RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

RACP submission: to National Strategic Approach to Maternity Services consultation

June 2018

RACP submission to National Strategic Approach to Maternity Services consultation

Thank you for the opportunity to provide feedback to the 'Developing a National Strategic Approach to Maternity Services' (NSAMS) consultation paper prepared by the Department of Health.

The Royal Australasian College of Physicians (RACP), represents over 17,000 fellows and 7,500 trainees across over 30 specialties in Australia and New Zealand. Our membership includes 5,100 paediatric fellows and trainees, who routinely work with newborns, infants, young children and their families. Our Paediatric and Child Health Division (PCHD) works across a range of children's health policy issues. Current focuses include inequities in child health, early childhood and Indigenous child health.

For this submission, we consulted with members of the PCHD, the Australian Diabetes in Pregnancy Society (ADIPS) and the Society of Obstetric Medicine of Australia and New Zealand (SOMANZ). The RACP acknowledges the expert contribution of ADIPS and SOMANZ to this submission.

While we appreciate the intent of the consultation paper to develop a national strategic approach for appropriate and comprehensive maternity services of Australian women who are pregnant, the RACP is concerned about the lack of emphasis in this consultation paper on:

- pregnant women with complex health care needs;
- the importance of specialist preconception care, in particular the role of obstetric physicians, endocrinologists and other allied health professionals;
- the lack of access to specialist obstetric medicine services by rural, remote and indigenous populations;
- the importance of pregnancy and medical co-morbidities in relation to mental health, and family establishment.

Consultation questions

1. Can you in one or a few brief sentences provide what you think would be an overarching key outcome statement for the NSAMS?

The RACP agrees with the World Health Organisation (WHO)'s vision which aims to see a world where 'every pregnant woman and newborn receives quality care throughout pregnancy, childbirth and the postnatal period'[1].

The RACP recommends that the overarching key outcome statement for the NSAMS should be inclusive of the following:

- Every woman in Australia should receive high quality, safe care prior to conception, during pregnancy, and during the period of family establishment.
- Every woman in Australia should feel well supported by health professionals and the wider community to give birth in her chosen setting and environment.

[1] World Health Organisation 2018. Quality, equity, dignity: the network to improve quality of care for maternal, newborn and child health. Available at: http://apps.who.int/iris/bitstream/handle/10665/272612/9789241513951-eng.pdf?ua=1 (accessed June 2018)

- Australian maternity services are woman-centred, of best quality and delivered in a collaborative, professional, non-judgemental, evidence-informed, inclusive and safe way for every woman and her newborn.

2. Do you think there should be a set of values that underpin the NSAMS? If so, could you list the top four values you would like to see included?

The RACP agrees that a set of values should underpin the NSAMS and would like to see the following top five values included:

1. Woman centred – acknowledging each woman's unique aspirations and values providing a wide choice of models of care appropriate to the needs of the woman - especially to the needs of woman with complex, high risk pregnancies.
2. Safe and best quality care - safe care for women with complex comorbidities and complex health care needs in pregnancy as well as safe care for newborn babies with special needs. High risk babies (e.g. multiple births, extremely premature babies) need delivery care in appropriate environments. Best quality care is tailored to meet each individual woman's and child's needs prior to, during, and after pregnancy and underpinned by mutual trust and respect for the woman, her family as well as for and between the maternity services health professions.
3. Respectful, non-discriminatory - culturally appropriate and personally acceptable for the woman, her partner or support person, and between all maternity carers. Maternity care services should be provided in open, honest, and unbiased communication between all stakeholders involved. Every woman deserves equal access to specialist services, regardless of geography, ethnicity or socio-economic status
4. Supportive – the need to support the mental and physical health needs of women and their partners at this critical stage of life.

3. Can you outline three or four positive aspects of maternity services in Australia?

The RACP believes that expecting parents and infants require a range of supports and services to remain healthy and well, and enable them to participate meaningfully in society.

The RACP recognises the following positive aspects of maternity services in Australia:

1. The current variety of models of maternity care available to women in Australia, especially midwife-led collaborative models providing the required continuity of care to women without pre-existing complex health conditions and who are having a normal, low risk pregnancy.
2. Antenatal care is provided to most women giving birth in Australia with 95% of women having five or more antenatal appointments[2], however the differences in uptake of antenatal care for women living in low socioeconomic or remote areas, Aboriginal and Torres Strait Islander women and for women from culturally and linguistically diverse backgrounds needs to be urgently addressed (see also answers to question 4, 5 and 6).
3. The recognition that preconception care provided by GPs in primary health care settings is an important opportunity to identify biomedical, behavioural and social risks to a women's health and pregnancy outcomes. However, the current insufficient preconception care for

[2] AIHW (2015): Australia's mothers and babies 2015 – on brief, page 5. Available at: https://www.aihw.gov.au/getmedia/728e7dc2-ced6-47b7-addd-befc9d95af2d/aihw-per-91-inbrief.pdf.aspx?inline=true (accessed June 2018)

women with obesity, diabetes and chronic medical conditions is poor resulting in unacceptably high congenital malformations rates[3,4] (see also answers to question 4 and 5).

4. Postnatal care should be provided in acute and community health care settings in Australia, however the access to early childhood and maternal and child health nurses and GPs is not consistently provided to all women in Australia (see also answers to question 4 and 5). The RACP recommends that robust, systematised[5], multidisciplinary, and multiagency integrated perinatal care service systems are provided through implementing sustained health home visiting and perinatal targeted parenting education and support initiatives.

4. What do you think are the three or four key gaps or issues for maternity services in Australia? Of these which is most important to you?

While the current system of maternity services in Australia provides overall excellent perinatal outcomes compared to those in other Organisation from Economic Co-operation and Development (OECD) countries, the RACP is concerned about outcome disparities between population groups in Australia as well as some areas of poorer outcomes compared to other OECD countries.

Therefore, we would like to highlight the following key gaps and issues for maternity services in Australia:

1. A lack of emphasis on highly specialist pregnancy care services for women with complex health needs, both in terms of medical co-morbidities and mental health.
   While most obstetric care is low risk, some of it is becoming exceptionally high risk. A significant burden to maternity services is the increasing number of women with complex health care needs due to:
   - increasing age [6],
   - increasing BMI [7],
   - increasing numbers of medical comorbidities [8],
   - increasing numbers with pre-existing diabetes,
   - increasing numbers of women who have survived complex childhood medical illness[9],
   - increasing rates of cancer detection in pregnancy, and
   - increasing rates of assisted conception and associated morbidities [10], and
   - Maternal and perinatal mental health issues;

   Many women are taking drugs to manage these co-morbidities which need rationalisation prior to pregnancy making preconception care critical.

   The RACP agrees that the increasing burden of conditions and complications such as infertility, gestational diabetes, pre-existing diabetes in pregnancy, hypertensive disorders of

[3] Towner, D. et al (1995): Congenital Malformations in Pregnancies Complicated by NIDDM: Increased risk from poor maternal metabolic control but not from exposure to sulfonylurea drugs. Diabetes Care 1995 Nov; 18(11): 1446-1451. Available at: http://care.diabetesjournals.org/content/18/11/1446.short (accessed June 2018)
[4] Wong VW, Suwandarathne H, Russell H: Women with pre-existing diabetes under the care of diabetes specialist prior to pregnancy: are their outcomes better? The Australian & New Zealand journal of obstetrics & gynaecology 2013, 53(2):207-210. Available at: https://obgyn.onlinelibrary.wiley.com/doi/10.1111/ajo.12044 (accessed June 2018)
[5] Systematised, e.g. protocolled meaning all women have BP check and urine check, mental health check for example
[6] AIHW (2015): Australia's mothers and babies 2015 – on brief, page 1. Available at: https://www.aihw.gov.au/getmedia/728e7dc2-ced6-47b7-addd-befc9d95af2d/aihw-per-91-inbrief.pdf.aspx?inline=true (accessed June 2018)
[7] AIHW (2015), page 12
[8] Adult medical illness such as cancer, auto-immune disease, renal, liver, kidney, heart disease, epilepsy for example
[9] Childhood illnesses such as cystic fibrosis, congenital heart disease, end stage lung/liver/kidney/heart disease (transplanted), childhood cancers
[10] Fitzgerald O, Harris K, Paul RC, Chambers GM 2017. Assisted reproductive technology in Australia and New Zealand 2015, page 1. Sydney: National Perinatal Epidemiology and Statistics Unit, the University of New South Wales Sydney. Available at: https://npesu.unsw.edu.au/sites/default/files/npesu/surveillances/Assisted%20Reproductive%20Technology%20in%20Australia%20and%20New%20Zealand%202015.pdf (accessed June 2018)

pregnancy, thrombo-embolic disease (blood clots), increasing caesarean section rates and postpartum complications are best managed in a multidisciplinary team. However, not every woman in Australia has currently access to these highly specialised physician services for these high-risk pregnancies.

Therefore, the RACP strongly recommends that obstetric physicians are included in the model of maternity care called *Public hospital high risk maternity care* (page 14 of the consultation paper). These multidisciplinary teams are caring for the increasing numbers of women with medical co-morbidities under this model of care. For those with pre-existing Type 1, Type 2, or rare forms of diabetes, a diabetes multidisciplinary team including an endocrinologist with an interest in diabetes in pregnancy, educator and dietitian should be included, in addition to the obstetric physician.

2. A lack of emphasis on the importance of specialist preconception care. Preconception care is critical for the health of future Australians. Preconception assessment of pre-existing diabetics for example is essential to improve blood glucose control and prevent fetal malformations. As explained above in our response to question 3, poorly controlled diabetes in the first trimester increases rates of miscarriage and serious congenital malformations. These complications can be improved by good preconception diabetes control. Specialist preconception care has been demonstrated to be cost effective and prevents adverse pregnancy and neonatal outcomes, including congenital anomalies. There is indisputable evidence for this in pre- pregnancy diabetes.[11,12,13]The RACP recommends that a national statement and national support for high quality preconception care is included in the National Strategic Approach to Maternity Services.

   Similarly, there is growing evidence that preconception weight loss in obese women improves pregnancy outcomes and reduces medical complications. Weight loss also improves fertility rates and reduces the need for expensive reproductive technologies.

   The RACP makes the case above but more research is also critical to show the benefits of preconception care. As such, the RACP disagrees with the following statement presented on page 15 of the consultation paper: *There is a lack of randomised controlled trial evidence on the effectiveness of preconception care in improving outcomes for women who are overweight or obese[25] or women with diabetes.[26]* The RACP recommends deleting or revising the statement to remove the emphasis on randomised controlled trials for e.g. pre-pregnancy care when a known key issue is non-attendance prior to pregnancy and therefore population based approaches are a better study design.

3. Inequitable perinatal mental health care - lack of emphasis of assessment of mental health issues prior to pregnancy and appropriate management of these during pregnancy is essential for good outcomes for the mother and baby. There also needs to be an emphasis on postpartum mental health and appropriate perinatal mental health services which are often deficient, particularly in rural and remote areas in Australia.

4. Poor access to specialist pre-pregnancy and antenatal care for women in remote, regional and rural Australia - particularly for Aboriginal and Torres Strait Islander women and women with obesity, diabetes and chronic medical conditions. Since 2000, Aboriginal and Torres

[11] Egan, A M et al (2016): A pre-pregnancy Care Program for Women with Diabetes: effective and cost Saving. J Clin Endocrinol Metab, April 2016, 101(4):1807–1815.
[12] Murphy HR, Roland JM, Skinner TC, Simmons D, Gurnell E, Morrish NJ, Soo SC, Kelly S, Lim B, Randall J et al: Effectiveness of a regional prepregnancy care program in women with type 1 and type 2 diabetes: benefits beyond glycemic control. Diabetes Care 2010, 33(12):2514-2520. Available at http://care.diabetesjournals.org/content/33/12/2514.short?rss=1&cited-by=yes&legid=diacare;33/12/2514&patientinform-links=yes&legid=diacare;33/12/2514 (accessed June 2018)
[13] Yamamoto, Jennifer M. et al (2018): Community-based pre-pregnancy care programme improves pregnancy preparation in women with pregestational diabetes. Diabetologia (2018) 61: 1528. https://doi.org/10.1007/s00125-018-4613-3 (accessed June 2018)

Strait Islander women have been significantly more likely than other Australian women to die in relation to pregnancy from cardiovascular causes, suicide, hypertensive disorders, obstetric haemorrhage, sepsis and in early pregnancy.[14]

5. What four to six key improvements would you like to see in maternity services in Australia? Please consider these from a national perspective.

Australia is in the grip of an obesity and diabetes epidemic[15, 16]. Management of weight gain, dietary advice, health lifestyle advice, and advice on infant and toddler nutrition needs to be integrated into a seamless package of maternity care, that considers the fact that women and their families are embarking on establishing a family, and raising the next generation of Australians. The RACP argues that the Australian Government needs to invest in understanding how to give future Australians the best start in life.

The RACP recommends that antenatal or obstetric care be closely connected to paediatric care to ensure best outcomes for mother and baby. Healthy infant behavioural and emotional development, self-regulation and attachment are recognised as fundamental building blocks for adolescent and adult mental well-being and healthy relationships with others.

The RACP would recommend the following key improvements:

1. A nationally coordinated emphasis on pre-pregnancy health assessment to address any pre-existing obesity, hypertension, and diabetes which may be undiagnosed. Preconception care for women with existing complex medical conditions such as obesity, pre-pregnancy diabetes, hypertension and other complex health needs is vital as current rates of congenital malformations are unacceptably high due to poor preconception care particularly for diabetes.[17] The RACP recommends that pre-pregnancy care includes an assessment of maternal mental health issues prior to pregnancy as appropriate management of these is essential for good outcomes for the mother and baby. One model shown to be associated with reductions in malformations and perinatal mortality is the public hospital based multidisciplinary diabetes pre-pregnancy clinic[18].

2. Funding and resources for integrated perinatal mental health services are needed to support women with complex health care needs, who often experience difficult transitions to parenting. Many women with obesity, gestational diabetes and pre-pregnancy diabetes also experience depression, anxiety, and complex trauma[19]. These individuals need long term support to recover from severe childhood trauma and therefore need assistance in their transition to parenting, in the context of complex ongoing health needs and co-morbid mental health issues.

   Perinatal mental health also incorporates attention to the dyadic nature of infant mental health and to parental mental health and emotional wellbeing. The implications of a failure to prevent, identify and treat dysfunction in this area are felt in not only the current family but

[14] Australian Institute of Health and Welfare (AIHW) (2017): Maternal deaths in Australia 2012–2014. Cat. no. PER 92. Canberra: AIHW, page 16
[15] AIHW (2018: Australia's Health 2018. Chapter 4.10 Overweight and obesity. Available at: https://www.aihw.gov.au/getmedia/4b395076-f554-4818-9150-64ffe2fc3039/aihw-aus-221-chapter-4-10.pdf.aspx (accessed June 2018)
[16] SMH 20 June 2018: Australians are fat and getting fatter, says national report card Available at: https://www.smh.com.au/national/australians-are-fat-and-getting-fatter-says-national-report-card-20180619-p4zmgt.html (accessed June 2018)
[17] Correa A, Gilboa SM, Besser LM, et al. Diabetes mellitus and birth defects. Am J Obstet Gynecol 2008; 199:237.e1-237.e9. Available at: https://www.sciencedirect.com/science/article/pii/S000293780800639X (accessed June 2018)
[18] Wahabi HA, Alzeidan RA, Esmaeil SA (2012): Pre-pregnancy care for women with pre-gestational diabetes mellitus: a systematic review and meta-analysis. BMC public health 2012, 12:792. Available at https://www.ncbi.nlm.nih.gov/pubmed/22978747 (accessed June 2018)
[19] Hemmingson, E. et al (2014): Effects of childhood abuse on adult obesity: a systematic review and meta-analysis. Available at: https://onlinelibrary.wiley.com/doi/pdf/10.1111/obr.12216 (accessed June 2018)

are also intergenerational. Parental depression, particularly postpartum depression, is acknowledged as having the potential to make a negative impact on the ability of that mother and child to form an attachment.[20] Therefore, the RACP is concerned about the insufficient numbers and distribution of publicly funded mother-baby unit beds providing seven days care for women with a severe postnatal episode in Australia with no unit beds available in the ACT, NT and Tasmania. The inequitable access to, and distribution of, specialist and community perinatal mental health services for women with moderate to severe mental health issues needs to urgently be addressed.[21]

3. Nationally standardised access to specialist care for pregnant women with obesity, diabetes and chronic medical conditions regardless of where they live including streamlined referral processes and timely access to care. When these women have been assigned to continuity of midwifery care models, integration between specialist care and midwifery support needs to occur.

   The RACP acknowledges that midwifery case managed models of care work well for women with complex health care needs. Under these arrangements, the midwife accompanies the individual to all specialist appointments to coordinate their care. This can improve patient-doctor understanding and engagement giving women the midwifery support they require as well as access to specialist care.

4. Universally available postnatal care should prioritise support for breastfeeding and focus on postpartum mental health for both parents. The RACP is concerned that appropriate mental health services for postpartum parents are often deficient and not readily accessible, particularly in rural and remote areas (see also above).

   There is convincing evidence that breastfeeding may prevent women who experienced gestational diabetes from developing Type 2 diabetes.[22] Breastfeeding rates in Australia need to be much higher, particularly breastfeeding in women who have diabetes and obesity should be prioritised for support. The RACP acknowledges that the Australian Government is currently developing a National Breastfeeding Strategy which seeks to achieve the WHO's global nutrition target of increasing the rate of exclusive breastfeeding in Australia in the first six months up to at least 50% by 2025.[23]

5. Provide women with greater access to GP Management Plan for Chronic Disease Management appointments before and during pregnancy. The Department should investigate lifting the current 'exceptional circumstances' restriction, allowing services to be provided more frequently in such cases, and including access to specialist and allied health professionals.

[20] Schore A. N. The effects of early relational trauma on right brain development, affect regulation, and infant mental health. Infant Mental Health Journal. 2001; 22(1-2): 201–269

[21] As reported in the consultation paper on page 21

[22] Gunderson, E. P. et al (2018): Lactation duration and progression to diabetes in women across the childbearing years the 30-year CARDIA Study. JAMA Intern Med. 2018;178(3):328-337. Available at: https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2668634 (accessed June 2018)

[23] Department of Health (2018): Australian National Breastfeeding Strategy: 2018 and Beyond – Draft for public consultation – 22 May 2018. Available at https://consultations.health.gov.au/population-health-and-sport-division/breastfeeding/supporting_documents/Draft%20Australian%20National%20Breastfeeding%20Strategy%20%20%20PDF%20version.pdf (accessed June 2018)

6. Are there specific strategies that you could suggest for rural and remote services and/or, Aboriginal and Torres Strait Islander women and/or, women from culturally and linguistically diverse backgrounds?

The RACP recommends the following for rural and remote services, Aboriginal and Torres Strait Islander women and, women from culturally and linguistically diverse backgrounds:

1. Individual midwifery case management models.This should include the capacity for home visits and specialist consultations via telehealth in rural and remote areas of Australia.

   As mentioned above (at question 5), the RACP believes that midwifery case managed models of care work well for women with complex health care needs. Under these arrangements, the midwife accompanies the individual to all specialist appointments to assist in coordinating their care. This can improve patient-doctor understanding and engagement giving women the midwifery support they require as well as access to specialist care.

2. Introduction of Primary Nurse Practitioner / Midwife for rural regions to assist women (with medical complications of pregnancy e.g. diabetes, hypertension, renal issues) who cannot access/attend tertiary care by liaising with tertiary centres on their behalf to provide tertiary knowledge and care.

7. How will success be measured or how will we know if strategies are being successful?

The RACP recommends monitoring the consistency, utilisation and quality of maternity services across all jurisdictions in Australia with routinely collected data that can be easily collected by maternity service providers. These data should disaggregate maternal health condition prevalence and relevant pregnancy outcomes by locality, ethnicity and socioeconomic status.

The RACP supports the National Perinatal Data Collection by the Australian Institute of Health and Welfare (AIHW) and the Maternity Information Matrix (MIM)[24]. To measure the success of the NSAMS the RACP recommends that 3 - 5 National Key Performance Indicators for each Model of Maternity Care be collected by State and Territory Health Departments and benchmarked Australia-wide by for example, the Australasian Diabetes in Pregnancy Society (ADIPS).

[24] The Maternity Information Matrix (MIM) is a summary of data items in Australian national and jurisdictional data collections relevant to maternal and perinatal health. Available at: http://maternitymatrix.aihw.gov.au/Pages/About-the-MIM.aspx (accessed June 2018)