there are numerous less tangible benefits that are provided through primary midwifery, such as the quality of experience.

6.48 The woman is the client at the centre of the childbearing continuum, she is and ought to be the centre of attention. It is her needs (and those of her baby) as well as her desires and expectations that ought to be the central focus of those caring for her.

6.49 It is clear that women seek the assistance of professionals whom they can trust to provide them with the best care for themselves and their babies. It is important to recognise that many women look at the childbearing continuum from a holistic perspective. Melinda Cook describes the woman's perspective: [82]

---

79 World Health Organization, *Care in Normal Birth: report of a technical working group*, Chapter 1, p5-6, at http://www.who.int/reproductive-health/publications/MSM_96_24/MSM_96_24_Chapter1.en.html, accessed on October 11 2004.

80 Fewer midwives could carry a full caseload; however, the midwives have decided to share the 150 cases more widely so that a greater number midwives can be afforded the opportunity to practise as community midwives, even though it is on a half caseload capacity.

81 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004.

82 M Cook, 'The role of social support in midwifery practice and research' *Hunter Valley Midwives Association Journal*, November/December 1994, Vol 2, No 6, pp1-5, at http://www.efn.org/~djz/birth/HVMA/ socialsupport.html, accessed on May 17 2004.

> *While obstetricians are concerned with perinatal and maternal mortality rates and strive to achieve a healthy baby and mother, women view childbearing in a more holistic way. Not only does she want a live birth of a healthy infant, the mother strives for a satisfactory personal experience. (Graham and Oakley, 1981:54-5).*
>
> *This applies not only to the pregnancy and birth but to the subsequent mother-baby relationship and to the way in which motherhood is integrated with the rest of her life. (Graham and Oakley, 1981:55*).

6.50 Cook, drawing on Reid and Garcia (1989:133), emphasises the importance of the personal element of antenatal, labour, childbirth and postnatal care for women:[83]

> *Women expect personal care during pregnancy, an expectation that often remains unfulfilled by institutionalised antenatal care. Research indicates that women feel undervalued as individuals in hospitals. Contributing factors include long waiting times, poor clinic facilities, different caregivers each visit, and very little opportunity to ask questions and receive appropriate information. (Reid and Garcia, 1989:133*).

6.51 Primary midwifery, where a woman is able to choose her midwife and develop a relationship with that midwife over a seven month period, addresses a woman's need for personal care during this period of her life.

6.52 The Committee wrote to the Department of Health in relation to consumer satisfaction with the Community Midwifery Program. The Department advised that the Community Midwifery Program is funded to conduct client surveys "*to ensure that the service maintains a strong client focus and to assist with quality assurance.*"[84] Moreover, the Director General advised that "[i]*t is reported that the majority of survey respondents are very positive regarding their experience.*"[85] [86]

6.53 The Community Midwifery Program is described as being 'extremely' well received by the community and is seen as providing all of the benefits associated with primary midwifery listed above (paragraph 6.1).[87]

---

83 Ibid, pp1-5.

84 Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, March 31 2004, p3.

85 Ibid.

86 The Director General also notes that Customer Satisfaction Surveys are conducted by clinical, allied health and clinical support areas. He notes that "*Customer Service Unit statistics for complaints and compliments are assessed regularly*." Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, dated October 20 2004, p2.

87 Submission No 3 from Community Midwifery Program, April 22 2004, p4.

6.54 It is understandable that women, particularly those with private health insurance, would choose to see an obstetrician, not simply because of the specialist skills that he or she possesses in relation to complications in pregnancy, labour and childbirth, but because of the desire to develop a relationship over several months with the person who will assist them during labour. The ACMI submission notes, however, that: [88]

> *even women who choose to engage the services of a private obstetrician with a view to achieving some certainty about who will provide care during their birth, find that once in labour, they are cared for by midwives they are unlikely to know.*

6.55 Consumer support of the New Zealand model is encouraging with women who use midwifery care voicing tremendous satisfaction with the level of care. (See paragraphs 8.2 to 8.10.) Feedback also points to women perceiving midwives as providing more information than other professionals. Women also perceive that they receive more postnatal visits from midwives and "*they are confident that midwives will refer them to specialists when necessary*."[89]

> *The LMC model of primary maternity care is the cornerstone of the maternity service. All other services fit in around this model so that the woman experiences as seamless maternity service that meets her individual needs, whatever these might be. This model is unique in the world and has been highly success in New Zealand with women expressing considerable satisfaction with their maternity services*.[90]

7 ISSUES FOR CONSIDERATION

Is Primary Midwifery Safe?

7.1 As previously noted, a healthy outcome for mother and baby is the ultimate objective of every labour. Critics of primary midwifery point to concerns relating to the safety of primary midwifery. Proponents of primary midwifery argue that primary midwifery is as safe as standard hospital care.

7.2 Numerous reputable studies have been conducted that support the view that primary or caseload midwifery (with medical back up) is as safe as standard hospital care. [91] The

---

88 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p5.

89 S Stewart, 'Midwifery in New Zealand: a cause for celebration', *MIDIRS Midwifery Digest*, September 2001, 11 (3), p7.

90 'Midwifery: an independent profession', *Midwifery Practice in New Zealand*, www.midwife.org.nz/index.cfm/practice/, accessed on March 12 2004, p1. "*Midwives and GPs cannot charge women on top of the fee they receive from the government*", 'Midwifery: an independent profession', *Midwifery Practice in New Zealand*, website at www.midwife.org.nz/index.cfm/practice/, accessed on March 12 2004, p3.

91 See Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p11.

ACMI submission refers to a study conducted in Australia and published in the *British Journal of Gynaecology*:[92]

> *The systematic review comparing continuity of midwifery care with standard maternity services including data from all Australian trials shows that continuity of midwifery care is associated with lower intervention rates than standard maternity care, and that midwifery models of care are as safe as the existing standard services*.

7.3 The Maternity Coalition submits that:[93]

> *overwhelming evidence shows that women who are supported by midwives throughout pregnancy and childbirth will have equivalent or better outcomes than when primary care is provided by medical practitioners.*

7.4 The Committee sought information from the Department of Health in relation to safety statistics in relation to midwife assisted births compared to birth by conventional methods. The Director General advised the Committee as follows:[94]

> *Unfortunately we are unable to supply this information as there are currently no safety statistics for midwife assisted births compared with birth by conventional methods*.

7.5 In response to this statement, ACMI noted that there is "*ample data available from outside the State by which the safety of midwife managed services can be evaluated*."[95]

7.6 The Community Midwifery Program has conducted two evaluations of its services, which have stated that "[t]*he birth outcomes data demonstrates that the CMP provides safe, low intervention births for women at 'low risk' of complications during pregnancy, labour and birth.*"[96] The most recent evaluation (March 2003) notes that:[97]

> *The midwives accurately assessed complications, and in the vast majority of cases acted appropriately*.

---

92 Ibid, quoting U Waldenstrom and D Turnbull 'A systematic review comparing continuity of midwifery care with standard maternity services', *British Journal of Obstetrics and Gynaecology*, 1998, Vol 105, Issue 11, pp1160-1170.

93 Submission No 1 from The Maternity Coalition Inc., December 30 2003, p1.

94 Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, March 31 2004, p3.

95 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p10.

96 C Thorogood *et al*, *Community Midwifery Program (Western Australia), Evaluation, November 1997-December 2001*, March 2003, Executive Summary, p2.

97 Ibid.

7.7 The 2003 evaluation did, however, note that, at 12 percent, the rate of Primary Postpartum Haemorrhage (PPH) was much higher than the national average.[98] The Evaluation explained this aberration by noting the fact that "*most occurred in hospital following an operative delivery after an active management of third stage. Moreover, CMP midwives were not the accoucheurs*[99] *at most of these hospital births*."[100]

7.8 The ACMI submission also points to studies of planned homebirths that showed that "*home birth with a qualified midwife remains a demonstrably safe option for women who choose this model of care*."[101]

Is Primary Midwifery Care Accessible?

7.9 The combination of a shortage of midwives, general practitioner-obstetricians and obstetricians is increasingly resulting in greater difficulty accessing maternity care.[102] The increase in medical indemnity premiums has had a marked impact on the number of medical practitioners who are willing to continue providing obstetric care and with their exit from maternity services there is increased pressure to close smaller maternity facilities in favour of clustering maternity services around larger medical institutions.[103]

7.10 Despite the 'expansion' and success of the Community Midwifery Program, current funding arrangements mean that access to the Community Midwifery Program is currently restricted (or only available) to 150 women in the metropolitan area. Significantly, this equates to access for just 0.6 percent of the 25,000 women delivering babies in WA, and only 0.8 percent of the women delivering babies in the metropolitan area.[104]

7.11 It was submitted to the Committee that demand for the Community Midwifery Program exceeds the funding to supply services despite the fact that the Community Midwifery Program does not advertise because it is already unable to meet the current demand.[105]

---

98 Ibid.

99 An '*accoucheur*' is a midwife.

100 C Thorogood *et al*, *Community Midwifery Program (Western Australia), Evaluation, November 1997-December 2001*, March 2003, Executive Summary.

101 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p15.

102 The Maternity Coalition Inc. *et al. The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia*, September 2002, p15.

103 For example see *A Healthy Future for Western Australians*, Report of the Health Reform Committee, March 2004, Executive Summary, at http://www.health.wa.gov.au/hrc/finalreport/docs/Final_Report.pdf .

104 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p4.

105 Submission No 3 from Community Midwifery Program, April 22 2004, p1.

7.12 Information provided by the Director General of Health and the Minister for Health confirms that only very limited access to primary midwifery services exists.[106]

7.13 In WA in 2002 there were nearly 18,000 births in the metropolitan area. Sixty three point four percent of those births had no complications in pregnancy. There are a large number of women who, on health criteria, qualify for the Community Midwifery Program but are not able to access the Community Midwifery Program because of insufficient number of places being available.[107]

7.14 The Committee is of the view that with government funding of the Community Midwifery Program extending to only 150 women, it is difficult to argue, in a population of 25,000 women giving birth each year, there is sufficient access to this service.

7.15 The Committee wrote to the Minister for Health in relation to the WA Government's approach to the provision of maternity services and on the adequacy of the current midwifery programs available to women in WA. The Minister stated: [108]

> *The provisions* [sic] *of maternity services has already been widely debated through the recently published review of Statewide Obstetric Services. This report supports the need for more birth centres to be available for healthy women with normal pregnancies*.

7.16 The Minister acknowledged the Maternity Coalition's view that current midwifery programs "*are not likely to be satisfactory for those women who want choice in midwifery care and place of birth*".[109] He further advised that:[110]

> *Women's and Children's Health Service (KEMH) has developed a proposal for an integrated community maternity program based at the hospital with midwives as lead providers of care*.

7.17 The Committee acknowledges the Minister's support for choice in maternity services and his statement that "*Any expansion of the community based midwifery program is difficult at this time, given the current demands on the health system.*"[111]

---

106 Letter from Hon Jim McGinty MLA, Minister for Health, Western Australia, April 6 2004, p2 and Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, March 31 2004, pp1-2.

107 See Submission No 3 from Community Midwifery Program, April 22 2004, p1.

108 Letter from Hon Jim McGinty MLA, Minister for Health, Western Australia, April 6 2004, p2.

109 Ibid.

110 Ibid.

111 Ibid.

7.18 In terms of the current capacity to meet increased access to the Community Midwifery Program, ACMI submitted to the Committee that:[112]

> *The CMP has an inbuilt capacity to expand its numbers with existing staff, since the midwives are underemployed (average annual caseload of 19, when 35 to 40 women per midwife per year is FTE) and most would prefer a full caseload.*

Do Western Australian Women Have Choice of Care?

7.19 In addition to issues relating to access to care, there are also issues relating to birthing choice that were raised in submissions. With team midwifery operating at one hospital, only one FBC in the State and funding for only 150 women in the Community Midwifery Program, it was submitted that women's options for government-funded midwifery-led maternity services are severely limited.

7.20 Ms Val O'Toole, Program Manager with the Community Midwifery Program, submitted to the Committee that:[113]

> *The lack of Birth Centres apart from the one attached to King Edward Hospital means that the public system provides women and families in Western Australia very limited scope for choice in birthing*.

7.21 Community Midwifery Program provides a range of antenatal and postnatal education; however, limited funding means that Childbirth Information and Resource Centres are only open very limited hours. "*Expansion of hours and expansion in numbers especially in the northern suburbs where birth rates are extremely high, and in the Peel region would assist in creating informed choices.*"[114]

Funding of the Community Midwifery Program

7.22 Of primary concern to those in support of the Community Midwifery Program is the question of funding. In relation to funding of the Community Midwifery Program, the ACMI, notes:[115]

> *The service has not been able to secure a long term funding commitment from the Government or an increase in funding since 1999, despite there being significant unmet demand for the service, despite the service's proven record in providing high quality care, and despite repeated submissions over the past 5 years for additional*

---

112 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p4.

113 Submission No 3 from Community Midwifery Program, April 22 2004, p1.

114 Ibid, p3.

115 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p4.

funding made to the Department of Health by the contract organisation, Community Midwifery WA.

7.23 Despite the expansion of the service, unmet demand exists without advertising the program's services. Ms Val O'Toole, Program Manager, submitted to the Committee that demand for the Community Midwifery Program vastly exceeds the Program's ability to supply:[116]

> *The demand for the program is approximately 20 per month, and this is without any active promotion Program in place, due to the ethical position of the organisation not to advertise for places that are not available.*

7.24 An evaluation of the Community Midwifery Program (November 1997-December 2001) completed in March 2003 notes:[117]

> *In 32 documented cases women were refused a place because the Program was fully booked that month, there was no midwife available or because the woman lived outside the Program's catchment area.*

7.25 Both the Minister for Health and the Director General of the Department of Health have stated that they actively support choices in midwifery services to women.[118]

7.26 The Committee notes that in response to an invitation to comment on the Director General's letter to the Committee the ACMI stated that the Government's active support for choices in midwifery "*is not well supported by the evidence on services available to women.*"[119]

7.27 The Committee notes that each of these options for midwifery care are only available to women birthing in the metropolitan area. These options combined offer midwifery-led maternity care to five percent of the birthing population in WA, with primary or caseload midwifery comprising less than one of the five percent.[120]

8 MIDWIFERY SERVICES IN OTHER JURISDICTIONS

8.1 The value and benefits of primary midwifery have been recognised and embraced in other parts of Australia and in other countries, particularly over the past fifteen years. The ACMI submission notes that primary or caseload midwifery is on offer to around

116 Submission No 3 from Community Midwifery Program, April 22 2004, p1.

117 C Thorogood *et al, Community Midwifery Program (Western Australia), Evaluation, November 1997-December 2001*, March 2003, Executive Summary.

118 Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, March 31 2004, p1.

119 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p1.

120 Ibid, p4.

five percent of women in Queensland, New South Wales, Victoria, South Australia and the ACT as part of mainstream public hospital maternity units and birth centres.[121] Midwifery has been a legitimate and legislated form of maternity care for women in the United Kingdom for over a century.[122] In the Netherlands, homebirth is part of the national maternity plan.[123] More recently, countries such as New Zealand and Canada[124] have seen a dramatic increase in the availability and uptake of midwifery services. However, of perhaps greatest interest to Australians is the policy shift that has been demand-driven in New Zealand over the past fifteen years.

The New Zealand Model

8.2 Midwifery, together with child birthing, has undergone a revolution in New Zealand (**NZ**) over the past fifteen years. The creation of the New Zealand College of Midwives in 1990 to promote midwifery as a profession separate to nursing followed by the enactment of the *Nurses Amendment Act 1990* (NZ) has seen a radical change in the country's approach to maternity care.

8.3 The ACMI submission, referring to information contained in the New Zealand Ministry of Health's *Report on Maternity* (1999), notes:[125]

> *In New Zealand, consumer demand for continuity of care by a midwife has grown from around 10% of women in the early 1990s to more than 70% of women since this option has become widely available through the public health system*.

8.4 Under the NZ model, women have the choice of a maternity service in which midwives are autonomous and are able to provide maternity care through pregnancy, labour and birth through to six weeks post-partum. In addition to her traditional responsibilities, the NZ midwife (or LMC) is able to:[126]

- prescribe medications pertinent to childbirth;
- order diagnostic tests such as blood tests and ultrasound scans; and

---

121 Ibid, p9.

122 The United Kingdom passed the *Midwives Act* for England and Wales in 1902.

123 The Netherlands has an official homebirth system. *"A study conducted in the province of Gelderland, compared the "obstetric result" of home births and hospital births. The results suggested that for primiparous women with a low-risk pregnancy a home birth was as safe as a hospital birth. For low-risk multiparous women the result of a home birth was significantly better than the result of a hospital birth*." Wiegers *et al*, 1996, World Health Organization at http://www.who.int/reproductivehealth/publications. MSM_96_24/MSM/ 96_24_cha, accessed on October 11 2004.

124 In 2004, midwives in Ontario, Canada, celebrated the completion of ten years of regulated and funded midwifery.

125 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, p8.

- refer to obstetricians or paediatricians.

8.5 In NZ, all maternity care is provided "*free*" of charge except where a woman chooses a private obstetrician who can charge the woman a rate above the set fee that the obstetrician receives from the government.[127]

8.6 Under the NZ model, women can birth at home, in birthing centres (also known as primary maternity facilities) or in secondary maternity facilities (facilities that have caesarean section capabilities).[128] All maternity facilities must provide access to LMCs under a "*generic access agreement*".[129]

8.7 In relation to the high use of midwifery in New Zealand, the ACMI submission noted a number of important points of difference to the Australian system:[130]

- The New Zealand system provides one rate of maternity payment to the LMC regardless of whether that person is a midwife, GP or obstetrician.

- Maternity funding means that midwives have established private practices where women can go to receive maternity services for free in the same manner as Australians can access medical care for free from bulk billing GPs in Australia.

- National no-faults legislation has resulted in the New Zealand College of Midwives being able to purchase professional indemnity for its members in private practice.

8.8 The Committee wrote to the Department of Health requesting a comment on the high use of midwifery services in NZ and whether the NZ model would be appropriate for WA. The Director General responded that acceptance of community midwifery depend on the attitudes of consumers and medical professionals, which may be based on historical factors.[131]

---

126 S Stewart, 'Midwifery in New Zealand: a cause for celebration'. *MIDIRS Midwifery Digest*, September 2001, 11(3), p319.

127 'Midwifery: an independent profession', *Midwifery Practice in New Zealand*, at www.midwife.org.nz/index.cfm/ practice/, accessed on March 12 2004, p1. It is stated that "*Midwives and GPs cannot charge rates above the fees that they receive from the government*". Only a private obstetrician can charge above the Government rates. 'Midwifery: an independent profession', *Midwifery Practice in New Zealand*, at www.midwife.org.nz/index.cfm/ practice/, accessed on March 12 2004, p2.

128 Ibid, p2.

129 Ibid, p2.

130 Submission No 4 from Australian College of Midwives Incorporated, May 18 2004, pp8-9.

131 Letter from Mr Mike Daube, Director General, Department of Health, Western Australia, March 31 2004, pp2-3.

8.9 The Director General stated that he was not able to comment on the NZ model, but would undertake to seek further information about the midwifery situation in NZ.[132]

8.10 The Committee notes the rapid uptake of community midwifery services, by over 70 percent of the birthing population, in NZ as a result of the legislating of universal access in 1990 and the provision of corresponding funding.

9 THE NATIONAL MATERNITY ACTION PLAN

9.1 The Committee notes that The Maternity Coalition[133] [134] has developed *The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban and Regional Australia* (**NMAP**), a blueprint for an overhaul of maternity services in Australia.

9.2 NMAP advocates policy and legislative changes to establish the community-based midwifery program as the accepted model for birthing in Australia.

> *Universal access to continuity of midwifery care will ensure savings in health dollars and bring Australia into line with international best practice in addition to meeting community demands for a range of readily accessible and appropriate maternity services. Community midwifery is informed by international best practice standards that acknowledge midwives as "the most appropriate and cost effective type of health care provider to be assigned to the care of women in normal pregnancy and birth, including the risk assessment and the recognition of complications" (World Health Organization, 1999, Care in Normal Birth).*[135]

9.3 WA's Community Midwifery Program is the template for the NMAP's model, which recommends:[136]

> *That the Western Australian Community Midwifery Program, with its emphasis on community management and its provision of one-to-one*

---

132 Ibid.

133 The Maternity Coalition Inc. is a national non-profit, non-political and non-sectarian consumer advocacy organisation. The Maternity Coalition Inc. acts as an umbrella organisation to bring together support groups and individuals for effective lobbying, information sharing, networking and support in maternity services. See The Maternity Coalition Inc. website at http://www.maternitycoalition.org.au/, accessed on November 10 2004.

134 The Committee received a submission from The Maternity Coalition Inc. providing a resounding endorsement of the Program and urging "*a full and frank investigation into the preservation and expansion of primary midwifery programs in Western Australia*". Submission No 1 from The Maternity Coalition Inc., December 30 2003, p2.

135 The Maternity Coalition Inc. *et al,. The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia*, Executive Summary, p1, at http://www.maternitycoalition.org.au/nmap_execsummary.html, accessed on November 2 2004.

136 Ibid, p3.

continuity of midwifery care, be used as a proven and successful template for community midwifery programs to be established in all other States and Territories. Such Programs would ideally offer this type of care to women choosing to give birth in hospital delivery suites, birth centres or in the community.

9.4 The NMAP calls on the Government:

- To provide Australian women with the choice of having a known midwife care for her throughout her pregnancy, labour and birth and for the first weeks of her life with a new baby through public maternity services.[137]

- *To redirect some of the funding that is currently provided for maternity services from the standard health care system into the Community Midwifery Program to meet the demand for this service.*[138]

9.5 The NMAP notes many of the benefits previously discussed at paragraphs 6.1 to 6.55 above.

9.6 The NMAP identifies financial, legal and policy barriers that need to be removed, including the problems of indemnity insurance.[139]

10 COMMITTEE SUMMARY AND FINDINGS

10.1 Pregnancy, labour, childbirth and the transition to parenthood is one of the most important periods in the life of a woman and a family. The care that a woman and a family receive through this period is of tremendous importance.

10.2 The Petitioner has asked that the Committee inquire into the preservation and expansion of primary midwifery programs in WA and ensure measures are taken to make primary midwifery care a choice available to all pregnant women in Western Australia. (See paragraph 1.1.)

---

137 Ibid, p1.

138 Ibid, p27.

139 *The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia* raises as issues of primary concern: Medicare schedules need to be revised to include midwives; experienced midwives need to be encouraged to return to their profession (without indemnification issues); professional recognition needs to be accorded to practising midwives who must meet accredited standards and should be allowed professional access to women in hospitals; midwives should be accredited to order tests and pharmaceuticals that are commonly used in pregnancy, labour and birth; and the community and midwives need to be educated to move to the recommended model. The Maternity Coalition Inc. *et al., The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia*, September 2002, pp25-26, at http://www.maternitycoalition.org.au/THE%20FINAL%20NMAP%20Sepember%2024th%202002.pdf, accessed on November 2 2004.

10.3 The Committee's report provides an overview of the information contained in the submissions and information obtained in the course of its preliminary inquiries. In particular, the Committee draws the attention of the House to the following issues raised in this report.

10.4 The Committee notes that there are three types of midwifery-led maternity care available in WA (team midwifery at KEMH, the Family Birth Centre at KEMH and the Community Midwifery Program). However, these programs are only available to a very limited number of women who are delivering their babies in the metropolitan area. (Paragraphs 4.7 to 4.21.)

10.5 Intervention rates in childbirth in WA are reported to be amongst the highest in Australia. In 2002, in WA, 20 percent of women giving birth were induced; 51.1 percent of women had an epidural and 29.4 percent of women had a caesarean delivery. (See paragraphs 6.12 to 6.18.)

10.6 There are a range of benefits associated with primary midwifery including continuity of care, lower intervention rates, breastfeeding benefits, lower rates of postnatal depression and benefits for women 'at risk' and Indigenous women. (See paragraphs 6.1 to 6.55.)

10.7 Continuity of care is a key characteristic of the primary midwifery model of maternity care. (See paragraph 6.3 to 6.9.)

10.8 The Committee acknowledges that primary midwifery care can only be an option for healthy women with low-risk pregnancies.

10.9 The Committee is concerned about the adequacy of access to primary midwifery programs, particularly given the information which supports the view that there are a range of important benefits to be gained by expanding primary midwifery programs. There are both health and emotional benefits to be gained by the mother and her family. There are significant cost-benefits and more effective use of scarce obstetric resources to be accessed by expanding primary midwifery services in WA.

10.10 The Committee notes the very high levels of satisfaction with the Community Midwifery Program. (See paragraph 6.52 and 6.53.)

10.11 The Committee notes the rapid uptake in New Zealand of primary midwifery services (70 percent of women) as a result of legislative and funding changes that officially recognise midwives as midwifery professionals. (See paragraph 8.10.) The Committee notes a reported consequence of the shift to primary midwifery in New Zealand is a decrease in the maternity budget. (Paragraph 6.40.)

10.12 The Committee notes the NMAP and its call for State and Federal Governments to facilitate substantial change to the way in which maternity services are provided in

Australia. The Committee also notes that WA's Community Midwifery Program, "*with its emphasis on community management and one-to-one continuity of midwifery care, is the recommended template for community midwifery programs in all other States and Territories*."[140] (Paragraph 9.3.)

10.13 The Committee acknowledges that there have been a number of obstetric service reviews in WA. (See paragraphs 5.2 and 5.3.)The Committee notes that the Community Midwifery Program "*has not been able to secure a long term funding commitment from the Government or an increase in funding since 1999, despite there being a significant unmet demand for the service, despite the service's proven record in providing high quality care, and despite repeated submissions over the past 5 years for additional funding made to the Department of Health by the contract organisation, Community Midwifery WA.*" (See paragraph 7.22.)

10.14 The Committee acknowledges the Minister's support for choice in maternity services and his statement that "[a]*ny expansion of the community based midwifery program is difficult at this time, given the current demands on the health system.*"[141] (See paragraph 7.17.)

10.15 The Committee notes that, while the task of calculating the cost of primary midwifery in comparison to standard hospital care is complex, there are a number of studies that support the view that primary midwifery is a cost-effective mutually beneficial model for maternity service delivery. (See paragraphs 6.28 and 6.32.)

10.16 The Committee is of the view that with government funding of the Community Midwifery Program extending to only 150 women, it is difficult to argue, in a population of 25,000 women giving birth each year, that there is sufficient access to this service. (See paragraphs 7.10 to 7.18.)

10.17 There is considerable evidence in support of the request to expand access to primary midwifery, currently only available to less than one percent of women birthing in Western Australia.

Recommendations

Recommendation 1: The Committee recommends that the Minister for Health significantly expand the number of funded places in the Community Midwifery Program to meet community demand in the 2005-06 State Budget.

140 Ibid, p7.

141 Letter from Hon Jim McGinty MLA, Minister for Health, Western Australia, April 6 2004, p2.

Recommendation 2: The Committee recommends that the Government develop a response to The Maternity Coalition *et al.*'s *The National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia* within a holistic review of maternity services in Western Australia.

Recommendation 3: The Committee recommends that the Government provide secure long-term funding for the Community Midwifery Program.

Recommendation 4: The Committee recommends that the Government ensure the provision antenatally of a greater level of educational information relating to available models of care and their respective benefits.

Recommendation 5: The Committee recommends that the Government ensure that primary midwifery services are available in regional areas.

Hon Christine Sharp MLC
Chair

November 16 2004

APPENDIX 1

LIST OF REPORTS INTO MIDWIFERY, CHILDBIRTH AND MATERNITY SERVICES

Year	Report
1989	New South Wales, Department of Health, *Maternity Services in New South Wales. Final Report of the Ministerial Task Force on Obstetric Services in New South Wales,* Sydney.
1990	Western Australia, Department of Health, *Report of the Ministerial Task Force to Review Obstetric, Gynaecological and Neonatal Services in Western Australia,* Perth.
1990	Victoria, Department of Heath, *Having a Baby in Victoria: Ministerial Review of Birthing Services in Victoria*, Melbourne.
1995	Legislative Assembly, Western Australia, *Report of the Select Committee on Intervention in Childbirth*, Perth.
1996	National Health and Medical Research Council, *Options for Effective Care in Childbirth*, Canberra.
1999	Senate Community References Committee, *Rocking the Cradle: A Report into Childbirth Procedures*, Canberra.
1999	Western Australia, Legislative Council, *Report of the Standing Committee on Constitutional Affairs in relation to a Petition Requesting that Community Based Midwifery be included in State Health Services* (Report 48), Perth.
2001	Western Australia, Department of Health, *Enhanced Midwife Project*.
2003	Western Australia, Department of Health, *Statewide Obstetrics Services Discussion Paper*, Perth.

APPENDIX 2

LIST OF SUBMISSIONS

No.	From	Organisation	Date
1.	Ms Melanie Gregory	The Maternity Coalition Inc.	December 30 2003
2.	Hon Giz Watson MLC	Tabling Member	March 5 2004
3.	Ms Val O'Toole Program Manager	Community Midwifery Program	April 22 2004
4.	Dr Barbara Vernon Executive Officer	Australian College of Midwives Incorporated	May 18 2004