What have we learned from the Australian Rural Birth Index study?

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Background

- Rapid closure of birthing units, mostly rural and remote with 41% (n=255) reduction in maternity services in Australia over the last 20 years
- A Canadian study, led by researchers on this grant, found perinatal mortality for newborns increased the further one is away from services
- Rural women who have to travel for maternity care have increased rates of adverse perinatal outcomes
- Evidence confirms closure of maternity units over a 20 years in Australia and Queensland is significantly associated with an increase in BBA rate
Options

• Primary Maternity Units (PMUs) provide less expensive and more sustainable maternity care, with comparable or better perinatal outcomes for normal pregnancy and birth than higher level units

• Sustainability is a risk

• Australian rural units are medically led contrary to international experience when often midwifery led
Context of study

Planners & bureaucrats believe safe services require 24-hour on-site surgical and anaesthetic capability despite Australian evidence e.g. from a rural maternity unit approximately 1h from the nearest surgical service where:

- Contemporaneously, purposefully collected audit data and medical chart review provided to 2x as many young women & 5x times the average Aboriginal and Torres Strait Islander cohort as most Australian units had excellent results.
- Of 506 women booked to receive care through a midwifery group practice in this unit 74.5% gave birth at the local facility as planned with excellent outcomes
- Those transferred out in a timely manner also had excellent results
Our study aimed to

• Use data from around the 170 rural and remote birthing facilities across Australia (11)
• To determine if we could validate a maternity services planning tool for Australia
• Test and apply principles and initial work undertaken in Canada
We were able to do this but

• Fieldwork (4 jurisdiction and 107 staff and 24 consumers) showed contextual factors also needed to be addressed

• Developed a Toolkit with expert assistance

• The Toolkit
  • combines instructions for calculating the score mathematically
  • with questions planned to address to assess contextual and pragmatic issues
  • that impact the ability to deliver the services in a given rural community
We also found

• Closure of services often occurred very quickly without
  • Understanding the consequences locally or
  • Partnership or consultation with community or sometimes even the staff
• Lack of evidence justifying whether services should exist or not
• Exemplified in jurisdictional differences.
• Confirmed by some states more likely to have services than others without either being justified by “need”.
• Neither numbers of local births nor population vulnerability, determined by sociodemographic or clinical need, appeared to be the basis for the existence of or nature of services.
**Additional findings**

- Poor clinical governance of many rural and remote health services.
  - E.g. regional hospitals with staff specialists & registrars not supporting small towns only 100 kms or so away
  - Abdicated responsibility for local GP proceduralists
  - No planning for practitioners leaving & mostly an absence of support or clinical governance for procedural GPs
  - The absence or poor quality of networking, e.g. non qualified nurses trying to lead midwives or maternity services
  - Poor and outdated models of care not using skills of midwives well
Risk

- Fallacious or poorly informed sense of risk governing decisions that often added risk
- Most medical practitioners and health service managers perceived clinical risks were related to access to caesarean section
- Consumer participants and midwives emphasised social risks arising from a lack of local birthing services
- Data shows closure of services adds social risk, which actually exacerbates clinical risk
- e.g. non-qualified staff dealing with unplanned births or these occurring on the roadside,
- Avoidance of antenatal care to avoid being ‘forced’ to relocate to regional centre.
Risk

• Analysis showed that perceptions of clinical risk are privileged over social risk in decisions about rural and remote maternity service planning
• Without understanding they are linked (16).
• Formal risk analyses should consider the risks associated with **failure to provide birthing services** in rural and remote communities as well as the **risks of maintaining services**.