First print

Access to Maternal and Perinatal Care Bill 2023

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Access to Maternal and Perinatal Care Bill 2023

Act no. , 2023

A Bill for

An Act to expand access to individualised maternal and perinatal care in rural and regional NSW; and for other purposes.

Second Reading Speech

Mr JOSHUA SHAW(Wagga Wagga—Minister for Rural and Regional Affairs):

Former New Zealand Prime Minister Norman Kirk once said, “There are four things that matter to people - they have to have somewhere to live, they have to have food to eat, they have to have clothing to wear, and they have to have something to hope for.” I would argue there are actually five things - shelter, food, clothing, hope and healthcare. But the sad reality is that for pregnant people in rural and regional NSW, they do not receive the healthcare we as a state in the ‘lucky country’ should be able to provide for them.

In investigating this issue, the Rural and Regional Affairs Committee identified three key problems - the pressures of distance and travel, high mortality and complication risk, and staff shortages coupled with a lack of training opportunities.

The committee found that extreme distances for perinatal care places both a psychological and economic burden on patients. Not only must they somehow afford travel, but many also often already have children that must travel with them, however this poses the difficulty of caring for these children while receiving medical care. The existing Isolated Patient’s Travel and Accommodation Assistance Scheme faces a number of issues which mean it is too often ineffective at supporting pregnant people. Further, to be so far away from one’s family for a potentially extended period places patients at high risk of mental health complications.

Another key finding of the committee is the importance of keeping births within local communities. This not only protects against the issues previously mentioned but is more likely to provide a positive birthing experience. However, when it comes to culturally appropriate On-Country births for First Nations people, the committee found that existing programs to upskill medical practitioners to participate in On-Country births are inadequate.

At the crux of the issue for pregnant patients in rural and regional New South Wales is a higher risk of mortality, with 8% of direct maternal deaths taking places in areas accounting for 3% of the state’s population. This issue of mortality is coupled with an increased risk of complication or health issues during pregnancy, particularly relating to poorer education about behavioural risk factors during pregnancy, including drinking and smoking.

In order to keep births within local communities and improve perinatal education, the committee concluded that having midwives and obstetricians within local communities is essential. However, across rural and regional NSW, particularly remote areas, midwives, and obstetricians face chronic staff shortages. Both roles also lack training and professional development opportunities in the regions.

I am pleased to present the Rural and Regional Affairs Committee’s Access to Maternal and Perinatal Care in Rural and Regional Areas Bill to the 2023 Youth Legislative Assembly for consideration. The

committee has proposed solutions to improve the support provided to travelling patients, including the new RARA MTAS scheme and family care centres. We have also sought to create pathways to ensure more people train to provide perinatal care in our regions, particularly the creation of Rural Guarantee Pathways and Fee Relief. To address the issues of a lack of training for existing health professionals in this area, particularly for On-Country births, the committee wishes to implement new upskilling and training programs. Further, we wish to support First Nations patients with a dedicated right to First Nations health professionals, while also creating a more accessible healthcare system for all disadvantaged and diverse patients.

I would like to thank all the wonderful community members, including experienced translators, nurses, midwives, and obstetricians, who have provided such important insight into our Bill. I also acknowledge the work of members of the NSW Parliament in contributing to this legislation. Most importantly, I recognise the invaluable work of each and every member of the Rural and Regional Affairs Committee to creating a better New South Wales **for all**.

I commend the Bill to the House.

Explanatory Notes

Introduction to the Issue

According to the *Universal Declaration of Human Rights* access to healthcare is one of the fundamental human rights to which all people are entitled. Under this umbrella of "healthcare" falls maternal and perinatal care. Maternal care can be defined as "the health of women during pregnancy, childbirth and the postnatal period" according to the World Health Organisation. However, birthing people globally are faced with inadequate care in this part of their lives. Within remote, rural, and regional NSW there are particular issues in this area of the medical landscape. From inadequate and lacking facilities, lacking staff, the pressures of distance from resources and the associated travel on patients and the lack of flexibility for a broad range of situations in these areas, the healthcare system is rendered unable to fully address the needs of its patients.

A study from BMC Health Services found that there is a higher perinatal mortality rate in rural and regional Australia than in urban areas. There is also significantly increased risk for mothers, with the Department of Health reporting that 8% of direct maternal deaths took place in locations inhabited by 3% of the population. These disparities clearly illustrate the significance of this issue.

In rural and remote areas, birthing people often have to relocate before giving birth as they must be within 1 hour from a birthing facility when within a few weeks of their birthing date. Birthing people with high-risk pregnancies may be asked to travel earlier and may spend weeks away from their home and family. This move can result in isolation for these patients as they face a lack of support in this significant time of their life and can face major financial restraints due to the cost of the travel. Patients in rural and remote areas are more likely to be in a low-socioeconomic area and this process can deter them from receiving the recommended maternal care.

Travel for Healthcare

To account for these issues faced, maternity services should be made available from within 1 hour of each NSW town when viable. This is often not viable due to resource shortage, staffing availability and facility access in very rural and remote areas. To support people impacted by this, the system for people needing to travel to access maternity care must be made more accessible and supportive. The Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) provides some reimbursements for travel and accommodation costs for patients who travel long distances to access necessary health care. These reimbursements only account for a small proportion of travelling costs and do not account for families and the isolating impact if they cannot travel with the mother. Instead, a scheme should be providing initial payment and support instead of reimbursement, for the patient and the family. It will make this part of the planning processes for maternal care and allow automatic support to eliminate the slow, partial reimbursement process. This will include travel and accommodation costs for the recommended length of time to eliminate the financial pressure on the mothers and their families.

Keeping Care Local and On-Country Birthing Programs

To support birthing opportunities in community and on country for mothers in remote, rural, and regional areas, educational and training programs must be implemented to allow pregnancy care to be accessible and supportive in rural areas. Birthing people in remote areas can be detrimentally impacted by lack of access to maternity and perinatal care as they already had higher rates of behavioural risk factors and more pre-existing conditions. In 2019, for women who lived in remote areas, 26% smoked at any time during pregnancy (compared with 16% in regional areas and 6.8% in major cities). Women

in remote and regional areas are also more likely to be under 20, live in low socioeconomic areas and identify as Aboriginal and/or Torres Strait Islanders (NSW). To promote healthy pregnancy and births in these areas, trained professionals must be accessible to ensure these risk factors do not impact the health of mothers and babies. Whilst support for travel will be extremely beneficial to some, cultural birthing practices must be accessible to birthing people in these areas to reach the best outcomes and ensure all people are supported in their pregnancy. By implementing more training programs for people in isolated communities, especially indigenous people and local midwives, maternity care will become more successful, local, and therefore more supportive. Programs such as Birthing On-Country and cadetships for regional, rural, and remote people will allow communities to build skills to support their parental members and culture in perinatal and maternal care.

Workforce and Infrastructure Shortages

Rural and regional mothers are also challenged by workforce shortages and issues in maternal and perinatal care across three key roles - midwives, obstetricians, and theatre staff. Midwives are chronically sparse in areas classified as very remote under the Modified Monash Model, with around half of the midwives per 100,000 women aged 15-49 compared to all other regional and metropolitan classifications. This means that particularly in Western NSW, perinatal patients have to travel hours away from their families to give birth, which is distressing and can dampen the joy of the occasion. A 2022 report from the Legislative Council further found that the "*severe shortage of … midwives*" was a key issue in rural and regional NSW.

Additionally, obstetricians in rural and regional areas are not only in short supply; they are largely general practitioner (GP) obstetricians, a dual role which couples the challenge of isolation with a poor work-life balance. Existing rural and regional GP obstetricians also lack upskilling and training opportunities compared to metropolitan counterparts. Rural and regional general practitioners are notoriously overworked, with wait times of between 3 and 6 weeks in some areas. Additionally, infrastructure for maternal and perinatal care in regional and rural NSW is significantly lacking, particularly the operating theatres required for surgical births. Many GP obstetricians also harbour safety concerns catalysed by poor infrastructure [5]. The overall issues with the rural and regional perinatal and maternal workforce and infrastructure have contributed (among other factors) to a 40% decline in rural maternity services Australia-wide between 1992 and 2011.

Through restructuring of the regional, rural, and remote perinatal and maternity system maternity care will be made accessible and supportive for people in all situations, reducing the detrimental impact of the geographical location. Further development of rural and regional maternal care systems relating to transport and accommodation support, staff training and infrastructure development is vital to this improvement. A system relieving the terrible stress of transport and accommodation planning and financing in the form of RARA MTAS will facilitate massive improvements for patients in this area alongside positive changes in relation to support and resources accessible in rural and regional communities and general support for patients and their families. The horrific disadvantage faced by perinatal patients in rural and regional areas must be addressed - it is a matter of not only equity but our obligation as a state to provide for all.

The Youth Legislature of New South Wales enacts—

Part 1 Preliminary

1 Name of Act

This Act is the *Access to Maternal and Perinatal Care Act 2023*.

2 Commencement

The Act commences on the date of assent of this Act.

3 Relationship with other Acts and laws

This Act prevails to the extent of an inconsistency with another Act or law.

4 Objects

The objects of this Act are to—

(1) Ensure that pregnant people who are required to travel for perinatal care are supported to do so. This includes both economic and social support, covering monetary reimbursement, family and childcare support and psychological support.

(2) Ensure perinatal care tasks place within local communities means providing safe and well-equipped care services. To ensure this occurs, sufficiently trained health professionals, particularly midwives and obstetricians, are essential within rural and regional communities. A variety of programs will be implemented to achieve this, including Rural Guarantee Pathways and Fee Relief.

(3) Ensure better outcomes for rural and regional First Nations perinatal patients, on-country birth practices will be supported, a right to First Nations medical professionals must be established and local health staff must be trained in culturally appropriate practices.

(4) Acknowledge that rural and regional obstetricians and midwives should have the opportunity to upskill and engage in professional development, particularly around on-country births.

(5) Establish perinatal healthcare must be made accessible and inclusive for all patients regardless of gender identity, sexuality, First Nations status, family structure, cultural or linguistic diversity or any other factor. This means providing appropriate care and support for patients and education for perinatal health professionals.

(6) Understand rural and regional maternity wards should be appropriately staffed and equipped, and within an acceptable distance from patients.

(7) Implement perinatal education programs to improve rural and regional patient outcomes, including via telehealth.

5 Definitions

In this Act—

birthing on country means Indigenous peoples giving birth on their ancestral lands, and/or with their appropriate community.

birthing person means someone who gives birth, regardless of their gender identity, which may be female, male, nonbinary, or other.

IPTAAS means Isolated Patients Transport and Accommodation scheme.

maternal care means the care for and health of women during pregnancy, childbirth, and the postnatal period.

Modified Monash Model means a model used by the Commonwealth Department of Health and Aged Care to define whether a location is a city, rural, remote, or very remote.

perinatal care means medical services and support for pregnant people and their babies, before and after birth.

RARA MTAS means the Rural and Regional Access Maternal and Perinatal Transport & Accommodation Scheme, which will be established by this Bill.

rural and regional areas mean anywhere out of the greater Sydney area.

specialist maternal and perinatal care means any form of maternal and perinatal care not regarded as standard maternal and perinatal care.

standard maternal and perinatal care means regular obstetrics checkups, maternal education and support and birth-related medical care, including basic surgical birth techniques.

telehealth means health care provided mainly through technology, including but not limited to video conferencing or phone call.

Note— The *Interpretation Act 1987* also contains definitions and other provisions that affect the interpretation of this Bill.

Part 1 Transport and Accommodation

Division 1 Rural and Regional Access to Maternal and Perinatal Transport & Accommodation Scheme (RARA MTAS)

6 Establishment

(1) The support provided by IPTAAS for maternal and perinatal care will be replaced by RARA MTAS.

(2) To avoid doubt, IPTAAS will continue to operate for all other areas of healthcare.

7 Administration

RARA MTAS will be administered by the Minister administering the *Health Administration Act 1982 No 135.*

8 Referral to RARA MTAS

(1) The heath professional in charge of a person's perinatal or maternal care will be required to assess the needs of a person's care.

(2) This may be done via telehealth services where necessary.

(3) Based on this assessment, a person must be referred to a RARA MTAS case worker if they require—

(a) standard maternal and perinatal care services which cannot reasonably be provided within a 100 km distance of their place of residence; or

(b) specialist maternal and perinatal care services which cannot reasonably be provided within a 150 km distance of their place of residence; or

(c) both of the above, if the nearest care service which provides such services is located within another jurisdiction.

(4) This referral must state the services which cannot reasonably be provided.

9 Services included in RARA MTAS

(1) Perinatal and maternity services include but are not limited to—

(a) obstetricians,

(b) midwives,

(c) surgical birth facilities and staff,

(d) perinatal mental health support,

(e) language interpreting facilities,

(f) culturally appropriate care facilities,

(g) perinatal education,

(h) lactation consultants,

(i) neonatal care,

(j) speciality care services and

(k) any other services necessary as determined by a person's health professional.

10 Complaints process

If a patient is dissatisfied with the assessment made by the medical practitioner in charge of their care, then at their discretion they may seek advice and an assessment meeting the requirements of clause 8 from other appropriate medical professionals capable of carrying out such an assessment, including via telehealth where necessary.

11 Medical professionals able to carry out assessment

(1) Medical professionals capable of carrying out such an assessment are—

(a) an obstetrician,

(b) general-practitioner obstetrician or

(c) other relevantly and similarly qualified professionals.

(2) In exceptional circumstances, including but not limited to those related to location, other appropriate health professionals involved in maternal and perinatal care, including specifically trained midwives, may be regarded as capable of carrying out such an assessment.

12 Classification criteria for standard services

A person requiring standard maternal and perinatal services not reasonably accessible within 100km of their place of residence under section 8 shall be classified by their RARA MTAS Case Worker under table 1.

13 Classification criteria for specialist areas

A person requiring specialist maternal and perinatal services not reasonably accessible within 150km of their place of residence clause 8(3)(b) shall be classified by their RARA MTAS Case Worker under table 1.

Table 1: Classification

Column 1	*Column 2*
Category	Classification
Category 1	Able to drive self or by driven by family or friends.
Category 2	Require other transport.
Category 3	Requirement accommodation, which is only applicable if standard care services are not reasonable accessible within 200 kms of place of residence.

14 Subsidies on classifications

Patients classified under clause 12 and clause 13 will be paid subsidies based upon their category. Patients may be assigned to more than one category, based upon the relevant criteria, however, may not be assigned to both Category 1 and Category 2 for the same instance of travel. The subsidies shall be as in table 2.

Table 2: Subsidies based on classification

Column 1	*Column 2*
Category	Classification
Category 1	To be determined as a set cost per kilometre, including the first 100 kilometres of travel. This subsidy per kilometre of travel shall be determined on the 1 February each year by the Department of Health in consultation with relevant bodies.
Category 2	Alternative transport is to be arranged, booked, and paid in full by a patient's RARA MTAS Case Worker using funds allocated to the RARA MTAS scheme, with the patient's input and final agreement. Alternative transport must be within reason, and of a similar cost to Category 1 subsidies where possible, at the discretion of the case worker.
Category 3	Accommodation is to be arranged, booked, and paid in full by a patient's RARA MTAS Case Worker using funds allocated to the RARA MTAS scheme, with the patient's input and final agreement. Selected accommodation must be within reason and within appropriate proximity to the relevant healthcare services, at the discretion of the case worker.

Division 2 Role of RARA MTAS Case Workers

15 Employment of RARA MTAS Case Workers

RARA MTAS case workers will be employed by the Department of Health and the department will be responsible for selecting appropriate employees for this role, giving regard to the nature of the role.

16 Calculates and communicates the subsidy given

According to the services identified under clause 9 the case worker will calculate the subsidy with respect to the eligibility and classification criteria and subsidies listed under table 1.

17 Communication between caseworker and patient

Communication between a case worker and patient shall be through telehealth.

18 Telehealth services

(1) Patients should be provided support to access telehealth resources.

(2) Support in access to communication should also be provided through a translator if required.

19 Roles of case workers

(1) Supports the planning and booking of transport and accommodation related to accessing necessary services.

(2) Planning and booking of accommodation should be available to patients through the case worker.

20 Case worker to support booking process

(3) The case worker should explore the support needed by the individual in the booking process by—

(a) support should be provided at varied levels dependent on needs of patient, under constant recommendation from patient guided by patient preference; and

(b) financial aspects and provided subsidies must be made clear by case worker to patient in decision of booking accommodation and travel, in respect to the impact on the individual and family financially; and

(c) when accommodation and travel are not financially viable with subsidy given under clause 9, case workers can approve extra funding when they see circumstances are valid for this requirement.

21 Transport arrangements by case worker

(1) Case workers should explore a patient's access to transport and calculate their subsidies accordingly.

(2) If transport is not accessible, case workers should organise options of transport including, but not limited to car hire, taxi, flights, or private driver options.

(3) Transport options should be discussed with patients and their referring medical professionals under the above clause to ensure comfort and safety in the process of transport to and from medical services.

Division 3 Families and support people under RARA MTAS

22 Reimbursement to single family member

RARA MTAS will provide reasonable subsidies to fully reimburse a single family member or support person for all patients accessing the scheme in their travel and medical care.

23 When a patient requests more than a single family member

(1) When a patient is requesting more than one family member or support person to accompany them to the medical care, the subsidy of this is decided by the case worker, under the conditions that—

(a) the support people need to come due to high risk or stress medical care, or members of the family are unable to be cared for in their home community during the time; or

(b) the patient was referred to and discussed the issue with a social worker who assessed the needs were reasonable and realistic.

24 If a family must accompany

(1) In the situation that family must accompany the patient to the medical care, reasonable resources should be provided to the family including, but not limited to—

(a) family rooms in accommodation and in hospitals; and

(b) childcare access in close proximity to the place of medical care for the duration of any care necessary; and

(c) access to support services and resources for families as needed.

25 Payment of Subsidies

(2) Final subsidies are calculated by a RARA MTAS Case Worker as specified in this Act.

(3) Final subsidies must be paid at least three weeks before the remuneration is required by the patient for travel, accommodation or otherwise.

(4) If rare and exceptional circumstances exist, as determined by a patient's RARA MTAS Case Worker, the funds may be paid no later than one week before the remuneration is required by the patient. The primary consideration in making this determination must be the best interests of the patient.

Division 4 Review System (Appeal Panel)

26 Establishment of the RARA MTAS Decisions Review Panel

The RARA MTAS Decisions Review Panel shall consist of three persons appointed by the Department of Health, with the requisite experience to review decisions made by RARA MTAS Case Workers.

27 Makeup of panel

The three persons shall consist of at least one trained **and** experienced social worker and one trained medical professional with recognised training **and** experience in the perinatal and maternity care sector.

28 Panel members to not be RARA MTAS Case Workers

These persons shall not be current or past RARA MTAS Case Workers, current or past referring medical professionals to the RARA MTAS Scheme under sub-clause 2 or anyone otherwise involved or previously involved in the RARA MTAS Scheme.

29 Powers of RARA MTAS Decisions Review Panel

(1) The RARA MTAS Decisions Review Panel will have remit to consider all decisions made in the referral and following stages of engagement with the scheme, including all elements of the scheme.

(2) Upon considering such decisions under the above clause, the panel shall be able to either uphold the decision or overturn the decision, making a new finding in relation to the matter.

30 Right to request a review

Any persons engaged in RARA MTAS, including patients and their care team, will be able to request a review of decisions made by RARA MTAS Case Workers or other decisions as set out in clause 29 through the RARA MTAS Decisions Review Panel.

31 Ability to initiate investigations

The RARA MTAS Decisions Review Panel will also be able to initiate investigations and reviews of their own accord, particularly in cases of misconduct by RARA MTAS Case Workers.

32 Appeals of RARA MTAS Decisions Review Panel to the NSW Health Care Complaints Commission and NSW Ombudsman

Decisions of the RARA MTAS Decision Review Panel may be further considered by the NSW Healthcare Complaints Commission and NSW Ombudsman, under the jurisdiction afforded to these bodies by the Health Care Complaints Act 1993 (NSW) and the Ombudsman Act 1974 (NSW), respectively.

Division 5 Family Rooms and Childcare

33 Location of family resources

(1) Family accommodation, specifically family rooms for appointments under RARA MTAS are to be within a 15-minute travelling time of the appointment location.

(2) Childcare locations and resources must be provided in all appointments covered by RARA MTAS and should be located in the appointment location or within 5 minutes of location.

(3) Childcare should be delegated under patients' guidance of their comfort with the care and families should be accommodated to attend appointments as support when feasible.

34 Family support provided

(1) Alongside financial support from RARA MTAS, family members will be provided with support resources and materials whilst patient is attending required treatment including but not limited to—

(a) support with emotional and mental health for support persons and family; and

(b) allow the family of the patient to be provided with reasonable resources including materialistic items including but not limited to clothing and food if needed; and

(c) relevant services for existing children of both de facto and married couples, or single parents, including but not limited to confectionery for children; and

(d) locations of the patient's care should be fitted with a support dedicated area allowing family a place to locate at visiting times in the hospital and access to information on support available.

Part 3 Rural Pathways for Medical Professionals

Division 1 Rural Guarantee Pathways

35 Government to incentivise tertiary institutions

NSW shall incentivise tertiary institutions to offer limited places for rural students in medicine, nursing, and midwifery degrees with substantially lower selection ranks.

36 Objectives of obstetricians and midwives

(1) The Department of Education and the Department of Health shall negotiate with such tertiary institutions with the primary objective of securing a net increase in the number of obstetricians and midwives per 100,000 people with birthing capacity aged 15 to 49 in rural and regional areas of NSW and an equally important objective of ensuring workforce quality.

(2) This shall cover any tertiary institution offering a relevant qualification.

37 Administration

The Department of Education shall administer the scheme.

38 Payment of scheme

(1) The tertiary institutions who offer the scheme shall be paid $10,000 in equal annual instalments per student in a course given entry through a rural guarantee pathway.

(2) Payments shall only occur if a tertiary institution fills the particular course with more than 5% but less than 10% of students through rural guarantee pathway.

Fee relief for rural and regional tertiary students

39 Fee relief

(1) Students from rural and regional areas of NSW studying medicine, nursing or midwifery degrees shall have their tertiary education fees paid for by NSW, through a direct transfer of funds to the Commonwealth.

(2) Fee relief shall apply regardless of whether a rural and regional student is studying on a rural guarantee pathway.

40 Student requirements

(1) Students who receive fee relief as prescribed in this part must follow the following provisions, including—

(a) those completing a medicine degree must complete a mandatory training rotation with a GP Obstetrician or Obstetrician in rural or regional NSW, preferably in proximity to their local community of origin; and

(b) during this time, students are to receive funds of $750 per week of their placement; and

(c) if completing a nursing or midwifery degree, an individual must spend two years working in a rural or regional community in NSW, preferably in proximity to their local community of origin; and

(d) they must be reimbursed by their employer as a standard employee with their skillset, training, and experience.

(e) those completing a nursing degree are encouraged to take further training as a midwife, under the same fee-free provisions.

Division 2 Rural Medical Schools

41 Rural Health Training Schemes Panel

(1) The NSW Government shall establish an advisory panel, to be known as the Rural Health Training Schemes Panel (RHT Panel).

(2) The RHT Panel shall investigate the success of existing schemes in NSW to train medical students within rural and regional communities, for example, the UNSW and Notre Dame Rural Clinical Schools in Wagga Wagga.

(3) The RHT Panel shall consider how existing programs can be replicated in other rural centres across NSW, with a particular focus on how this can be utilised to address the need for obstetricians and general practitioner obstetricians in rural and regional areas.

(4) The RHT Panel will make recommendations to the NSW Government on funding, regulatory and legislative arrangements required to replicate such programs under 2(b)(iii)

42 Nursing and Midwifery Training in Rural and Regional Areas

(1) The RHT Panel shall also be tasked with investigating arrangements for nursing and rural and regional midwifery students to complete degrees remotely, with a limited in-person component of the course to develop and assess practical skills.

(2) The RHT Panel must consider the feasibility of this, arrangements for such a scheme including balance between virtual and face-to-face study load and the impact of such a scheme on quality of care provided to patients by those trained through such options.

43 Upskilling Existing General Practitioners and Nurses

(1) General Practitioners (GPs) who reside in rural or regional areas will be able to additionally train as GP Obstetricians, with their degree fully funded by the state government (through payment to the Commonwealth)

(2) Nurses who reside in rural or regional areas will be able to additionally train as midwives, with their degree fully funded by the state government (through payment to the Commonwealth)

(3) GP Obstetricians and Nurses who study and are reimbursed under these schemes must work in their rural or regional town or city of residence, or another rural or regional area of NSW, for at least three years following the completion of their further study.

Part 3 Upskilling of medical staff on Country and in Community

Division 1 Training for on- country care

44 Scope

Programs shall be run for indigenous peoples and preexisting midwives in rural and regional areas to develop skills that can increase the capacity and availability of birthing on country programs.

45 Resources to LHDs

(1) Resources are to be dedicated to LHDs according to the level of necessities for support and the level of disadvantage being experienced.

(2) Training scaffolds shall be provided to each LHD which will be developed on the basis of rural aboriginal peoples needs and experiences and following the guideline of connecting, listening and responding: a blueprint for action - maternity care in NSW.

46 Development

Training courses will be developed and ran by professionals in the areas of maternity care specialising in rural care.

47 Availability

Training on country courses will be available as training though NSW Health, TAFE NSW and can be applied to university partnerships.

48 Participants

Reasonable participants for the program and the work of on-country care should be decided by LHD staff and Aboriginal elders of the area.

49 Contents

(3) Contents of training program can vary dependent on LHD communities wants and needs, including but not limited to—

(a) midwife training for ultrasound use; and

(b) on-country birth and care for Aboriginal people; and

(c) perinatal support for people in isolated areas; and

(d) recognition of need for further support and specialty services by midwives; and

(e) support of people suffering perinatal mental illness in isolated communities.

Accessibility of Support

50 Accessibility of resources to people experiencing heightened disadvantaged

(1) All resources for maternal care are to be provided to each individual in a personalised way that allows those experiencing heightened disadvantage to have dignity in their maternity experience, this should be implemented by:

(a) Providing translators and disability support workers to allow clarity and understanding in processes and to assist them in developing themselves a personalised care experience; and

(b) When viable, allowing the option of medical professionals which provide greatest level of comfort for patient, for example—

(a) Aboriginal healthcare workers for aboriginal patients; and

(b) healthcare workers from related ethnic minorities or language abilities connected to patient; and

(c) using inclusive language surrounding patients in patient care, information and resources relating, but not limited to—

(a) parental titles, gender, and roles; and

(b) pronouns and diverse relationship structure; and

(c) family structure and relations.

51 Support in Maternal care

(1) Extra accommodations can be implemented for people experiencing heightened disadvantage through care planning with medical professionals and the case worker for the person.

(2) Additional medical risks should be recognised and extra resources or care should be provided to people with disadvantage.

(3) Additional accommodations relating to travel and accommodation are to be covered by RARA MTAS when deemed reasonable by medical professionals and case workers.

(4) Maternity care plans should be developed with large input from individuals in relation to preferences and cultural needs which should be demonstrated to the best extent depending on the risk of the pregnancy.

Part 4 Aboriginal Pregnancy Support

Division 1 Birth on-country

52 Option of birth on-country opportunities

Birth on country opportunities should be available to patients of low risk in rural and regional communities.

53 Birth on country training programs

Birthing on-country should be supported by training programs and maternity ward access.

54 Birthing on-country and perinatal care

Birthing on country is to extend to perinatal care and is to be focused on individual needs of people and their communities, the program should be developed according to this.

Division 2 Implementation of Aboriginal specific maternity resources and education

55 LHD education in Aboriginal communities

Education is to be LHD focused on Aboriginal communities and should be guided by Aboriginal elders and health professionals in the community.

56 Perinatal care education and plans

Perinatal care education and plans should focus on the health of Aboriginal people and their babies relating to; pre-existing health issues, lifestyle issues and environmental factors.

Division 3 Right to Aboriginal Health professionals

57 Focus on Aboriginal health professionals

Focus is to be placed on Aboriginal health professionals in the development of the rural and regional maternal care workforce.

58 Requirements of Aboriginal health professionals

(1) In each maternity care service, at least 1 Aboriginal midwife or obstetrician should be accessible in small communities.

(2) In larger maternity care facilities, appropriate and realistic amounts of Aboriginal obstetricians and midwives should be employed.

(3) Indigenous workforce should continue to be a focus in rural healthcare education until all Aboriginal people requiring care have access to Aboriginal health professionals, including the aforementioned programs such as fee relief and Rural Guarantee places.

59 Access to an Aboriginal health care worker

All Aboriginal peoples are to have access to an Aboriginal health care worker and can be over telehealth if not viable in other access pathways.

Part 4 Workforce, infrastructure, and telehealth

Division 1 Maternity Ward Access

60 Mandatory Maximum Distance

Rural and regional patients shall, by 2030, be no less than 300 km from a medical ward providing basic adequate maternity facilities.

61 Adequate facilities

(1) Adequate maternity facilities must be capable of safely conducting regular obstetrics checkups, perinatal education (via telehealth where necessary), and births, including low-risk surgical births.

(2) In order to achieve this, the Department of Health shall report to the Government on areas in which new or improved facilities are required to meet this target, with a particular focus on extremely remote or socio-economically disadvantaged areas.

(3) The Department shall make recommendations on what investment and changes should be made by the Government to ensure the level of care that is most appropriate to be provided by current or future maternity wards, having regard to the needs and size of the surrounding population.

Division 2 Telehealth Accessibility

62 Telehealth promotion

The government shall establish and promote telehealth programs specifically designed to provide specific perinatal care services to pregnant people in rural and regional areas.

63 Telehealth focus programs

Telehealth programs shall have a focus on perinatal education programs and limited medical services deemed appropriate by medical professionals after considering a patient's circumstances, to be delivered via telehealth.

64 Accessibility of Telehealth

Telehealth programs should be accessible in various ways, including but not limited to video consultations and phone calls.

65 Establishment of telehealth rooms

(1) A small private room for telehealth patients will be implemented into necessary isolated locations as a public service and resource in NSW.

(2) Private rooms are to have set computers and monitors, headphones, and a mouse.

(3) There is to be technology support available in telehealth locations.

(4) Clear step-by-step instructions are to be provided on how to use the rooms and equipment.

(5) Rooms should be built in such a way that complete privacy is available for all patients.

(6) Telehealth rooms are to be accessible for all people including those experiencing heightened disadvantage.

66 Use of telehealth systems by RARA MTAS case workers

Telehealth systems are to be set up in such a way that they can be used for access to RARA MTAS case workers and other necessary resources for their maternity care.

67 Standards for Telehealth Services

The government shall collaborate with healthcare providers and relevant collaborators to develop guidelines and standards for the provision of telehealth services for perinatal care.

Division 3 Rural and Regional Maternity Wards

68 Resources for rural and regional maternity wards

Resources should be allocated dependent on the level of a community's disadvantage, and to the extent deemed necessary by individual Local Health Districts (LHDs).

69 Emergency Plan

Rural and regional maternity wards are required to create and update annually an emergency plan for perinatal and maternal care, particularly birth situations, where an escalation of care is required.

70 Risk Rating

(1) The Department of Health, in consultation with relevant stakeholders, particularly rural and regional maternity wards and LHDs, is to, within 12 months, create a ratings system to classify the risks posed by pregnancy to a patient.

(2) This rating system shall be used to assess all births in rural and regional areas to determine the care required by a person, and if necessary, lead to referral to RARA MTAS.

71 Theatre Staff

(1) The RHT Panel shall investigate ways to boost the number of theatre staff available in rural and regional areas to ensure surgical births are conducted safely.

(2) In particular, the RHT Panel shall consider the feasibility, necessity, and impact of creating and expanding theatres in rural centres to provide surgical birthing facilities to surrounding locations.

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