Special Commission of Inquiry into Healthcare Funding

Statement of Rebekah Bowman

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Occupation:	District Midwifery Manager, Southern NSW Local Health District

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding as a witness. The statement is true to the best of my knowledge and belief.

2. This statement is provided in response to letters of 28 June 2024 and 19 July 2024 issued to the Crown Solicitor's Office, and addresses the topics set out in the 28 June 2024 letter relevant to my role.

A. INTRODUCTION

3. I am the District Midwifery Manager of Southern NSW Local Health District (**SNSWLHD**). In this role I manage the maternity services provided across SNSWLHD. Specifically, I work in coordinating the coverage of maternity services, conducting clinical reviews, implementing and evaluating new models of care and state and national strategies, expanding the midwifery scope of practice, and working on research projects in collaboration with a range of universities.

4. I report to the SNSWLHD Director Nursing, Midwifery and Clinical Governance. My direct reports are the Clinical Midwifery Consultants, Aboriginal Maternal and Infant Health Service midwives, and the Pregnancy Connect Coordinator for high-risk pregnancies and maternal transfers.

5. Although they do not report to me, I work with facility managers to support them in relation to their maternity services.

6. A copy of my curriculum vitae is exhibited (**MOH.0014.0233.0001**).

B. MATERNITY SERVICES AT SNSLWHD

7. On average, 1500 babies are born each year in SNSWLHD. However, an additional 800 – 1200 women receive antenatal and/or postnatal care in SNSWLHD that go on to birth in Canberra at the Level 6 Centenary Hospital for Women and Children and the Level 4 North Canberra Hospital.

8. The following five facilities in SNSWLHD provide maternity services:

   a. South East Regional Hospital (**SERH**, Bega) – with outreach services provided at Pambula and Eden. Across the last 5 years, an average of 245 babies are born each year at SERH;

   b. Cooma Maternity Service – with outreach services provided at Bombala and Jindabyne. Across the last 5 years, an average of 130 babies are born each year at the Cooma Maternity Service;

   c. Goulburn Maternity Service – with outreach services provided at Yass. Across the last 5 years, an average of 304 babies are born each year at the Goulburn Maternity Service;

   d. Moruya Maternity Service – with outreach services provided at Batemans Bay and Narooma. Across the last 5 years, an average of 259 babies are born each year at the Moruya Maternity Service;

   e. Queanbeyan Maternity Service. Across the last 5 years, an average 545 babies are born each year at the Queanbeyan Maternity Service.

9. The above five facilities provide antenatal, birthing, and postnatal care services; and all have service Level 3 Maternity / Level 2 Neonatal capability services pursuant to the NSW Health Guideline, *Maternity and Neonatal Service Capability* GL2022_022. No SNSWLHD facility has a staffed nursery. As per a Level 2 Nursery, midwives and doctors provide care to a baby requiring assistance prior to being transferred out to a higher level of service, which should occur within 6 hours. Babies that do not require transfer stay with their mothers in a postnatal room and receive care from the multidisciplinary team.

10. Other maternity services in SNSWLHD currently include community health services, (such Child and Family Health Nurses), antenatal and postnatal care at Yass, and the Aboriginal Maternal Infant Health Services – which is offered at Moruya and Queanbeyan.

11. As stated above, I estimate approximately 800 - 1200 SNSWLHD women birth in the ACT each year. This may be for reasons other than service capability, including choice, and closer proximity to their home. There is no current accurate data as NSW and the ACT use data platforms that do not link. Requests have been made to the ACT to clarify

these numbers and reasons. We are awaiting Canberra Health Services to have capacity to provide this.

C. MIDWIFERY GROUP PRACTICE MODEL

12. SNSWLHD has implemented a midwifery model of care called the Midwifery Group Practice (**MGP**). The MGP model is a continuity of care model, where a particular midwife is assigned to a woman across the antenatal, birth, and postnatal periods. The intended benefits are improved outcomes for women and babies and improved midwifery workforce retention. In addition, the model has been shown to reduce costs by 22% in the Australian context[1].

13. This model of care was implemented at Moruya Hospital 10 months ago, and at S 3 months ago. It has also supported SNSWLHD to keep maternity services open and the use of agency staff down by attracting external midwives to the area. For example, in Moruya Hospital, prior to this model being implemented, SNSWLHD had five to six agency staff in maternity. Now after 10 months of having the MGP model, only two agency staff members are needed and 2 more employed midwives are expected to be onboarded in the next few months. The initial 6-month evaluation of the Moruya MGP model identified a 23% decrease in caesarean sections with no adverse outcomes (among other benefits, including overwhelmingly positive feedback from staff and consumers, retention of midwives resulting in a reduced cost of agency staff and increased breastfeeding rate). The 12-month evaluation will include formal costing evaluation, and it is anticipated that this model will be less expensive given less caesarean sections and postnatal inpatient stay.

14. SNSWLHD is working towards implementing this model at Goulburn Base Hospital, and is working with stakeholders to implement it at Queanbeyan District Hospital. Stakeholders in this space include women and families, midwives, obstetricians, General Practice (**GP**) obstetricians, hospital management, executive staff, child and family health nurses, the NSW Nursing and Midwifery Association and paediatricians.

15. In my view, the successes of this model from a workforce viewpoint are that the continuity of care is more professionally rewarding for midwives, and it provides them with more autonomy over their day-to-day planning compared to the shift work model. The

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[1] Callander EJ, Slavin V, Gamble J, Creedy DK, Brittain H. Cost-effectiveness of public caseload midwifery compared to standard care in an Australian setting: a pragmatic analysis to inform service delivery. Int J Qual Health Care. 2021 May 28;33(2)

improved outcomes for women and babies positively impact midwifery professional resilience. This is reflected in both national and international literature.

D. CHALLENGES

(i) workforce

16. SNSWLHD has a maternity workforce challenge relating to midwives, GP Obstetricians, and Obstetricians. The biggest reducible cost to maternity services in SNSWLHD are locum obstetricians and agency midwives.

17. At Cooma Hospital, SNSWLHD has implemented a fly-in, fly-out (**FIFO**) midwifery workforce model since 2022 to maintain the service. The Cooma Hospital midwifery service requires 12 full-time equivalent (**FTE**) midwives. At present, around 2.5 FTE is filled by local Cooma midwives employed by SNSWLHD. The rest are a combination of FIFO midwives and agency midwives. The current FIFO shift model is for 12 hours, two weeks on and two weeks off with a 6-month contract. Associated FIFO costs include accommodation costs, local care hire, meals and travel costs.

18. While the FIFO midwifery model at Cooma Hospital is less expensive than a full agency model, in my view it is not sustainable. It is more expensive than permanent midwives, and can have impacts on teamwork and morale. The higher remuneration for FIFO midwives creates an inequity for local staff. There is limited-service resilience with no permanent contract for FIFO midwives. A 6-month contract can be terminated quickly by the FIFO midwife when required because of their needs at home due to the long-distance context. Two weeks on and two weeks off impacts the ability to provide continuity of care in the midwifery space. However, it has kept Cooma maternity service viable over the last 2 years. The long-term focus is to grow our own Cooma midwives for sustainability. While the obvious strategy includes increasing student placements, this needs to be nuanced to ensure students have an opportunity to complete their requirements for competency given the limited birth numbers.

19. The planned Eurobodalla Regional Hospital is aiming to have a Level 4 maternity service capability, which will enable more births close to home. These episodes of care would have otherwise required transfer to Canberra. Such a site will require an uplift of staffing, and planning processes are in the early stages, however recruiting and accommodation challenges for staff will compound this issue, as will the increased cost. It can be difficult to recruit obstetric specialists to regional areas when there are small birth numbers for their professional currency and interest.

20. Another issue is the activity-based funding (**ABF**) model for low volume facilities such as Cooma Hospital where in some years there are only an average of 2 births per week. Birth is unpredictable, so at times 2 weeks go by with no activity. Such facilities do not have enough activity for ABF to cover the costs of providing the service. It is imperative that these services remain open for the safety of women and babies given the distances to a birthing facility. On balance the net cost involved for these transfers would also be close to or higher than running an efficient well-staffed service, particularly if an MGP model.

21. I also note the MGP model has its own challenges in capturing activity. This is because additional rostering is still needed for Obstetricians to be on-call, and midwives still need to be rostered on the wards (for example, postnatal care for caesarean sections).

(ii) funding

22. Fee-for-service funding models are a major barrier to innovation and any effort to improve quality of care to our regional communities, as they only fund existing services based on legacy systems and there is limited scope to resource and implement change within the scope of these funding models.

23. The transition to new models can also be viewed as costly and risky to established interests. For example, engagement with local private providers such as GP Obstetricians is an essential element of providing maternity care in rural Australia. Often these private providers have built their business models and lifestyles around the maternity service delivery and funding models in their area. In this context, the transition to new service delivery models can be viewed as risky to their incomes and disruptive to their lives and engender strong resistance, irrespective of any potential benefits for women, babies or the broader system. This acts as a significant barrier to change where such change is reliant on the support of these providers and there is limited scope to implement alternatives to fee-for-service payment approaches.

24. Fee-for-service arrangements for GP Obstetricians are at times not a financially favourable remuneration model for the GP Obstetricians, with reducing birth numbers in regional areas making their income sources unreliable and volatile. It has been observed in our region that it also may impact midwives' clinical skills if it becomes competitive to 'complete a task' for financial reasons. Likewise, evidence in the literature

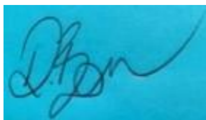
and anecdotal evidence suggests unwarranted intervention may be more likely to occur where a fee for service model exists. A preferred alternative model is to employ GP Obstetricians on a sessional arrangement, which provides income security for the GPs, enhances scope of practice for all professions, and reduces the risk to women and babies by reducing unnecessary intervention. While this may be more expensive to the health service, in the context of team-based care the overall net cost to the system could be marginal.

E. OPPORTUNITIES

25. Opportunities are to: expand the MGP model of care within SNSWLHD; ensure midwifery staff are working to the top of their scope of practice; review employment mechanisms for GP Obstetricians; and identify attractive models for Specialist Obstetricians to attract them to the rural and regional hospital setting. These models may include linking specialist Obstetricians with a higher level service for period of times for consolidation of skills, collaboration, networking and support.

26. The new Eurobodalla Regional Hospital is planning to open with a Birthing on Country model, for the best start to life for Aboriginal babies and families. Community engagement is commencing to co-design what this model looks like for the Yuin community.

27. There is also evidence that Aboriginal midwives improve outcomes for Aboriginal children and mothers. Work is underway to develop pathways with a local university to initiate and increase an Aboriginal midwifery workforce, including ability for end to end training in the region.



Rebekah Bowman

7 August 2024

Date

Witness: Adrian Webster

7 August 2024

Date