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Maternity services for rural and remote Australia: barriers to operationalising national policy

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ABSTRACT

Introduction: In Australia, many small birthing units have closed in recent years, correlating with adverse outcomes including a rise in the number of babies born before arrival to hospital. Concurrently, a raft of national policy and planning documents promote continued provision of rural and remote maternity services, articulating a strategic intent for services to provide responsive, woman-centred care as close as possible to a woman's home. The aims of this paper are to contribute to an explanation of why this strategic intent is not realised, and to investigate the utility of an evidence based planning tool (the Toolkit) to assist with planning services to realise this intent.
Methods: Interviews, focus groups and a group information session were conducted involving 141 participants in four Australian jurisdictions. Field notes and reports were thematically analysed.
Results: We identified barriers that helped explain the gap between strategic intent and services on the ground. These were absence of informed leadership; lack of knowledge of contemporary models of care and inadequate clinical governance; poor workforce planning and use of resources; fallacious perceptions of risk; and a dearth of community consultation. In this context, the implementation of policy is problematic without tools or guidance.
Conclusions: Barriers to operationalising strategic intent in planning maternity services may be alleviated by using evidence based planning tools such as the Toolkit.

1. Introduction

Planning and delivering maternity services in rural and remote Australia poses considerable challenges. These include workforce recruitment and retention (and renewing and retaining evidence-based and emergency care skills in the workforce), long distances between communities and services, restricted travel due to seasonal weather influences and poor access to transport, and the difficulty of establishing and maintaining effective networks between services (networks defined following Goodwin et al. [1]) [2–6]. Between 1992–2011, there was a 41% reduction in the total number of maternity units in Australia from 623 to 368 [3]. This included the closure of 255 units that had fewer than 500 births per annum and the addition of 21 units with over 2000 births per annum. The closure of small maternity services is associated with rurality [3]. These closures correlate with an increase in unplanned births of babies being born before arrival to hospital in Queensland [3] and Victoria [7] where the rate of unplanned out of hospital births almost doubled over this time. Whilst the provision of

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Table 1
Key maternity policy and planning documents 2005–2012.

Year	Policy document	Brief synopsis
2005	Rebirthing Report: A review of Queensland Maternity services [17] Independent review undertaken in Queensland (which the State Government reported against up until 2014)	An independent review of maternity services provision undertaken in 2004/05 including services for pregnancy, birth and neonates across Queensland. Identifies priority areas for improvement including outcomes for Aboriginal and Torres Strait Islander Women, and care for women who live in rural and remote areas.
2006	National Consensus framework for rural maternity services [4] Rural Doctors Association of Australia	Offers principles developed for use in policy and planning. The principles are presented as ways to ensure rural maternity services are: people and family centred; equitable in terms of distribution and access; able to provide for future generations; grounded in quality and safety; supported by a sustainable workforce; and protected in Australian Health Care Agreements.
2008	Primary maternity services in Australia: A framework for implementation [18] Australian Health Ministers' Advisory Council	This framework was endorsed by all State and Territory Health Ministers and reflects the Australian Health Departments' commitment (from 2005) to primary maternity service models for women with uncomplicated pregnancies in remote, rural as well as urban Australia. The framework focuses on the needs and preferences of women, promoting greater access to continuity of care and fostering collaborative working relationships between care providers. In 2006 this commitment was translated into an agreed work plan including the development of core competencies and an educational framework for Maternity Services [23].
2009	Improving maternity services in Australia: The Report of the Maternity Services Review [19] Commonwealth Government of Australia	This review of maternity services in Australia led to the National Maternity Services Plan (NMSP) being developed in 2011 (see below). The review identified that providing rural and remote services was particularly problematic and recommended changes to support the expansion of collaborative models of care, improved access for rural and Indigenous mothers and reduced workforce pressures (particularly in rural and remote areas).
2010	Maternity services in remote and rural communities in Australia [20] Royal Australian and New Zealand College of Obstetricians and Gynaecologists	Statement developed and reviewed by the Women's Health Committee of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and approved by the Board and Council. Aimed to provide advice on the provision of maternity services to remote and rural communities in Australia.
2011	National Maternity Services Plan [21] From a national committee on which each state and territory was represented	The NMSP provided four priorities each with a range of action items. These formed the basis for driving a change agenda to provide maternity services through primary care models of care. The NMSP also outlined priority areas including the provision of equitable access for rural and remote women particularly Aboriginal women.
2012	National Maternity Services Capability Framework [22] From a national committee on which each state and territory was represented.	The Capability framework describes a six level structure of maternity and neonatal services for both public and private maternity services across all rural, regional and metropolitan settings, outlining the minimum requirements for each level.

other rural and remote health services face similar challenges, there are particular risks associated with lack of maternity services. For example, unplanned births without attendance when birthing services are not provided in a community, and women being separated from their children and their social support networks, often for long periods, at a potentially stressful time in their lives [8–10].

Many rural and remote communities across Australia have experienced population decline and do not have the population base to support a full range of health services [2]. Whilst this provides some explanation for the closure of maternity services, it does not explain it all. Decisions to close services have also been attributed to a variety of other factors including difficulties with workforce, particularly medical recruitment and retention [5,11]. Service closures are also linked to centralisation of services with perceptions of improved safety in larger centres with cost savings for government (not families) [11].

Decisions about closure (or not) have not necessarily been based on evidence, a consistent rationale or on community demand [8,11]. As a result, many Australian women whose local service has closed must travel great distances. This impacts on communities as well as on the safety of mothers and babies and introduces considerable social, emotional and financial costs for families [8,9,12–14]. Many women from rural and remote locations struggle to accommodate these costs. They are disadvantaged due to their socioeconomic position [2], level of education [15], lack of access to services [2], and are often younger mothers [16], all of which can lead to poorer perinatal outcomes.

In Australia over the last decade, while rural and remote maternity services have been closing [3], a raft of state and national policy and planning documents have been developed, supporting the continuing provision of maternity services [4,5,17–22] (Table 1). During this period, there was prolonged national public and professional dialogue culminating in a formal consultation in 2008–9 led by a national committee (the Australian Health Ministers Advisory Council) on which all state health departments were represented, to develop the Australian National Maternity Services Plan (NMSP) [20] and subsequently the National Maternity Services Capability Framework (NMSCF) [21]. The NMSP recognized the importance of maternity services and provided a strategic national framework for implementation to 2015. It articulated a nationally agreed clear and consistent strategic intent for maternity services to provide responsive, woman-centred care (including choice for rural women), as close as possible to a woman's home. Also, within this timeframe (since 2011), local control and devolution of governance to local health boards has driven localised decision making in maternity service provision in some jurisdictions [23].

A key action item of the NMSP regarding planning, design and implementation of maternity services was to ensure the provision of woman-centred services, including a "...rigorous methodology to assist in future planning for maternity care, including in rural and remote communities" [20] p.53. In an audit of methodologies and tools suitable for planning maternity services [24] only the Rural Birthing Index (RBI) from British Columbia, Canada [25] was identified. We reviewed and then adapted the Canadian RBI for use in Australia, which we then referred to as the Australian Rural Birthing Index (ARBI) [26].

To review the RBI we combined modelling of data on births and demography to produce a score, which was then analysed using the expertise of a multi-skilled research team and expert panel [27]. During this process, our research team undertook qualitative fieldwork. The aim of the fieldwork was twofold. First, to investigate the face validity and utility of the Canadian RBI applied in Australia with Australian data in nine rural or remote health services. Second, it aimed to deepen our understanding of the specific historical, social and geographical context of rural birthing services and to examine perceived barriers to sustainable service delivery.

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