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Royal Australian College *of* General Practitioners

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28 November 2018

Ms Karen Cook
Senior Nursing and Midwifery Adviser
National Strategic Approach to Maternity Services
MDP 515
Australian Government Department of Health
PO Box 9848
Canberra ACT 2601

Dear Ms Cook,

Re: Strategic Directions for Australian Maternity Services consultation

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide comment on the Department of Health's second round of consultation for the *Strategic Directions for Australian Maternity Services*.

The RACGP provides some general comments on the paper, as well as comments relating to the specific values and principles outlined in the draft document.

A team approach to obstetric care

The RACGP is concerned that fragmentation of care will occur when maternity providers cross-refer to allied health and specialist services without reference back to the GP. GPs provide comprehensive whole-person care, with many infants and children visiting their GP on a frequent basis[1]. Cross-referrals often result in extra cost to patients and a lack of information flow back to their GP.

The WHO recommendation and Cochrane Review[2] are only partly applicable in an Australian context where, uniquely, GPs can provide highly skilled care with high levels of continuity. GPs often play a key role in longitudinal management of a pregnant woman. It is highly likely the regular GP has provided care before pregnancy and will continue to do so post-delivery for both the woman and her child.

GP involvement in obstetric care has the potential to improve long-term health outcomes for both the mother and child[3]. GPs provide developmental checks, immunisation advice, parenting interventions, postnatal depression management and manage co-morbidities. The RACGP is concerned that models of obstetric care in the current draft document seem to focus on care until 6 weeks post-partum and predominantly for low-risk women. Re-organisation of maternity services as described in the document would effectively exclude GPs, and may result in unintended consequences. One consequence will be a loss of continuity of care. Continuity of care has been associated with increased patient satisfaction, greater adherence to medical advice, decreased use of hospital services and lower mortality rates[1].

Resolving ongoing cultural issues

It is important to recognise that cultural problems exist between some midwifery and obstetric specialist services. GPs are often trying to find the middle ground. These differences should be addressed by building a team approach to all care pathways in order to provide optimal care and choices to pregnant women.

A focus on measurable outcomes of care

The RACGP suggests a key focus on measurable outcomes of care such as maternal and baby health outcomes including patient reported outcome measures (PROMs), experience measures (PREMs) and indicators on the sustainability of the medical workforce. The RACGP advocates for ongoing research into Australian models of care with attention to the quadruple aims of quality improvement[4]: health outcomes, patient experience, costs and health provider experience.

Specificity to the Australian context

Australia has unique features that make international comparisons of models of care delivery problematic. According to the 2016 Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Activities Report, there are 2569 GPs with additional qualifications in obstetrics, compared to 1817 RANZCOG Fellows. Australian GPs who engage in antenatal, intrapartum, and postnatal care are highly trained, compared to GPs in other countries. This is particularly true of GPs in rural and regional areas, where local populations rely on these highly trained GPs for obstetric care. It is essential for GPs to have the opportunity to gain and maintain these obstetric skills, so hospital services in urban and regional areas need to provide access for GPs to do this.

Consequently, the RACGP is concerned about the ongoing reduction in the choice and availability of maternity services in rural areas. It is vital that these services are not eroded. This report should recommend a system for:

- monitoring the availability of maternity services
- out of pocket expenses
- waiting times.

This information should also be made publicly available, so that state and federal providers are held accountable.

Overdiagnosis

The RACGP believes that the report should provide focus on the risks, costs and harms of overdiagnosis. A systematic review of the evidence and adequate peer review is required, with consideration of wider implications, before updates or changes are made to existing guidelines. As an example, changes in the diagnostic criteria definition of gestational diabetes has led to an increase in the number of women defined as having the condition without improvements in outcomes. This has ongoing consequences for the costs and sustainability of maternity care, in addition to the lifelong implications of women who are placed in this category.

The following comments concern the specific values and principles outlined in the draft document.

2.2 – Improving access to maternity care
This report should recognise that access to maternity services close to home can be best achieved by supporting the patient's known and trusted GP to provide a proportion of maternity services.

2.3 – Improving access to mental health support
This report should recognise that GPs provide the majority of mental health case-finding, management and relapse prevention in the Australian community. There are no other widely accessible health providers with the skills, experience and access to treatment options.

3.1 – Providing information about local maternity services
This section should acknowledge that many GPs can offer antenatal and even intrapartum care. GPs also provide shared antenatal care. It is important for all women to have a regular GP for intercurrent illness and the management of risk factors and chronic diseases. The RACGP believes it is important for GPs to have the opportunity to maintain and use skills in antenatal and postnatal care so that GPs can appropriately manage this aspect of patient care when a woman visits the GP for an unrelated reason.

4.2 – Supporting the maternity care workforce
This report should recognise that maintenance of a diverse maternity care workforce (which includes GP obstetricians, GP anaesthetists and non-procedural GPs credentialed for shared care) must not be limited to rural and remote settings. The risk of a rural-only approach is that urban living clinical and other healthcare professionals will lack skills and confidence to practice rurally, contributing to ongoing workforce shortages.

Implementation
The RACGP proposes this report clearly articulate the measurements of successful implementation.

Thank you again for the opportunity to comment. For any queries on the RACGP's submission, please contact Mr Stephan Groombridge, Manager, e-health and Quality Care at (03) 8699 0544 or stephan.groombridge@racgp.org.au

Yours sincerely

Dr Harry Nespolon
President

References

1. The Royal Australian College of General Practitioners. Maternity care in general practice. East Melbourne, Vic: RACGP, 2018.

2. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5

3. The Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice. 9th edn. East Melbourne, Vic: RACGP, 2016.

4. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med 2014;12:573–6. doi:10.1370/afm.1713