

Robyn Williams: Our next speaker is Rosemary Bryant who was Executive Director of Royal College of Nursing, Australia for eight years before being appointed to the new position as Chief Nurse and Midwifery Officer of the Department of Health and Ageing. Rosemary has had a career in acute hospital and community nursing as well as government relations in the Victorian Health Department. She has had experience in the area of nursing education policy, policy for regulation of nursing and so on with the World Health Organisation and was in the Nepal Nursing Council as well. She was elected Member of the Board of the International Council of Nurses in 2001 and was elected as its Second Vice-President in 2005. She is here to talk to us about investing in rural maternity services. Rosemary Bryant.

Investing in rural maternity services

Rosemary Bryant¹

¹Chief Nurse and Midwifery Officer

Thank you, Robyn, and good morning everyone. Yes, I was at the Royal College of Nursing Australia for eight years but I've actually, some people would say, have gone over to the dark side in that I work for the Department of Health and Ageing now. First of all I would like to acknowledge the traditional owners of the land where we are meeting today. I'd also like to thank the Rural Health Alliance for inviting me to speak to you today.

It's actually a bit of a relief to be speaking following last Tuesday because, in the few months in leading up to Tuesday, I actually had to get up and fudge a bit about what I had been doing because, of course, I had been working on the significant reforms in the area of maternity services and nursing within the budget. I was appointed to my position in July last year so, of course, it's the first time I've been through a budget cycle. I'm very pleased to be here to talk about the review which I led and, in particular, the outcomes of the review and the steps the government is taking to act on its recommendations. But at the outset I would like to confirm the support of the Minister for Health, the Honourable Nicola Roxon MP, for rural health services.

Australia, as you probably know, and if you've read the maternity services report, is one of the safest countries in which to give birth or be born. However, there is, of course, always room for improvement. A maternity services review was undertaken because the government was concerned that the health system was not meeting the needs of all Australian women and their families as well as it might. After many years of the declining birth rate, recent years have seen a reversal of this trend. This reversal, along with workforce pressures, led the government to look at how to provide safe, high quality maternity care based on good evidence to Australian mothers and their babies and, in fact, we probably, I'm told, will reach about 300,000 births this year.

The maternity workforce, as with the overall health workforce, is characterised by workforce shortages. Rural and remote Australia has experienced medical workforce shortages for a considerable period—I don't need to tell you this—but particularly in general practice and obstetrics and gynaecology. Whilst there's not a particular shortage of nurses and midwives, there are pockets, of course, where particularly midwives are in short supply. While mortality and morbidity rates connected to childbirth have improved, the gains are not shared equally across the population. Rural and remote families experience higher rates of maternal death, rural women have significantly higher rates of neonatal deaths and remote women have higher rates of foetal deaths.

Today, as I have said, I will be talking about the outcomes from the review and the recently announced budget initiatives arising from the review's recommendations. But before I do that, I would like to thank all of those who contributed to the review and, of course, those submissions, really, sort of broadly could be

divided into two main groups; those from organisations such as the National Rural Health Alliance and other stakeholder groups, and those from individual mainly women—although I did read all the 900 submissions, there were a few from men, but mostly from women, I might say, of varying ages, from sort of new mothers, or people who are not mothers, through to grandmothers, but they certainly shared their stories with me. We also conducted roundtables and the discussion the roundtables and the submissions we received were critical to informing the review team and in helping us prepare the final recommendations. So you can see up there a précis of the recommendations.

The findings of the review provide recommendations for the future of maternity services in Australia and the recommendations from the report canvass the following issues: the need to improve choice and access to a range of collaborative models of maternity care; the need to improve the evidence base for practice through guidelines, data collections and additional research; supporting midwives with appropriate qualifications and skills to play a greater role in the maternity care team; improving information and other supports available for women throughout pregnancy; and supporting the maternity workforce, particularly in rural Australia and, of course, as a subset of that, improving the numbers of Indigenous members of that health workforce. Not surprisingly, rural remote and Indigenous issues featured strongly in the review with six of the 18 recommendations from the final report directly related to addressing inequalities in maternity services which are experienced in rural remote and Indigenous communities.

So, the budget, what happened last Tuesday. Of course, as I've in fact spoken twice publicly since last Tuesday and it's interesting for those who just have access to the newspaper, some of the detail of these reforms was not contained in there, so I hope this might provide a better explication of what is actually in the budget papers. Our budget document was over 700 pages, so one can understand why. So the government has now responded to the report with the maternity reform package announced last week and it is \$120.5 million, a package of measures designed to improve choice and access to maternity services for women who are pregnant and for new mothers in Australia. As a result of this package, families will have greater choice in the type of care they wish to receive when having a baby. The package also recognises the important role played by appropriately qualified and experienced midwives in the birthing experience of many Australian women, and many of the submissions were advocating for that change.

So the package itself includes: Medicare Benefit Schedule and Pharmaceutical Benefit Schedule rebates for services provided by midwives to provide greater access to maternity care provided by those midwives working in collaboration with doctors; a government subsidised professional indemnity insurance scheme for eligible midwives—and some of you will be aware that there has been no such scheme available for midwives since 2002 and more services for rural and remote communities where the state of maternity services is poor, through the expansion of the successful medical specialist outreach assistance program. This program will enable more than 9500 women and their babies living in rural and remote communities to be able to access antenatal and postnatal services in their local community. The integrated outreach maternity services teams will comprise obstetricians and/or registered midwives, maternal and child health nurses and/or allied health professionals such as dieticians and Aboriginal health practitioners.

And again something which has been raised by previous speakers, there will be extra scholarships for general practitioners and midwives to expand the maternity workforce, particularly in rural and remote Australia. It will fund 110 eligible GPs over four years to undertake the additional training necessary to become a GP obstetrician or a GP anaesthetist. It will also fund 20 scholarships each year for midwives to obtain the formal qualifications to be able to provide Medicare subsidised services and access to the Pharmaceutical Benefits Scheme. Expanding and improving the existing national pregnancy telephone counselling helpline to deliver a new 24-hour, seven days a week telephone helpline and information

service to provide women, their partners and families with greater access to maternity information and support before and after birth.

Finally, the package also includes funding for improvements to national maternity data collection and for a small program of research aimed at improving the safety and quality of maternity services. I personally was quite amazed to find that we really have quite a paucity of data around maternity services as the collections in each state differ through issues of definition and support and funding. We, of course, have to have data to be able to make informed decisions about improving services.

The package will be implemented progressively through the development of a national maternity services plan with new arrangements for midwives beginning from 1 November 2010. For those of you who think that's a long way off, again, the devil is in the detail. There's a lot of work to be done before that and we deliberately chose that date because it is after the implementation of the recently announced decision to go ahead with the national registration from the 1 July 2010. So we hope all the building blocks will fall into place. But I should note though that the arrangements are subject to agreement with states and territories on a national maternity services plan because, of course, the Commonwealth does not deliver the majority of maternity services or, indeed, fund the majority of maternity services. The states and territories will be asked to make complementary commitments and investments, particularly around the provision of birthing centres and rural maternity units.

At the heart of these reforms is increasing choice for women, better utilisation of the midwifery workforce and encouraging collaborative models of care. The reforms provide the opportunity for an expansion of models of maternity care that can better respond to the local needs of women and their communities. This, of course, will particularly benefit women in rural and remote areas. I was reminded yesterday, listening to our Canadian presenter, Joshua Tepper, we did in fact receive information about an Inuit model of care for remote communities which we will be drawing upon in the development of the maternity services plan.

It's important to emphasise that these reforms will not be at the expense of safety and quality. For midwives to be eligible to provide services under this measure they will need to meet new credentialing requirements to ensure that midwifery practice is of a high standard, involving collaborative care arrangements with GPs, obstetricians and hospitals.

Another important and, in fact, I think, central part of the package is funding for the National Health and Medical Research Council to develop new national cross-professional guidance to support collaborative maternity care. What does that actually mean? I know that I have read that there are different interpretations of what that actually might mean. So we do need to get that sorted out. It was a recurring suggestion raised in the review. The benefits of collaborative maternity care arrangements were highlighted to the review team. The arrangements involve health professionals working together to provide care in accordance with a woman's needs. It recognises the different roles, knowledge, skills and experience that all members of the maternity care team bring to providing Australian women with the best possible care throughout their pregnancy, birth and postnatal period.

Midwives participating in the new arrangements will not be limited to providing care on behalf of medical practitioners but will be able to treat their own patients who will then have access to Medicare benefits. As part of the collaborative approach, midwives will need to demonstrate that they have appropriate referral pathways in place—again a safety and quality issue—for example, with hospitals and obstetricians in order to obtain a Medicare provider number and a Pharmaceutical Benefits Scheme provider number.

So our next step is the national maternity services plan. Maternity services in Australia are a complex mix of Commonwealth, state, territory and private arrangements. About 60 per cent of births take place in the

public sector. While this maternity reform package represents a significant investment from the Commonwealth, it is clear that there are issues that can only be addressed through a coordinated approach of all governments in the context of an agreed plan, such as the priority areas of rural maternity services and birth centres and it is really important that we get it right. One of the submissions I received indicated that there had been something like 19 reviews of maternity services in this midwife's lifetime. I may have the number wrong, but it was an awful lot, put it that way.

So it's for this reason that the government is committed to developing a national plan for maternity services across Australia and the plan will need to be in place before the proposed start of the new Medical Benefits Scheme arrangements for eligible midwives on 1 November 2010. We have actually started the process for developing the plan with state and territory governments and will be consulting with key stakeholders in order to ensure that this an effective plan for future years. As with many things, a stakeholder group will be established to provide advice to the Department of Health and Ageing on the implementation of the reform package, including the national maternity services plan. I can assure you, there will be more than one stakeholder group depending on what the issue is we are actually developing. So there will be a number of stakeholder groups. The priority areas for discussion with states and territories on the plan will be the availability of rural maternity services and birthing centres.

So if I were to sum up the maternity reforms, I would describe the key elements as follows: they build on Australia's strong record of safety and quality; they support collaborative care arrangements across the maternity workforce; they provide more choice for women; and they recognise that while Commonwealth leadership is vital, the solution will require state and territory health professional and consumer engagement. There is a good model from the UK. For those of you who are very familiar with maternity service provision, the UK has a wonderful charter which I hope we will be building on.

For me personally, this has been a very rewarding time. The maternity services review was one of my first, or probably the first major project as the Chief Nurse and Midwifery Officer and the response to it has generally been very positive. However, this is just the first stage though in the reform process and I look forward to continuing to work with women and their families and other stakeholders as the Department begins to implement the raft of budget initiatives. Thank you.

Robyn Williams: Thank you, Rosemary. Before you leave, with so much news, we've got a few moments for questions, if you wouldn't mind staying. There are microphones spread around the place. So questions for Rosemary on some of those initiatives you've heard.

Peter Eastaugh: Thank you for that. I'm Peter Eastaugh. I'm a paediatrician. I'm a little disappointed not to hear at least some acknowledgement of the role of paediatricians and the care of babies and doing government reviews of neonatal deaths. I frequently come across people who are extremely well-credentialed in the care of babies yet do not demonstrate competence. I do believe that credentialing is an important aspect but competence has to be attached to that. I would strongly recommend that some acknowledgement to the role of paediatricians and neonatal resuscitation be incorporated in your processes.

Rosemary Bryant: Thank you. First of all, we were a little disappointed that no paediatricians came to our roundtables. They were invited but did not participate, so we were disappointed about that. That's the first thing. Second is that paediatricians are on our list of key stakeholders, so there will be some contact with paediatricians. Thirdly, in terms of credentialing, again, what does that mean? The credentialing of midwives will be determined by a small group of stakeholders. From my understanding of the word "credentialing", it does include competency. I totally agree with you in terms of competence because we can have all the paper qualifications or educational qualifications but actually doing things and being competent to provide care is particularly important.

Ellen McIntyre: Thanks, Robyn. Ellen McIntyre. I'm from the Primary Health Care Research and Information Service at Flinders University, but I'm also a lactation consultant. I'm just wondering what would the competent midwife look like and how many of them do we currently have that will be able to use those MBS and PBS items and will it include anything on breastfeeding?

Rosemary Bryant: Thank you. Going on from my earlier response, what a competent midwife will look like will be determined by a group of key stakeholders which will include midwives, of course. We believe that a competent midwife will, of course, have education in knowledge of medications needed for access to the Pharmaceutical Benefits Scheme and that list again will be determined by a group. We have not yet, because we haven't met with a group yet, determined the final qualifications of a competent midwife, but we have done some work on how many midwives there are practising independently at the moment. A large number of them would qualify to be what we would call nurse practitioners, in other words, they are registered as a nurse practitioner with, in brackets, midwifery or, indeed, a midwife practitioner. That exists only in New South Wales at this time. There is a large number. But we will, of course, provide scholarships for midwives to be able to access the requirements which will be determined to become competent midwives or eligible midwives.

Ellen McIntyre: Certainly the Lactation Consultants Association will be very willing to help in building up these competent midwives so that breastfeeding is included as well because that's really important too.

Rosemary Bryant: Yes, it is. There is quite a lot on breastfeeding in our report as well. They are one of the areas to which the new national helpline will be referring patients to, or clients I should say.

Ellen McIntyre: Yes. We have certainly seen the Australian National Breastfeeding Helpline being set up in January this year and it's going really well. That's totally supported by volunteers. So this is a really amazing thing that these women do. So, thank you, and we'll be in touch.

Lesley Barclay: Lesley Barclay. I'm speaking, I guess, as an old midwife, not necessarily related to years, though that actually is probably correct as well, but having been involved in midwifery now and maternity care research, I was part of the first council for safety and quality that actually sponsored the Australian College of Midwives to undertake research and then work in practice development that has actually built, as far as the profession goes, credentials for competency and scrutiny of practice. So many people may not be aware of the fact that this now has been going on for about two years and is a very good research base practice that many, many midwives, salaried and non-salaried midwives, have gone through. So it's a very good foundation to work further with government on this next step.

Rosemary Bryant: Thanks, Lesley. We're very aware of that program and we will certainly be drawing on that program to determine the requirements for the advanced practice midwife. Thank you.

Robyn Williams: Thanks very much. And before I ask the next question, if anyone would prefer me to leap up the stairs, just put your hand up. Over here. Don't be shy. But we've got another question there. But wave at me otherwise for the next one, please.

Cory Bingden-Heath(ph): My name is Cory Bingden-Heath. I'm a midwife from a rural town in South Australia. And I suppose my comment is for—the comment I wanted to put to you is about the last bit about—

Rosemary Bryant: I'm sorry, I can't hear you very well.

Cory Bingden-Heath: I'm sorry, being over 6 foot this microphone's in the wrong spot.

Robyn Williams: Shrink.

Rosemary Bryant: That's much better, thank you.

Cory Bingden-Heath: It was around your last comment around the scholarships—

Rosemary Bryant: Yes.

Cory Bingden-Heath: —that are being put forward. I suppose, as a midwife, I was disappointed to hear the number is 20 and the number for obstetricians and GPs are up over 100, especially when, in my observations in years as a midwife, the bulk of the care is actually given by midwives. So I wonder—because that's less than three per state, which is, I'm sorry, in my observation, a bit tokenistic.

Rosemary Bryant: Thank you. I think that that—we just need, again, to contextualise that. The Australian government has a large number of scholarships for nurses and midwives which are particularly targeted at rural, regional and remote areas. So although 20 might not look like an awful lot, we recently announced, late last year, scholarships for nurse practitioners. We also have—I can't give you the number off the top of my head at the moment—but a large number of scholarships for postgraduate nurses and midwives living in rural and remote areas. So it's an augmentation, shall we say, targeted at midwives specifically, but, if you take it in the overall, there are quite a number of scholarships for nurses and midwives living in those areas. I will, however, take your comment back.

Cory Bingden-Heath: Thank you.

Robyn Williams: And may I give you a present.

Rosemary Bryant: Thank you.

Robyn Williams: And thank you for taking all of those questions.

Rosemary Bryant: Thank you. Thank you.

Robyn Williams: And, indeed, thanks for your questions. There will be more on other occasions, of course.

Presenter

Rosemary Bryant commenced in the position of Commonwealth Chief Nurse and Midwifery Officer in July 2008. She was formerly Executive Director of the Royal College of Nursing, Australia, a position she held for eight years.

She has had a broad career in acute hospital and community nursing, as well as in government relations. Executive positions she has held include Director of Nursing at Royal Adelaide Hospital and also at the then Child, Adolescent and Family Health Service in SA and the chief government nursing position in Victoria. She also spent some time in private consulting undertaking projects on nursing and health. During this time she was a consultant to the World Health Organization.

Rosemary has had a broad experience in policy development both in nursing and the broader health sector. Her academic interests revolve around the regulation of health professionals, having had practical experience as a member of three nurse regulatory bodies.

Rosemary was elected as the Second Vice President of the International Council of Nurses in 2005.

