Health policy and rural maternity care: Four case studies in north Queensland

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in May 2009

for the degree of Doctor of Philosophy
in the Schools of Medicine and Public Health
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I declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university or other institution of tertiary education. Information derived from the published or unpublished work of others has been acknowledged in the text and a list of references is given.

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STATEMENT ON THE CONTRIBUTION OF OTHERS

Supervisors:

- Professor Craig Veitch, Faculty of Health Sciences, University of Sydney
- Professor Richard Hays, Dean of Medicine, Keele University, UK
- Professor Michele Clark, Faculty of Health, Queensland University of Technology
- Dr Sarah Larkins, School of Medicine and Dentistry, James Cook University

Project costs:

This project was granted financial assistance of $9918.88 by the Queensland Premier's Department through the Growing the Smart State PhD Funding Program. These funds were spent on project costs (such as travel and interview transcription fees) and not used as stipend.

Scholarship stipend:

The student received an Australian Postgraduate Award stipend.

DECLARATION ON ETHICS

The research presented and reported in this thesis was conducted within the guidelines for research ethics outlined in the *National Statement on Ethics Conduct in Research Involving Human (*1999*),* the *Joint NHMRC/AVCC Statement and Guidelines on Research Practice* (1997)*,* the *James Cook University Policy on Experimentation Ethics*. *Standard Practices and Guidelines* (2001), and the *James Cook University Statement and Guidelines on Research Practice* (2001)*.* The proposed research methodology received clearance from the James Cook University Experimentation Ethics Review Committee (approval numbers H2264 H2453).

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Rebecca Evans Date

ACKNOWLEDGMENTS

Endless thanks are due to my supervisors Craig, Richard, Michele and Sarah for sharing their wisdom and for their patient guidance throughout this process. I have learnt much more from them than this thesis can contain. Thanks also to Julie Watson who provided mentoring through the Queensland Premier's Growing the Smart State PhD Funding Program.

To the staff at the James Cook University Rural Health Research Unit, so many thanks for your encouragement and support throughout. Particular thanks and acknowledgment to Teresa O'Connor for so cheerfully giving of her time to read through and comment on this thesis.

To my family, for their love and ongoing support. To Heath especially, for his ceaseless love and encouragement.

Abstract

Equity, access, safety and quality are prominent themes in Australian health policy. Yet, in one area of health care, maternity services, rural facilities have continued to close. During 1995-2005, over 130 rural maternity units closed across Australia and 36 out of 84 units closed throughout Queensland. These closures raise serious concerns about equity of access to, and quality of, maternity care for rural residents. Few studies examine the relationship between policy discourse and citizens' lived experiences of policy outcomes. However, it is important that policy-makers obtain such qualitative information to discern the appropriateness of present strategies and to inform future policy-making. This project was guided by two research questions, namely, to identify prominent policy influences on rural maternity care and to understand the lived experiences of residents who provide and/or access this care in rural north Queensland. A methodology comprising a policy review followed by four case studies was used to explore the relationship between health policy discourse and the lived experiences of rural residents in seeking or providing maternity care.

Thematic analysis of relevant policies was undertaken to better understand the present policy environment and resulted in the identification of a number of key themes. Firstly, there were overarching themes of equity of access to care found in large-scale policies. Secondly, very little policy support specifically for rural maternity services could be found; this insufficiency was also emphasised during interviews with health professionals. Thirdly, policy discourse revealed an inclination to centralise health services. This, mostly implicit, policy direction was reinforced by the reality of service migration away from rural towns and towards more urbanised centres. Fourth, there was a notable emphasis on avoiding clinical risks which subsequently influenced the practice of rural maternity care professionals. Fifth, achieving cost-efficiencies was a concern in many, particularly state-level, policies which is characteristic of corporate rationalists.

Case studies of four rural north Queensland towns were completed and illustrated the lived experiences of residents who seek and provide maternity care. The four case study sites experienced a variety of outcomes: one town had recently seen their birthing service close; another unit had just established an innovative midwifery-led model of care; another provided maternity care in the traditional medical model and had retained a robust proceduralist roster; and yet another officially had a service,

though it was quite inconsistent. Despite the variety of outcomes, all maternity units experienced a common pressure to constrain services and all had faced some service downgrading. A number of recurrent themes emerged through the inductive analysis of data and were sorted into four groups.

Firstly, there were themes closely related to community. It was clear that rural communities still valued local maternity services, especially birthing. For most individuals, local services offered a more convenient and acceptable option for accessing maternity care. At a community level, viable local maternity services were perceived as important for the sustainability of rural towns. The level of true community engagement with health services or policy was found to be negligible, although locally initiated public *action* was instrumental in maintaining services at two of the towns. The majority of interviewees, especially health professionals, saw benefits in engaging the local community in health service decision-making, but they also held common reservations about the success of such initiatives in their own towns.

Secondly, workforce insufficiencies remained the biggest threat to the sustainability of rural maternity units. Despite the considerable policy attention that has been paid to rectifying the maldistribution of medical practitioners, recruitment and retention difficulties still caused major problems for all the maternity units in this study. Ageing and short supply of rural midwives were equally pressing. The progressive downgrading of services led to (a) a loss of local skills as health professionals left to practice in other towns, or else remained and ultimately became de-skilled; and (b) a collective demoralisation among hospital staff with progressively less scope to provide holistic health services of a high quality with continuity of carers.

Thirdly, the quality of care (not necessarily clinical quality) experienced by rural residents was profoundly affected by the downgrading of rural maternity services in a number of ways. Most obviously, the loss of services caused less equitable geographic access to care. This led to the introduction of more carers and facilities, thus causing care to become increasingly fragmented. In addition, the financial costs of accessing care increased significantly for rural residents and included costs of regular travel, lost work and relocation to the regional centre weeks prior to delivery.

Fourth, there were issues of safety and risk. Many health professionals reported the pressure they felt in reconciling higher patient expectations of health care with the nature of adverse events in obstetrics. This pressure was exacerbated by a policy

environment that was perceived as highly risk-averse. For rural residents, the removal of local services appeared to encourage them to take more risks in accessing maternity care. Further safety concerns were voiced by health professionals in relation to the cessation of rural birthing services. The subsequent loss of important clinical skills leading to reduced capacity to manage local obstetric emergencies also threatens the sustainability of a range of other local health services.

Overall, it was found that government policies and the general policy environment did not support the sustainability of rural maternity services. Instead, rural maternity units were vulnerable to pressures of service centralisation, achieving cost-efficiencies and risk-aversion. Thus, while rural maternity units are not supported and continue to close, disparities in the geographic location of birthing units grow, ultimately having the effect of transferring to rural families the costs and risks that were once borne by the government. A number of recommendations for future policy-making emerge from the findings of this study including the need for specific policies to support rural maternity services; developing policy initiatives to bolster the workforce, infrastructure and models of rural maternity care; and the implementation of policies which better compensate rural residents for decreased geographic access to services.

Table of Contents

List of Tables

List of Figures

List of Abbreviations and Acronyms

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
ACM	Australian College of Midwives
ACRRM	Australian College of Rural and Remote Medicine
AHCA	Australian Health Care Agreements
AIHW	Australian Institute of Health and Welfare
ALP	Australian Labor Party
AMA	Australian Medical Association
AMWAC	Australian Medical Workforce Advisory Committee
ARIA	Accessibility/Remoteness Index of Australia
ASGC	Australian Standard Geographical Classification
CME	continuing medical education
CRANA	Council of Remote Area Nurses of Australia
CSCF	Clinical Services Capability Framework
DoN	Director of Nursing
DRANZCOG	Diploma of the Australian and New Zealand College of Obstetricians and Gynaecologists
FTE	full-time equivalent
GDP	gross domestic product
GP	general practitioner
GPRIP	General Practice Rural Incentives Program
HCRRA	Health Consumers of Rural and Remote Australia
HREC	Human Research Ethics Committee
IMG	international medical graduate
IRSD	Index of Relative Socio-Economic Disadvantage
JCU	James Cook University
MBS	Medical Benefits Schedule
NAHS	Northern Area Health Service
NRHA	National Rural Health Alliance
O&G	obstetrics and gynaecology
OECD	Organisation for Economic Cooperation and Development
PBS	Pharmaceutical Benefits Scheme
PTSS	Patient Travel Subsidy Scheme

RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RDAA	Rural Doctors Association of Australia
RFDS	Royal Flying Doctor Service
RHSET	Rural Health Support Education and Training
RHWA	Rural Health Workforce Australia
RRMA	Rural, Remote and Metropolitan Areas
RUSC	Rural Undergraduate Steering Committee
RWA	rural workforce agency
SEIFA	Socio-Economic Indexes for Areas
SLA	statistical local area
SMO	Senior Medical Officer
SPP	Special Purpose Payment
WHO	World Health Organization
Wonca	World Organization of Family Doctors or longer name: World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians

Glossary

Antenatal period: The time from conception to the onset of labour (*Mosby's medical, nursing and allied health dictionary*, 2002). Prenatal, antenatal, pregnancy and antepartum are all terms used interchangeably in the literature to refer to the same period of time.

Area health service: Queensland Health applied geographical divisions of Queensland for organisational purposes. 3 area health services existed at the commencement of the thesis: southern, central and northern area health services. This thesis was placed within northern area health service boundaries which can be found in Appendix 5. Area Health Services were abolished during Queensland Health restructuring in late 2008.

ASGC: A method for classifying the rurality of Australian locations. The ASGC is one of three commonly-used remoteness classification systems used in Australia and comprises six remoteness categories: major cities; inner regional; outer regional; remote; very remote and migratory. The ASGC remoteness categories are described in more detail in Appendix 1.

Birthing: Actions associated with giving birth to offspring. "Intrapartum period" can also be used to refer to this time.

FTE: In this thesis, full-time equivalents (FTE) are understood to be "calculated by multiplying the number of medical practitioners by the average weekly hours worked, and dividing by the number of hours in a 'standard' full-time working week. FTE gives a useful measure of supply as it takes into account both those working full-time and those working part-time" (Australian Institute of Health and Welfare, 2008b, p. 22).

GP proceduralists: Term used to refer to medical practitioners with primary qualifications but with additional postgraduate qualifications in a

	procedural discipline such as anaesthetics, obstetrics and/or general surgery.
IMG	International Medical Graduate (IMG) refers to medical practitioners whose primary medical qualifications were obtained in countries other than Australia.
Intrapartum period:	The term “intrapartum” refers to the period of time from the onset of labour to the final stage of birth (*Mosby's medical, nursing and allied health dictionary*, 2002). Used interchangeably with the term “birthing”.
Maternity care:	Collective term for antenatal, intrapartum and postnatal care, that is, care during pregnancy, birth and immediately following birth, respectively.
Medical practitioner:	A person with the appropriate qualifications, experience, skills and knowledge to be registered as a medical practitioner under the *Medical Practitioners Registration Act 2001* ("Medical Practitioners Registration Act," 2001).
Midwife:	A registered nurse (RN) who has completed additional training in midwifery care.
North Queensland:	Generally referring to the area covered by the former Northern Area Health Service (Mackay to Cape York and west to the Queensland-Northern Territory border). Refer to map in Appendix 5.
Policy:	In the public policy sense, refers to any direction made by government as to the action to be taken on given issues. Explicitly, policies may be identified through such things as government press releases, published documents that are labelled as policies, initiating projects or the provision of funding. Grey literature, the absence of action, funding or support may provide implicit indications of government policy intentions.

Postnatal: The first few days following childbirth (*Mosby's medical, nursing and allied health dictionary*, 2002), although in common and medical parlance, this period often extends out to 6-8 weeks after birth. Used interchangeably with postpartum.

Queensland Health: The government department for health care in the state of Queensland.

Regional hospital: In this thesis, the next nearest hospital to which local practitioners may refer or transfer cases that require care beyond that which can be offered at the rural hospital. These are usually at the nearest regional town and increasingly specialised services can mostly be found in the appropriate capital city. "Referral hospital" may be used interchangeably.

Rural: For the purposes of this study, rural has been defined as areas classified as RRMA 3-7; 1.84-12 on the ARIA scale; and 2.4-15 on the ASGC system.

SLAs: Statistical local areas (SLAs) are spatial units "based on the administrative areas of local government where these exist. Where there is no incorporated body of local government, SLAs are defined to cover the unincorporated areas" (Australian Institute of Health and Welfare, 2004, p. viii).