Remote and Rural Maternity Services

POSITION STATEMENT

College position

Rebuilding and maintaining rural maternity care must be treated as a national priority. This requires a coordinated national response to prevent further downgrading of rural maternity services[1] and to prioritise the re-establishment of closed facilities.

People living in Australia's remote, rural and First Nations communities deserve access to high-quality, safe, and affordable maternity and birthing services. These services should reflect the best possible model of care for each context, while respecting women's preferences and cultural needs. This includes access to timely medical care and clear pathways for escalation in emergencies and when complications arise. Maternity services should provide high-quality care close to home, grounded in a model that prioritises continuity of care.

Implementing these models requires genuine, respectful and sustained local community engagement to ensure services are contextually and culturally appropriate. Service design must reflect the specific needs of the impacted women and their families—not be driven by budgetary constraints or administrative convenience.

The provision of high-quality rural maternity care relies on effective services collaboration across hospital and community-based settings through pregnancy, childbirth and the postpartum period. This involves the coordinated contributions of RGs, Obstetricians, General Practitioners, Nurses, Midwives, Aboriginal and Torres Strait Islander Health Workers and other health professionals as appropriate to each context.

Rural Generalists (RGs) are central to gold standard models of rural maternity care, as they can provide continuity of care from antenatal to postnatal stages, as well as obstetric, in-patient and emergency care.

ACRRM calls on both Federal and State governments to make a sustained commitment to improving access to rural maternity services. This includes retaining existing services, reintroducing previously closed facilities, and establishing new models of care, tailored to meet the needs of rural and remote communities.

Remote and Rural Context

Each year, over 30,000 babies are born in locations classified as outer regional, remote and very remote where access to appropriate maternity services is limited.[2] For a variety of reasons, including staffing availability, many rural hospitals are unable to consistently offer maternity care, and a continuing national trend of facility closures and periodic bypassing of existing rural maternity units worsens these challenges. The decreasing availability of local maternity services creates significant difficulties for women and their families.

In 2024, approximately 1,100 different models of care were reported to be operating across 250 maternity services in Australia, reflecting the complexity and variability of care provision.[3] When local birthing facilities close or maternity-skilled health professionals leave rural communities, pregnant women face increased risks and may need to travel long distances or relocate to urban centres well before delivery. These circumstances impose additional financial, social, cultural, and emotional burdens for families.[4]

The impact of losing maternity services extends beyond the delivery of birthing care and has wider community impacts. It is usually associated with a progressive de-skilling of the medical workforce and a downgrading of facilities and overall level of services, so access to a wider range of health care services becomes poorer.[5] The loss of services can affect the economic and social fabric of the community,[6] resulting in temporary or permanent relocations and difficulty in bringing families to the affected areas. Rural communities report the importance of local maternity services to attracting and retaining young families to their area.[7]

Funding high-value Rural Maternity Services

Rural and remote models of care often differ from those in urban settings, but they must still meet the highest standards of quality and safety. People living in remote and rural parts of Australia already face a significant deficit in funding for their healthcare services relative to their urban counterparts. Even with the comparative scale economies in providing urban services, it has been calculated that per capita per year, $850 less is spent by governments on the healthcare of the people in rural areas compared to those living in major cities.[8] While modes of care may be adapted to local contexts, this must not become a pretext for implementing lower-cost, lower-value services for those living outside major cities.

Safety and Quality for Rural Maternity Services

Rural and remote maternity service closures put expectant mothers at a greater distance from birthing care. However, there is ample evidence that outcomes for well-managed birthing services can be as good, or better than those in larger centres, and that the risks to mother and baby are greater where access to these services is limited by distance.[9,10] In particular, those led by RGs can offer obstetric care to an equivalent safety standard of that in cities including for medium risk obstetric deliveries.[11,12]

There are clear linkages between the need for extended travel time to access maternity services and increased rates of mortality and adverse outcomes. Canadian studies have found that women with no local access to maternity services have worse maternal and newborn outcomes than women from similar communities with local access to even limited birthing services.[13]

It has commonly been the case that quality and safety standards have been set that rural services did not meet, and services have been closed[14] rather than steps being taken to remedy the specific issues of concern and provide additional support to improve those services. When this occurs, risk is transferred from the health service to the woman, her family and her community. This risk management approach needs to change so the design and maintenance of high-quality services that meet identified community need becomes the key objective.

A risk lens should be taken to each clinical context, identifying the optimal, context-appropriate services in the event of safe deliveries without complications as well as for obstetric emergencies and that appropriate escalation points are in place. Strong continuous collaborative care promotes early obstetric risk identification and provision of safe-care pathways.[15] It is important that a medical practitioner with obstetric training is part of the management framework for every expectant mother in the care model best fit to the context. RGs offer an ideal professional scope for these models of care. Their role will be most effective where they have early engagement as part of the continuity of birthing care.

It is inevitable that unplanned births will occur in rural and remote facilities for a range of reasons. These present a much greater risk to the mother and baby where the facility has been downgraded, and staff deskilled. Appropriate and well-maintained infrastructure and equipment should be available at all rural facilities and staff adequately trained to cope with unplanned births.

Quality-assured, safe models of care should adopt a holistic approach that minimises clinical risk and considers the social, cultural and environmental factors that may impact quality and safety for rural women and their families.

- **Woman and family-centred**

  High quality maternity care respects and responds to the needs, values, and preferences of women and their families. A woman- and family-centred approach ensures that each individual is supported with clear, relevant information to make informed decisions about how they engage with their care.[16] In the rural and remote context, this should ensure that expectant mothers have the opportunity to consider and understand their choices, the risks and the escalation options if required.[17]

  Women in remote and rural communities, like all women, often prefer to stay close to home throughout their pregnancy and birth. They seek care that is safe, culturally respectful, and tailored to their unique life circumstances. For low socioeconomic groups, financial stressors, separation from family, and lack of transportation options can all materially impact care decisions and health outcomes.[18] Studies have identified the strong value island women placed on being able to give birth locally.[19] Other studies have highlighted the extreme stress experienced by rural women undergoing antenatal transfer to larger centres.[20]

- **Culturally-safe**

  Safe, high-quality care for First Nations people and particularly in remote communities must be culturally safe and responsive. This involves strong engagement with local communities in the design and delivery of models of maternity care and an approach to care which recognises and values the preferences and unique cultural perspectives of their First Nations patients and their families.

  Having strong local maternity services for the continuum of maternity care up to an including for obstetric emergencies is especially important in providing quality care for First Nations peoples. There is a strong preference in First Nations communities for birthing on country.[21,22] These mothers and their families are also more likely to have difficulties in accessing affordable transport and other financial and social supports to enable them to travel to larger centre for care.[23]

- **Context appropriate and adaptive**

  National guidance, including the Second Edition Consensus Framework for Rural Maternity Services, underscores the need for adaptable service models that reflect the diversity of rural contexts. These models must be flexible enough to accommodate different care pathways and delivery arrangements that honour women's autonomy and support their choices in how maternity care is provided and uphold safety and quality standards.

The Role of the RG

RGs are a cornerstone of rural, remote and First Nations maternity service delivery. These doctors play a vital role in delivering holistic and integrated maternity care and their versatility significantly enhances access to high quality, safe, and continuous maternity care in communities that would otherwise face critical service gaps.

RGs are trained to meet the diverse and complex healthcare needs of their communities through a broad scope of practice. This includes comprehensive primary care, public health, and advanced clinical skills tailored to local needs. They have the ability to provide a full continuum of services – from preconception through antenatal, intrapartum and postnatal care, as well as providing obstetric and other services such as anaesthetics, and emergency care.

ACRRM Fellows are trained to the RG scope of practice. All Fellows attain skills in prenatal and postnatal care, basic obstetrics including emergency obstetrics and in emergency and in-patient care. Many ACRRM Fellows also choose to complete an additional year of Advanced Specialised Training (AST) in Obstetrics and Gynaecology as an optional pathway to completing their Fellowship requirements, providing them with skills vital to rural, remote and First Nations communities. Others may attain AST level skills in important areas such as Anaesthetics or Emergency Medicine.

Securing Sustainable Rural Maternity Services

Improving the sustainability of rural maternity services requires a coordinated national strategy which includes the following components:

Designing and delivering rural, remote and First Nations models for maternity services

Design should start with recognition that rural and remote people deserve the highest quality and the highest value healthcare.

Design and delivery should involve genuine and respectful community engagement to design contextually and culturally appropriate models of care, relevant to community needs and circumstances.

Delivery needs to have effective collaboration along the care pathway. Providing high quality care in rural, remote and First Nations settings that do not have the breadth of specialised staff and resources of tertiary centres, requires effective healthcare teams. In these settings, maternity healthcare teams need to be tailored to each individual location, allowing for flexibility and adaptability of team construction depending on the local context. Obstetric RG led teams supporting midwives present a gold standard model for ensuring the delivery of the highest quality collaborative care in these settings.

Models of care should be flexible and innovative, supporting locally based solutions and team-based continuity of care and using a range of tools including digital solutions to support the delivery of services.

Quality and Safety

Safe, high-quality services which are cognisant of clinical and cultural safety and the needs of rural and remote women and their families:

- Prioritising access, continuity and comprehensive care that encompasses pre-and post-natal periods
- Developing strong clinical networks and support mechanisms for rural maternity teams
- Implementing access-enabling service capability frameworks which can be understood by both patients and clinicians
- Maintaining core facility infrastructure and equipment and staff skills

Training and Skills Development

Access to training that reflects rural and remote needs is vital developing confident, competent practitioners. Key priorities include:

- Securing dedicated training posts for RG trainees to acquire the necessary procedural skills and qualifications.
- Providing appropriate rural maternity training for all GP/RG trainees.
- Supporting ongoing skills maintenance through training grants and other programs.
- Ensuring that staff working in rural and remote facilities are trained in basic obstetric care, emergency management, and equipment use relevant to their practice.

Ongoing access to structured training is essential to maintain a skilled and confident workforce.

Workforce Support

A skilled rural maternity workforce which is supported through:

- Recognition of the RG model as essential for effective service delivery close to home.
- Valuing and enabling team-based care through strategic planning at government and service levels.
- Practical support including certainty of locum relief; ensuring that staff accommodation is of a suitable standard; and regular opportunities for study and other leave
- Access to clinical advice and strong governance, including consultant support and structured clinical handovers.

The maternity workforce must be integrated within broader rural health service delivery and workforce policies to identify and address gaps effectively.

Infrastructure and Clinical Support

Federal and State strategies must prioritise new rural birthing services and maintain and improve existing rural birthing facilities, together with appropriate infrastructure and clinical support to accommodate planned and unplanned deliveries in facilities which do not routinely provide birthing services.

Coordination and Collaboration

Coordinated approaches to risk management and mitigation, retrieval, and effective communication to facilitate continuity of care and a seamless care pathway.

Evaluation and Evidence

Robust and transparent evaluation frameworks, involving all stakeholders and prioritising the needs and experiences of rural and remote women, are essential to inform ongoing improvements.

Endnotes

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Find out more

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ACRRM acknowledges Aboriginal and Torres Strait Islander peoples as the custodians of the lands and waters where our members and staff work and live across Australia. We pay respect to their elders, lores, customs and Dreaming. We recognise these lands and waters have always been a place of teaching, learning, and healing.