14 November 2023

Select Committee on Birth Trauma

Post-hearing response from AMA (NSW) on behalf of Ms Fiona Davies and Dr Kathryn Austin
Hearing Date: 9 October 2023

Question taken on Notice:
Page 64 of Minutes - Question from Chair: Following on from that, you mention in your submission some of the reimbursement amounts for different appointments. They seem quite low numbers, in regard to those reimbursements. I know you have made a recommendation that that whole space is reviewed. What would you ideally like to see come out of such a review?

Antenatal care is complex, and every birthing parent has different needs, histories, and expectations. Health physicians need an adequate amount of time to support expectant parents through appropriate antenatal care and maternity services. This must be met with adequate remuneration for the level of complex care and time spent with individuals.

As highlighted by our submission, the Medicare Benefits Schedule (MBS) for a routine antenatal consultation is item code 16500, with the scheduled fee provided $51.65. Within the past financial year, 371,318 MBS 16500 item codes have been processed within NSW, the highest amount compared to any other state or territory (1). Since AMA (NSW)'s submission, item code 16500 has been reviewed and raised to $51.90, an increase of just 0.25 cents. This menial increase does not even begin to accurately remunerate health workers, as stated by Vice-President, Dr Kathryn Austin, at the hearing; 'For the incredible value of brining life into the word and the obvious complexity that that takes with it, it is under-resourced and undervalued."

Upon discussions with AMA (NSW) general practitioner (GPs) members, we found it to be common practice that GPs will bill an MBS item code 36 as an antenatal appointment in comparison to a 16500, due to attendance for antenatal consults generally extending beyond the covered time of 20 minutes under 16500. GPs offer a whole-person centred care approach to an individual during pregnancy, catering to physical and mental needs. They provide most of the pre-conception and maternity care for most women, until 20 weeks' gestation, and almost all postnatal care. A more in-depth analysis of the importance of general practitioners in maternity care can be seen in AMA's position statement, attached at the end of this document.

The current descriptor of MBS item 16500 as an ''antenatal attendance'' has not been updated since it was introduced in December 1991, a spokesperson from the Department of Health and Aged Care spokesperson confirmed (2). This does not even begin to depict the level of complexity in antenatal care provided by GPs and specialist obstetricians, it is outdated, and falls short of covering the level of care provided and expected during pregnancy.

AMA (NSW) believes that significant resources are required for continuity of care, collaborative care with a multidisciplinary approach, staffing levels, retention of staff and a review of the rates and items in the Medicare Benefits Schedule. We must have a funding model in which affords medical practitioners the time for what can be difficult and ongoing conversations with parents about the realities of birth, the prevalence of serious and lifelong birth impacts, and to address unrealistic expectations of control. Further funding is necessary to ensure that adequate information is conveyed equally including to young parents, people of culturally and linguistically diverse backgrounds, First Nations people and those in regional, rural, and remote NSW.

AMA (NSW) acknowledges that this Inquiry is state focused, and the MBS is a Commonwealth program. Highlighting these limitations in trying to deliver good antenatal care when the rebates are substantially lower is critical, as this either affects the time spent with a patient or the patient's out of pocket costs.

AMA (NSW) recommendations that the committee propose recommendations to the Australian Government to review the Medicare Benefits Schedule with a view to improve remuneration for all healthcare providers within the maternity and obstetrics specialty.

References:

1. http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp
2. https://www1.racgp.org.au/newsgp/professional/mbs-antenatal-care-item-descriptor-doesn-t-scratch#:~:text=GPs%20are%20pushing%20for%20an,it%20was%20introduced%20in%201991.

Transcript corrections:

A **PDF** of transcript corrections has been attached here for the Select Committees official record.

General Practitioners in Maternity Care

2021

Introduction

1. With almost 85 per cent of Australian women[1] having children during their lives, the care that is required before, during and after pregnancy is one of the most common reasons women and their families encounter the health system in Australia.

2. The period from pre-conception until 12 months after birth may be the most important influence on the lifelong health of a child.[2] For this reason, the health and wellbeing of women at the time of conception is fundamental to their health during pregnancy, as well as to the health of the newborn, and influences child health outcomes strongly.[3]

3. As the age of women becoming pregnant increases, and lifestyle diseases and risk factors increase, an increasing number of women have general health issues that need to be addressed before, during and after a pregnancy, to optimise the health and wellbeing of their children.

4. Evidence shows that lack of continuity of care in the postnatal period is associated with adverse outcomes for the mother and baby; for example there is an increased risk of readmission of neonates to hospital, a higher incidence of breastfeeding problems, and perhaps most importantly lack of recognition of postnatal depression and other mood problems.[4]

5. Optimal maternity care is provided by a multi-disciplinary team of health professionals led by an obstetrician or GP-obstetrician in partnership with a patient's usual GP, and includes midwives, nurses, physicians, allied health professionals and Aboriginal health workers. Only an obstetrically trained doctor[5] can provide maternity care for the entirety of pregnancy.

General Practice and maternity care

6. General Practitioners have the most comprehensive training of all maternity care providers when addressing whole person health needs. GPs provide almost all pre-conception care, maternity care – for most women – until about 20 weeks, and almost all postnatal care.

7. The GP-led patient centred medical home is a model of care that provides for patients physical and mental health needs by providing comprehensive, team-based, coordinated and accessible services. There is high-level evidence that this model delivers improved levels of health care outcomes, continuity of care, and patient satisfaction.[6] High-quality continuity of care has a strong impact in promoting the best outcomes for mothers and babies,[7] and results in fewer errors.[8] Fragmentation of care is associated with increased costs, higher rates of preventable

[1] Throughout this document we refer to women, however we acknowledge that the content is also relevant for transgender men and people who identify as non-binary.
[2] Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Maternity Care in Australia. 1st edition. 2012. Available from: https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/About/Maternity-Care-in-Australia-Web.pdf.
[3] Dean SV, Lassi ZS, Imam AM, Bhutta ZA. Preconception care: closing the gap in the continuum of care to accelerate improvements in maternal, newborn and child health. Reprod Health. 2014 Sep 26;11 Suppl 3:S1. doi: 10.1186/1742-4755-11-S3-S1.
[4] Fogel N. The inadequacies in postnatal health care. Current Medicine Research and Practice 2017; 7(1): 16-17.
[5] Specialist obstetrician, GP obstetrician, or rural generalist with accredited skills in obstetrics.
[6] See page 21 of Delivering better care for patients: The AMA 10-year framework for primary care reform.
[7] D'haenens F, Rompaey B V, Swinnen E, Dilles T, Beeckman K. The effects of continuity of care on the health of mother and child in the postnatal period: a systematic review. Eur J Public Health. 2020 Aug 1;30(4):749-760. doi: 10.1093/eurpub/ckz082; Kikuchi K, Okawa S, Zamawe CO, et al. Effectiveness of Continuum of Care-Linking Pre-Pregnancy Care and Pregnancy Care to Improve Neonatal and Perinatal Mortality: A Systematic Review and Meta-Analysis. PLoS One. 2016 Oct 27;11(10):e0164965. doi: 10.1371/journal.pone.0164965.
[8] Kroll-Desrosiers AR, Crawford SL, Moore Simas TA, et al. Improving Pregnancy Outcomes through Maternity Care Coordination: A Systematic Review. Womens Health Issues. 2016 Jan-Feb;26(1):87-99. doi: 10.1016/j.whi.2015.10.003.

hospitalisations, and a departure from clinical best practice.[9] As such, the GP-led patient centred medical home is an ideal setting for the provision of all out of hospital maternity care.

8. The provision of safe and accessible maternity care is essential for the health and wellbeing of Australians. The primary objective of all maternity services should be healthy mothers and babies.

9. General Practitioners are trained and ideally placed to provide antenatal maternity care for most women and GP-led models of antepartum care are safe for women with low complexity pregnancies.[10] Care provided by General Practitioners is associated with a high level of satisfaction for patients.[11]

Continuous and Comprehensive maternity care by GPs

10. A woman's usual GP provides the most comprehensive continuity of care. GPs provide pre-conception healthcare, first trimester maternity care and postnatal care to the woman and child. Many GPs also provide second and third trimester care, often in shared maternity care arrangements with hospitals and other maternity care providers.

11. As chronic health conditions and risks become more prevalent in pregnant women, the role and effect of a woman's GP in the provision of non-maternity health care during pre-pregnancy, pregnancy and post-pregnancy is increasingly important. GPs provide the only model of whole person care with a life-cycle view of the pregnancy.

12. Strengthening and supporting the role and ability of GPs to be involved in the entire continuum of maternity care:

    - increases the ability of women to have accessible, continuous whole person care;[12]
    - increases the ability for women to be cared for in their community; and
    - improves equity for women who are marginalised and/or live in rural and regional areas and for Aboriginal and Torres Strait Islander women and women from culturally and linguistically diverse backgrounds.

AMA Position

13. Women should be encouraged and supported to consult with their GP for pre- and peri-conception care.

14. Maternity service models of care must include meaningful and ongoing input from general practice.

15. GPs should be supported, both at a policy level by government policy and at a practical level by maternity services, in providing antenatal (and intrapartum, with appropriate back up) care to their patients of low and normal risk who request their GP to be their main care giver.

16. GP obstetricians, who have more specialised training and expertise in antenatal care and/or intrapartum care, are well placed and should be supported in undertaking antenatal care for higher risk women and undertake intra-partum care in maternity hospitals with birthing units.

[9] Frandsen B, et al, Care fragmentation, quality, and costs among chronically ill patients, Am J Manag Care. 2015: 21(5):355-362.
[10] Lowe S W, House W, Garrett T. Comparison of outcome of low-risk labour in an isolated general practice maternity unit and specialist maternity hospital. The Journal of the Royal College of General Practitioners 1987;37(304): 484-487.
[11] Australian Institute of Health and Welfare. Patient experience of health care. In: Australia's Health 2020. Available from: https://www.aihw.gov.au/reports/australias-health/patient-experience-of-health-care.
[12] Arabin B, Baschat AA. Pregnancy: An Underutilized Window of Opportunity to Improve Long-term Maternal and Infant Health—An Appeal for Continuous Family Care and Interdisciplinary Communication. Front. Pediatr., 13 April 2017. https://doi.org/10.3389/fped.2017.00069.

17. All women must have care led by a doctor with obstetric training. A woman's usual GP is an integral part of the care team. To maximise the health of mother, child and family, all maternity models of care must include a mother's general practitioner as a core member of the collaborative group providing the service.

18. Maternity services must encourage and assist women and their families to have a usual general practice to address their postnatal and ongoing health care for them, their child and family.

19. GP obstetricians providing care in public hospitals should have industrial certainty of jurisdictionally provided indemnity insurance.

20. National and service maternity indicators should include indicators and targets to measure and support the role of GPs in antepartum, partum and postnatal care.

21. Government policy must include increased support, training and skills maintenance for GP obstetricians and rural generalists with accredited advanced obstetrics skills should be a priority.

22. The trend of excluding medical practitioners (GPs, GP obstetricians, and obstetricians) from models of maternity care must be immediately reversed. The trend of reducing comprehensive maternity services in parts of rural Australia must be immediately reversed.[13]

23. The closure of rural maternity services not only reduces access to safe and effective maternity care for the almost 30 per cent of Australian women who live outside of major cities, but also undermines skills of GP obstetricians and rural generalists, nurses and midwives.

24. More than 30 per cent of women in Australia have their babies by lower section caesarean section; many women have other treatment or interventions intra-partum and maternity care has an inherent associated unpredictability. As such, all maternity services need to be supported to provide an ability to undertake an emergency caesarean section, assisted delivery, regional and general anaesthesia, and maternal and neonatal resuscitation.

25. Research in GP-led models of maternity care need to be supported by government and research funders.

26. Funding for GP care should recognise the amount of work and value GPs provide in caring for the maternity and non-maternity related needs of women and their babies.

See also:

AMA Position Statement: Maternal Decision Making 2013
AMA Position Statement: General Practice and Primary Care 2016
AMA Position Statement: Women's Health 2014
AMA Position Statement: A plan for better health care for regional, rural, and remote Australia 2016
AMA Position Statement: Fetal Alcohol Spectrum Disorder (FASD) 2016

[13] The gradual exclusion of experienced GP obstetricians from rural and regional public hospitals in certain states reduces the choice of women in these areas and fragments their care. Denying women the right to be cared for by the GP obstetrician who delivered her previous babies simply because the local hospital no longer supports this model of care is forcing rural women to experience a level of care which would not be denied an urban mother.