Closing of Level 2 Maternity Services: Understanding the Risks

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• Around 30% of Australians live outside major cities

• Australia has closed 41% (n=368) maternity units over the past 20 years, many in rural and remote areas

• Challenges to services include distances, low population density, staff recruitment and retention and transport

• Closure of rural services reflects a global trend
Evidence of negative health and social effects of closures

Includes increased family stress, distress and costs

Less favourable clinical outcomes for mothers and babies

Exacerbated for Aboriginal Australians—loss of cultural/spiritual significance

*Associated with increase in babies BBA or without maternity care*
• The Australian National Maternity Services Plan (2010), wants maternity care ‘close..to where women live’

• *Despite evidence of safety and supportive policy-continued decline in no. of rural and remote birthing services in most Australian jurisdictions*
What did we do?

• The Australian Rural Birthing Index (ARBI) team, funded by NHMRC, tested a population based planning tool; based on Canadian work

• Mapped services for 1,000-25,000; analysed these

• National experts (n=23) validated and critiqued results
• We undertook qualitative fieldwork to investigate maternity services that had closed, that appeared vulnerable or that seemed to be sustainable.

• Concepts of risk, not need, were crucial to understanding the sustainability or closure of rural maternity services.

• Produced a toolkit; UCRH website
Goal of study reported here

• to explore perceptions & examples of risk related to pregnancy and childbirth in rural and remote Australia

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• their influence on the planning and delivery of maternity services.
• Fieldwork was conducted in four jurisdictions at nine sites with in rural (n=3) and remote (n=6) Australia.

• 117 health service employees including additional interviews with leaders in 4 regional settings

• 24 consumers
Data collection; across 12 months in 2014

- 88 semi-structured individual and group interviews (n=102)
- 3 focus groups (n=21)
- one group information session (n=17)
- 2 researchers conducted fieldwork in 4 jurisdictions
- Field researchers included 3 midwifery researchers; an experienced GP proceduralist and 2 social scientists
- reports were prepared and feedback given to each site
Most medical practitioners/health service managers perceived clinical risks related to access to caesarean section.

Distance matters; Canadian paper.

Consumers were more likely to emphasise social risks resulting from absence of local services.
To describe fieldwork participants’ perceptions of risk and how these influenced the planning of rural and remote maternity services
An interpretation of the data identified two categories of risk:

• 1) Health services risk & 2) Social risk

• Distinct and different definitions were described by women and health service participants
The analysis described differences in definitions but also showed how they were related.

These were labelled as two major themes: 'health services risk' and 'social risk'.

Together they described a 'comprehensive risk'.
COMPREHENSIVE RISK

Health Service Risks
- Clinical
- Operational
- Financial
- Legal
- Political

Social Risks
- Cultural
- Emotional
- Financial
<table>
<thead>
<tr>
<th>Code</th>
<th>Definitions</th>
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<tbody>
<tr>
<td>Clinical Risk</td>
<td>Risk to the mother or baby of an adverse biophysical event.</td>
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<tr>
<td>Corporate Risks</td>
<td></td>
</tr>
<tr>
<td>Legal</td>
<td>Complaints, duty of care, legal an regulatory responsibilities, medico-legal.</td>
</tr>
<tr>
<td>Political</td>
<td>Community, political and media expectations, relations with government, organisational culture.</td>
</tr>
<tr>
<td>Financial</td>
<td>Budget and resource allocation, contract management, risk management processes, fiduciary failures</td>
</tr>
<tr>
<td>Operational</td>
<td>Service models and models of care, clinical and management policies and procedures, workforce management and clinical governance</td>
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## Social Risk

<table>
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<tr>
<th>Code</th>
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<tbody>
<tr>
<td>Cultural</td>
<td>Experiences of threats to traditional values and spirituality.</td>
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<tr>
<td>Emotional</td>
<td>Experience of system-initiated personal or family distress.</td>
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<tr>
<td>Financial</td>
<td>Compromised family budgets due to costs incurred in relocating for birth.</td>
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Most said local services without emergency surgical services would increase clinical risk for mothers and infants.

E.g. a medical practitioner said that it is essential to have caesarean section and anaesthetics for birth services (Field Site 3) and

A health service leader in a regional centre said mothers from small rural towns are safer giving birth at the regional hospital than at their small local hospital (Field Site 7).
The converse

• No one reported services without caesarean section experiencing an adverse or catastrophic events \textit{but}

• Without birthing services available, \textit{all sites} reported unplanned births, often without the presence of skilled staff.
• In the last 12 months there had been six unplanned births at a closed service without staff (Field notes Site 7)
• One woman who could not leave her town avoided antenatal care, presenting at term with a stillborn baby (Field notes Site 3)
• A young mother gave birth to her first baby on the airport tarmac after not accessing antenatal care and presenting in advanced labour (Field Site 3).
• At another site it a 17 year old laboured at home alone for many hours before presenting to the local hospital in advanced labour (Field Site 1)
In a rural town where midwives were employed as nurses they had difficulty extracting themselves from the hospital shift to -

- search for women in the community who had returned without hand over or records being set in a timely fashion (Field Site 7).

Women’s return to the community after birth, added another risk.
Political Risk

- Refusal or too late to transfer led to tarmac & roadside births.
- In one community with a closed service women presented in advanced labour to avoid transfer out of the community.
- An Aboriginal Elder described this as a ‘forcing manoeuvre’ that the community hoped would ultimately demonstrate to staff that local birthing services were essential (Field Site 3).
• A woman asked to delay her transfer from 36 to 37 weeks’ gestation and was told that she would be reported to ‘child safety’ if she did not travel at 36 weeks (Field Site 3).

• Powerlessness in this community led to discussions by Aboriginal leaders with a community legal service about the right of the health service to make women comply with such an unacceptable system and

• Threats of court action (Field Site 3).
A resident in a remote town with no local birthing service told her midwife she did not want to go to the regional hospital for the birth. The woman had an uncomplicated pregnancy and it was her second baby. The midwife discussed this with her as did the visiting obstetrician. woman’s decision and they could not force her to leave. The Director of the hospital was informed and agreed on the condition that the plane would be called when she presented in labour in case of complications. The woman presented in the first stage of labour and gave birth normally. The plane arrived, at considerable cost, and was not needed.
Costs

- Travel is funded by the health system for those without private means of transport and in an emergency.
- At two remote sites we visited the current practice was to send a plane if birth was imminent or the woman was refusing transfer to the regional town, regardless of the reported $10-12,000 expense (Field Sites 1 and 3).
• Clinicians were used to drive women from one small town to antenatal appointments and tests in the closest regional centre (Field Site 4).

• Clinical work time of 6-8 hours was lost per trip.

• Despite this, at this site participants also described six unplanned births in a small nearby non-birthing facility, since local birthing ceased.
A small town with a closed birthing service used a local GP for emergency call outs. One health practitioner was concerned about the skill level of the GP, stating that he/she did not appear capable to deal with emergency callouts and was very nervous. An obstetrician at the regional hub confirmed the lack of qualifications and experience of this GP.
• At most sites safety was compromised by lack of regional support or medical/midwifery oversight.

• Small town staff not embedded in a networks

• services and skills lack eg DoNs without midwifery managing out of date models of care (Field Sites 3, 5, 7) GPs without support/guidance.

• Clinicians not influencing decisions made at executive/board level.
Aboriginal participants emphasised their links to the land and the role that ‘country’ played in their overall health and wellbeing.

Relocation: ‘That link to country is robbed from them – [this is] another form of genocide’ (Field Site 2).
A small regional hospital in a remote area provides birthing services for many remote communities in the region. Even though women would prefer to stay in their communities to give birth, they mostly transfer to this small regional community to give birth at the hospital. When the birthing service at this regional hospital was threatened with closure, Aboriginal participants said that women were not safe to travel a further two hours flying time to a larger tertiary facility. They believed it would be a cause of sickness, significantly increasing the degree of distress caused by threatened closure of the service.
Absence of cultural awareness in staff

Vignette; Location for a smoking ceremony site.

The hospital staff chose a site that was unacceptable and therefore smoking did not occur. Aboriginal participants explained that using hospital grounds as an area to ‘welcome’ babies home is problematic as ‘many Aboriginal people believe that people die in the hospital so lost spirits are walking around’ (Field Site 3).
Emotional Risk

• All participants in this study, Aboriginal and non-Aboriginal, described the distress and loneliness experienced as a result of routine transfer to regional settings at 36-38 weeks gestation.

• Participants told us about the impact on families of having to leave young children and be away from home and family for weeks at a time.
Financial Risk

• One disadvantaged family spent $250 dollars on taxi fares for a routine antenatal appointment in a regional town (Field Site 7).

• A woman told how all the money saved for maternity leave was used to pay motel accommodation for the three weeks before her baby was born (Field Site 3).
Discussion

• Perceptions of biophysical risk or negative clinical outcomes were **NOT** based on research evidence, probability rates or prior experience.

• Clinical risk was privileged in the planning of rural and remote maternity services
• Canadian research undertaken at two points of time and with large ‘all risk’ rural populations found that those from communities with PMUs had better outcomes than those from communities without local services. The study population included 150,797 women.

• Excellent results from Mareeba study; Qld, large Aboriginal population.
Cultural, emotional and financial risks for women add risks to health services

- Closure of rural birthing services creates significant family risks but also risks for the health service
- Women may avoid antenatal care and health professionals to prevent evacuation and increase clinical risk
- Supported by other research studies in both British Columbia and Northern Territory
- In some cases, clinical risk is exacerbated as women arrive in advanced stages of labour to give birth without qualified staff.
Key conclusions

• Our analysis demonstrated that the closure of services adds social risk, which exacerbates clinical risk.

• Analysis also highlighted that perceptions of clinical risk are privileged over social risk in decisions about rural and remote maternity service planning.

1. Why decisions are made and by whom?
2. Evidence that these are wrong
3. How to do better:
   - Risk Analysis
   - Tool Kit