Submission to the Senate Select Committee on Women's Health

Adelaide Mums & Babies Clinic



Improving postnatal care in Australia

Building an integrated adequately funded model of care

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Executive summary

We are General Practitioners, practice owners and mothers. Our practice, Adelaide Mums and Babies Clinic (AMBC), has developed a particular focus on postnatal care, breastfeeding and lactation medicine, maternal mental health and women's physical health.

We welcome the opportunity to provide evidence to this inquiry because our clinical experience has consistently demonstrated a gap between the care women need after birth and the care the current health system is structured and funded to provide. Australia has substantial infrastructure around pregnancy and birth. The postnatal period is different.

After discharge from maternity care, women may simultaneously be:

- **recovering physically from pregnancy and birth;**
- **establishing breastfeeding or navigating infant feeding;**
- **severely sleep deprived;**
- **managing pain, pelvic floor dysfunction or surgical recovery;**
- **adapting to parenthood;**
- **experiencing anxiety, depression or birth trauma;**
- **managing contraception and reproductive health;**
- **caring for other children; and**
- **trying to understand whether their baby's feeding, sleep, crying or behaviour is normal.**

These issues do not occur in isolation. Yet our healthcare system frequently responds to them through separate services, appointments, referral pathways and funding arrangements. We believe Australia needs to move towards a GP-led, multidisciplinary and longitudinal model of postnatal care, supported by appropriate Medicare funding and strong links to midwifery, lactation medicine, women's-health physiotherapy, perinatal mental health, paediatrics and community services.

Senator Marielle Smith has asked us specifically to explain what works and the barriers to those models. AMBC offers an existing example of integrated care that patients value, but substantial patient gaps and service fees have not made the model financially sustainable. Significant, sustained government funding is needed to make this care viable for providers and affordable for families.

Our clinical experience is supported by the experiences of our patients. In September 2026, AMBC conducted a voluntary patient survey about experiences during the first 12 months after having a baby. There were 338 responses to the principal question about postnatal challenges, with 227 free-text responses to the question asking what respondents wanted the Senate inquiry to understand about postnatal healthcare.

The survey is not nationally representative. Respondents were self-selected and connected with a clinic specifically focused on postnatal care. We therefore do not present these data as estimates of national prevalence. Rather, the survey provides valuable patient-experience evidence that complements our clinical experience.

- The final survey figures below use 338 responses for postnatal challenges, 334 for barriers, 337 for antenatal preparation and 329 for valuable aspects of AMBC care. [1, Q1, Q3, Q4 and Q6]

The findings were consistent:

- **69.53%** identified breastfeeding or infant feeding as a major challenge;
- **63.91%** identified infant sleep;
- **58.88%** identified maternal mental health or emotional wellbeing;
- **53.55%** identified exhaustion or fatigue;
- **48.82%** identified difficulty understanding what was normal for their baby; and
- **35.80%** identified feeling isolated or unsupported.

Women also described barriers to obtaining appropriate care, including cost, waiting times, difficulty finding appropriately skilled clinicians, conflicting advice and fragmented care. Of 334 respondents, 168 (50.30%) reported conflicting advice from different healthcare professionals.

The survey also showed that women did not feel adequately prepared for the reality of the postnatal period. 69.14% wanted better preparation for the "fourth trimester", 55.79% wanted better preparation around infant sleep, crying and behaviour, 46.88% wanted better breastfeeding and infant-feeding preparation and 43.03% wanted better preparation around maternal mental health. When asked what aspects of AMBC care had been valuable, respondents particularly identified:

- **69.60%** GPs with additional breastfeeding/lactation expertise;
- **67.17%** feeling listened to and having concerns taken seriously;
- **65.05%** longer appointments with enough time to discuss concerns;
- **58.66%** being able to address maternal and infant health together; and
- **54.41%** being able to address several concerns in one appointment.

This is a consistent message. Women are telling us that time, continuity, expertise and integrated care matter. One respondent put it particularly clearly:

"If there is one thing I would want the Senate inquiry to understand, it is that time is healthcare."

Survey respondent | Q10, response 54, pp. 30–31. Excerpt; original wording retained.

We recommend that the Committee consider the following reforms:

1

Establish a national model of comprehensive postnatal care

Recognise the first 12 months after birth as an important period of preventive and longitudinal healthcare, with clear expectations for comprehensive maternal and infant follow-up.

2

Reform Medicare funding for postnatal care

Review existing MBS arrangements and develop funding that reflects the time and complexity of contemporary postnatal care, including longer consultations and care involving both mother and baby.

3

Establish multidisciplinary Postnatal Care Hubs

Support community-based models bringing together GPs, midwives, lactation medicine, women's-health physiotherapy, perinatal mental health and appropriate paediatric/ community services.

4

Improve access to breastfeeding and infant-feeding care

Recognise appropriately trained breastfeeding and lactation medicine within the healthcare system, with national education, credentialing, clinical guidance and equitable funding.

5

Make maternal mental health and pelvic health routine components of postnatal care

Move beyond screening alone towards assessment, treatment and referral integrated with physical postnatal care.

6

Improve antenatal preparation for the postnatal period

Prepare families realistically for feeding, infant sleep and behaviour, maternal recovery, mental health, pelvic health, relationships and where to obtain help.

7

Develop national postnatal clinical guidance and data collection

Improve professional education and establish national data on postnatal outcomes, including infant feeding and access to care.

8

Ensure postnatal care is accessible regardless of ability to pay

Funding and service design should reduce the extent to which access to appropriate care depends on private payment, health literacy, location or a woman's ability to navigate multiple services.

1

The postnatal period is a distinct period of healthcare

The Committee's terms of reference specifically ask for evidence regarding best-practice postpartum care, women's physical and psychological experiences after birth, the cost and accessibility of postpartum services, infant feeding, mental health, physiotherapy, allied health, professional education and data collection. Our submission addresses each of these issues through the lens of primary care and patient experience.

The first year after birth should not be understood as simply a short period following maternity care. For many women, it is a period of substantial physiological, psychological and social change. A woman may be recovering from a caesarean section, severe perineal trauma or postpartum haemorrhage while simultaneously breastfeeding a newborn every few hours. She may be experiencing severe sleep deprivation.

She may have concerns about infant weight gain, crying or sleep. She may be experiencing anxiety or depression. She may have pelvic floor dysfunction or pain. She may be adjusting to another child in the family. These problems interact. Our survey demonstrates this interconnectedness. Breastfeeding, infant sleep, maternal mental health and exhaustion were among the most frequently reported challenges.

The respondent described attending hospital outpatient care, an obstetrician, CAFHS and a lactation consultant and receiving information that was not always consistent or evidence-based. The issue is therefore not simply whether individual services exist. It is whether the system enables those services to work together around the woman and her baby.

"It felt less like a network of support and more just overwhelming."

Survey respondent | Q1, other response 18, p. 3. Excerpt; original wording retained.

2

Our perspective as clinicians and mothers

We are both GPs, practice owners and mothers, with additional training in obstetrics and breastfeeding/lactation medicine. Our personal experiences of breastfeeding and early parenthood significantly influenced our clinical practice. We experienced challenges including infant weight loss, low milk supply, mastitis, blocked ducts, jaundice, expressing, supplementation and breast refusal. Despite our medical knowledge, these experiences were challenging.

They changed our understanding of how vulnerable a new mother can feel when something does not go according to plan. They also changed how we approach our patients. A woman experiencing breastfeeding difficulties does not necessarily need another leaflet.

She may need a clinician to assess her health, her baby's health and feeding together, understand what has happened, identify contributing factors, provide evidence-based advice and develop a plan that is realistic for her. Our patients describe the same need.

When asked what they valued about AMBC, 69.60% identified access to GPs with additional breastfeeding/lactation expertise, 67.17% feeling listened to and taken seriously, and 58.66% being able to address their health and their baby's health together.

These percentages are based on 329 respondents to the final survey question about valuable aspects of AMBC care. [1, Q6, pp. 16–18]

3

The clinical reality mother and baby are a dyad

Postnatal healthcare is unusual because the health of the mother and baby are often inseparable. Breastfeeding difficulties may affect maternal mental health. Infant sleep difficulties may contribute to maternal exhaustion. Maternal pain may affect feeding and caregiving. Birth trauma may affect bonding, mental health and subsequent healthcare engagement. Pelvic pain may affect relationships and sexual health.

A baby with feeding difficulties may require simultaneous assessment of maternal supply, infant oral function, feeding technique, weight gain and maternal wellbeing. Yet women are frequently required to see separate professionals for these concerns. **The survey included the following comment:**

"Not one practitioner to look at the big picture for my sons feeding challenges"

Survey respondent | Q1, other response 13, p. 3. Excerpt; original wording retained.

"Without having a doctor who would address both my baby and my health concerns, as I was lucky enough to have, I would have forgone any appointments for myself and only attended for my baby."

Survey respondent | Q10, response 35, p. 28. Excerpt.

Another respondent described the value of seeing one clinician who treated mother and baby together:

Each remains an individual patient, with their own clinical needs. Integrated assessment helps ensure that the mother's health receives attention alongside her baby's. This is the rationale for a GP-led model. The GP does not need to provide every service. The GP can provide the clinical home in which multiple concerns are identified, prioritised and coordinated.

4

Time is healthcare

One of the strongest findings from the survey is that women value time. When asked what aspects of AMBC care were valuable:

- **65.05%** selected longer appointments with enough time to discuss concerns;
- **67.17%** selected feeling listened to and having concerns taken seriously;
- **54.41%** selected being able to address several concerns in one appointment.

These figures use 329 respondents. [1, Q6, pp. 16–18]

This is not surprising. A postnatal consultation may need to cover:

- **maternal physical recovery;**
- **breastfeeding;**
- **infant weight;**
- **infant sleep;**
- **maternal mental health;**
- **contraception;**
- **pelvic health;**
- **medications;**
- **family circumstances; and**
- **safety concerns.**

A short consultation may not allow sufficient time for this assessment. The current MBS contains specific postnatal items, but they are limited in timing and frequency. For example, item 16407 provides for a postnatal attendance between four and eight weeks after birth, lasting at least 20 minutes and payable once per pregnancy. Item 16407 also includes an offered mental health assessment and other eligibility conditions.

Item 16408 applies to certain attendances between one and four weeks after birth, lasting at least 20 minutes, for patients privately admitted for the birth. It excludes consulting-room, hospital and residential aged-care attendances and is payable once per pregnancy, subject to provider and other item restrictions.

[6, 7] These items have an important role, but they do not constitute a comprehensive longitudinal model of postnatal care across the first year.

The policy question is therefore not simply whether a postnatal MBS item exists. It is whether Medicare adequately supports the amount, duration and complexity of care women require. In our experience, it does not currently do so consistently.

Other eligible Medicare attendances remain available beyond these early postnatal items. The issue is whether the overall funding arrangements adequately support repeated, complex care and the work required to coordinate it.

5

Affordability and access

Cost is a significant issue in postnatal care. The survey identified cost, waiting times, access to appropriate expertise and fragmented care as barriers. Of 334 respondents, 131 (39.22%) identified cost, 129 (38.62%) difficulty finding appropriate expertise and 115 (34.43%) difficulty obtaining an appointment. [1, Q3, pp. 5–8]

One respondent wrote:

"Womens healthcare is EXPENSIVE - it's such a shame when you have to choose whether to continue follow up with a physio or lactation consultant because you simply can't afford it!"

Survey respondent | Q10, response 64, p. 32. Excerpt; original wording retained.

Another described being able to access appropriate care because of her education and financial circumstances and recognised this as a privilege. This is important because postnatal care occurs at a time when many families have reduced household income.

A woman on maternity leave may simultaneously face:

- reduced income;
- increased household costs;
- childcare costs;
- private lactation fees;
- physiotherapy costs;
- psychology costs;
- GP out-of-pocket fees; and
- costs associated with investigations and specialist referrals.

A system that relies heavily on private payment risks creating inequity. The survey's findings therefore support the Committee's specific consideration of the cost and accessibility of postpartum healthcare.

The cost of the AMBC model

Our financial disclosure, effective from 17 September 2026, lists a $225 patient gap for a standard 60-minute joint parent-and-baby consultation. The eligible baby's component is bulk billed and the gap is charged to the parent. A 90-minute consultation for twins has a $260 gap, and a 60-minute weekday home visit for breastfeeding and infant support has a $325 gap.

Home visits are available on enquiry, with additional travel and after-hours charges where applicable. [2]

Three standard joint consultations would therefore cost a family $675 out of pocket. This is an illustration, not an observed average course of care, and excludes other appointments, investigations, medicines and allied health. Full consultation fees are payable upfront, with applicable rebates processed separately. Education and parent groups also carry private fees. [2]

"I absolutely love the Mums and Babies clinic but the pricing is so out of reach for myself"

Survey respondent | Q10, response 87, pp. 34–35. Excerpt.

One respondent described the resulting difficulty:

Reducing these fees without replacing the revenue would further undermine the service. Government investment must address both the cost borne by patients and the resources required to provide comprehensive care.

6

Breastfeeding and lactation medicine

Breastfeeding should be supported as a public-health priority while respecting individual family circumstances and feeding choices. However, breastfeeding difficulties are not always matters of education. They may involve medical conditions affecting the mother, the infant or both. Appropriate assessment may require clinical history, physical examination, infant assessment, medication review, feeding assessment, investigation and follow-up.

The survey identified breastfeeding or infant feeding as the most frequently reported challenge, at 69.53% (235 of 338 respondents). [1, Q1, pp. 1–3] When asked which professional support should receive increased government funding, breastfeeding and lactation support was selected by the greatest proportion of respondents: 230 of 334 (68.86%). [1, Q9, pp. 21–23] Women also described difficulty obtaining appropriately skilled care. **One respondent wrote:**

> ***"The right support from people who know exactly what they're doing in the space is vital."***
>
> Survey respondent | Q10, response 95, p. 35. Excerpt; original wording retained.

Another described receiving conflicting breastfeeding advice from multiple providers.

We recommend:

- recognition of breastfeeding and lactation medicine as a defined area of clinical practice;
- appropriate education and credentialing;
- national clinical guidance;
- Medicare recognition for appropriately trained clinicians;
- research funding; and
- equitable access to skilled care.

7

Breastfeeding support must be evidence based and non judgemental

Supporting breastfeeding should not mean assuming that every woman will breastfeed exclusively or that breastfeeding outcomes are a measure of maternal success.

Women require evidence-based information about:

- **breastfeeding;**
- **combination feeding;**
- **expressing;**
- **formula feeding;**
- **transitioning between feeding methods; and**
- **management of complications.**

One survey respondent described being told "breast is best" when asking about mixed feeding and transition to formula, and wanting to feel better equipped with alternatives without guilt. [1, Q4, other response 19, p. 11] The objective should be informed choice and skilled support, not maternal guilt.

At the same time, women who want to breastfeed should not be disadvantaged by inadequate access to appropriate clinical care.

8

Maternal mental health

Maternal mental health should be integrated into routine postnatal medical care. Our survey found that 58.88% of respondents (199 of 338) identified mental health or emotional wellbeing as a major challenge. Women also identified mental health as an area where they wanted better antenatal preparation: 43.03% (145 of 337) selected this option.

[1, Q1, pp. 1–3; Q4, p. 9] Screening is important, but screening alone is not treatment. Women need clinicians who have enough time to understand their circumstances, identify risk, consider physical and social contributors and coordinate appropriate treatment. The survey included experiences of postnatal depression, significant anxiety and difficulty accessing affordable psychological care.

One respondent described paying substantial out-of-pocket costs for postpartum psychological care while on maternity leave and consequently delaying care. A GP-led model can help because mental health can be considered alongside the physical and infant-related concerns that are often contributing to distress.

9

Pelvic health

Pelvic floor and women's physical health should be considered routine components of postnatal care. The survey found that

23.37% (79 of 338) reported pelvic floor or continence problems and

16.86% (57 of 338) reported sexual health or pain problems.

[1, Q1, pp. 1–3] These problems can be embarrassing for women to raise spontaneously. Routine enquiry and accessible referral pathways are therefore important.

We recommend:

- **Medicare-funded postnatal women's-health physiotherapy;**
- **routine pelvic-health assessment;**
- **improved access to public postnatal physiotherapy;**
- **clear referral pathways for complex pelvic-health problems; and**
- **continued care where symptoms persist beyond arbitrary time limits.**



10

The fourth trimester and antenatal preparation

The survey strongly supports better preparation during pregnancy for the reality of the postnatal period. Of 337 respondents to this question:

- **69.14%** wanted better preparation for the fourth trimester;
- **55.79%** wanted better information about infant sleep, crying and behaviour;
- **46.88%** wanted better breastfeeding and infant-feeding preparation; and
- **43.03%** wanted better preparation for maternal mental health. [1, Q4, p. 9]

This is not simply a request for more information. Families need realistic preparation.

They need to know:

- what normal newborn behaviour can look like;
- how feeding may affect sleep and maternal wellbeing;
- what physical recovery may involve;
- when pain or bleeding requires assessment;
- what pelvic-health problems should prompt review;
- what symptoms may indicate depression or anxiety;
- what support they may need;
- how partners and families can help; and
- where to seek assistance.

Antenatal care currently has a strong focus on pregnancy and birth. It should also prepare families for what comes afterwards.

11

Multidisciplinary Postnatal Care Hubs

We recommend the development and evaluation of multidisciplinary community Postnatal Care Hubs.

Potential services could include:

- GPs;
- midwives;
- breastfeeding and lactation medicine;
- women's-health physiotherapy;
- psychology;
- social work;
- dietetics;
- paediatric referral pathways; and
- community maternal and child health services.

The purpose would not be to replace existing services. It would be to connect them. The survey showed the value women place on being able to address multiple issues in one appointment and on having maternal and infant health considered together.

One respondent described the current experience:

> ***"But some days it feels like I am drowning in appointments (particularly add the needs of an older child)."***
>
> Survey respondent | Q10, response 115, p. 37. Excerpt; original wording retained.

The same respondent suggested centralising appointments and providing professionals adequately trained in perinatal care. This is the principle behind a Postnatal Care Hub.

In the final survey, 173 of 334 respondents (51.80%) selected multidisciplinary clinics or hubs as a funding priority. [1, Q9, pp. 21–23]

We recommend substantial, multi-year service funding for suitable existing clinics and new services where access is poor. This should support infrastructure, care coordination, follow-up, parent education and workforce development alongside Medicare-funded consultations. Funding agreements should specify the services provided, avoid duplicate payment for the same activity and require reduced patient costs, including fully funded access for families unable to pay.

12

Postnatal day stay care

There is an important gap between routine outpatient care and hospital admission. Some women and babies require several hours of intensive support but do not require inpatient admission. The survey included strong positive experiences of existing intensive postnatal services, including residential programs. One respondent described a three-night postnatal stay as addressing breastfeeding difficulties, maternal psychological distress and birth trauma, while allowing physical and mental rest.

[1, Q10, response 99, pp. 35–36]

We recommend government-funded pilots of postnatal day-stay services, with evaluation of:

- **maternal mental health;**
- **infant feeding;**
- **emergency presentations;**
- **hospital admissions;**
- **breastfeeding outcomes;**
- **maternal confidence; and**
- **healthcare utilisation.**

Day-stay services should be linked with community and hospital pathways, with appropriate clinical governance and escalation when required. These are proposed services to evaluate; the survey does not establish the clinical effectiveness or cost savings of a particular day-stay model.

13

Continuity of care

Continuity matters. Women repeatedly described the importance of seeing a clinician who knows their history and can follow both mother and baby over time.

Continuity is particularly important when there are:

- **mental health concerns;**
- **breastfeeding difficulties;**
- **birth trauma;**
- **complex infant feeding;**
- **pelvic health issues; or**
- **multiple interacting problems.**

One respondent described the benefit of seeing one GP for herself and her baby and receiving consistent information from clinicians who shared a common approach. Continuity should therefore be a design principle of postnatal care rather than an incidental benefit.

Funding should support the work between appointments, including communication with other clinicians, care planning, referrals and review. Named points of contact and clear handovers from maternity care would reduce the coordination burden on families.

14

Education training and national clinical guidelines

The survey identified conflicting advice as a significant problem. Of 334 respondents, 168 (50.30%) reported receiving conflicting advice from healthcare professionals. [1, Q3, pp. 5–8]

Women should not be required to reconcile professional disagreements themselves.

We recommend improved education and training for:

- GPs;
- GP registrars;
- medical students;
- obstetricians;
- paediatricians;
- midwives;
- nurses;
- physiotherapists;
- psychologists; and
- other relevant allied health professionals.
- Training should include:
- breastfeeding and lactation;
- maternal mental health;
- pelvic health;
- infant feeding;
- normal infant sleep and behaviour;
- recognition of red flags;
- birth trauma;
- contraception;
- referral pathways; and
- mother-and-baby dyad assessment.

The Committee's terms of reference specifically identify research, education and training as areas for consideration.

15

Data and research

Australia needs better data about what happens to women after they leave maternity care.

We recommend a national postnatal minimum dataset incorporating:

- maternal physical health;
- maternal mental health;
- pelvic health;
- infant feeding;
- breastfeeding duration;
- access to feeding support;
- infant health;
- healthcare utilisation;
- emergency presentations;
- postnatal readmissions;
- access to allied health; and
- relevant social and demographic factors.
- A specific National Infant Feeding Minimum Dataset should include, where appropriate:
- breastfeeding initiation;
- exclusive breastfeeding;
- combination feeding;
- formula feeding;
- duration;
- intended versus actual feeding outcomes;
- access to professional support; and
- maternal and infant outcomes.
- The purpose should be service improvement and research, not judgement of individual women. The Committee's terms of reference specifically identify data collection, reporting, monitoring and research relating to postpartum healthcare.

Early support and long term health

Maternal health is important in its own right. Supporting mothers can also support their babies and families. The World Health Organization recommends integrating maternal mental health support into early childhood health and development services. Research on early development describes how responsive relationships and supportive environments contribute to the foundations of lifelong health. [3, 4]

These findings support investment in early care, without implying that a difficult start determines a child's future. Evaluation should include maternal confidence and wellbeing, infant outcomes, access, patient costs, workforce sustainability and healthcare use. Long-term clinical and economic benefits of particular models should be tested rather than assumed.

16

Equity

The current model places considerable responsibility on women to identify what is wrong, find the right professional, obtain an appointment and pay for care.

This particularly disadvantages women who have:

- **limited financial resources;**
- **lower health literacy;**
- **limited family support;**
- **language barriers;**
- **disability;**
- **mental illness;**
- **housing insecurity;**
- **family and domestic violence;**
- **rural or remote residence; or**
- **complex medical or social circumstances.**

One survey respondent described being able to navigate a complex situation because she was educated, worked in the area and could afford appropriate care. She recognised that other women may not have those advantages. That is an important policy consideration.

A high-quality healthcare system should not rely upon women having the capacity to become expert healthcare navigators at precisely the time when they are exhausted and caring for a newborn.

Service design should involve the communities it serves, including Aboriginal and Torres Strait Islander families and Aboriginal Community Controlled Health Organisations. Appropriate interpreting, navigation support, outreach, home visits and telehealth can complement in-person care. Access should include families after loss, neonatal admission, multiple births and subsequent babies.

17

Workforce sustainability

A comprehensive postnatal model requires an appropriately trained workforce. This includes GPs, midwives, lactation clinicians, physiotherapists, psychologists, nurses, paediatricians and other allied-health professionals. However, workforce sustainability is itself affected by remuneration. General practice involves substantial cognitive and relational work that is difficult to capture in short consultations. This is particularly relevant to women's health and postnatal care.

If longer, complex consultations are not financially sustainable, clinicians and practices may be forced towards shorter or less complex models of care. The solution is not simply to ask clinicians to provide more care. The system must fund the care it expects to receive.

Our experience at AMBC is that, despite substantial patient gaps and service fees, comprehensive postnatal care remains financially difficult to sustain. Our GPs can earn more through shorter consultations in other clinics with lower service fees and lower patient gaps. Asking patients to pay more does not resolve this underlying mismatch between the work required and the funding available.

Australian research by Stone and colleagues examined 770 female GPs who were retiring, substantially reducing their clinical work or considering doing so. Participants described financial and occupational pressures alongside commitment to their patients. This selected sample does not establish a national exit rate, but it reinforces the importance of workforce sustainability when considering access to longer consultations and women's healthcare. [5]

Adelaide Mums and Babies Clinic as a case study

AMBC was established in response to a gap we observed in conventional postnatal care

The clinic provides:

- comprehensive GP care;
- breastfeeding and lactation medicine;
- maternal mental health care;
- infant feeding support;
- infant sleep and settling support;
- contraception;
- women's health;
- midwifery;
- nursing;
- women's-health dietetics;
- perinatal social work and psychology;
- parent groups;
- Circle of Security Parenting; and
- antenatal education.

Five of our GPs are IBCLCs. The clinic provides long consultations because this is what complex postnatal care requires. Our patient survey provides evidence that women value this model, particularly the combination of time, expertise, continuity and mother-and-baby care. However, the model is difficult to sustain under the current funding environment. The out-of-pocket cost is a significant barrier for some families.

This creates a paradox: The model of care women tell us they need is available, but access to it can depend on whether they can afford it. Our objective is not to advocate that AMBC itself become the national model. Rather, we want the principles that underpin the service-time, continuity, expertise, coordination and care of mother and baby together-to inform broader health-system design.

One respondent described what this care had meant for her:

> ***"I feel that I was able to enjoy that time of my child's life due to the support I had through AMBC."***
>
> Survey respondent | Q10, response 93, p. 35. Excerpt.

The survey also includes critical feedback about follow-up and feeling heard. This should inform service improvement, alongside the positive experiences. Funding should support evaluation, accessible feedback and reassessment, so that expansion is accompanied by accountability for the care provided.

Recommendations

We respectfully recommend that the Committee consider the following reforms.

1. **National postnatal care framework**
   Develop a national framework recognising the first 12 months after birth as an important period of preventive and longitudinal healthcare.

2. **Medicare reform**

   Review and reform postnatal MBS arrangements to support:

   - longer consultations;
   - complex postnatal care;
   - repeated care where clinically required;
   - care involving both mother and baby;
   - mental health assessment and management; and
   - longitudinal GP care.

   Reform should address the adequacy of attendance rebates, incentives and safety-net arrangements together, preserving support for complex pregnancy and mental health care.

3. **Postnatal Care Hubs**

   Fund and evaluate multidisciplinary community Postnatal Care Hubs integrating primary care, midwifery, lactation, pelvic health, mental health and appropriate paediatric/community services. Provide multi-year funding for suitable existing services and new capacity, including coordination and infrastructure, with demonstrably lower patient costs.

4. **Breastfeeding and lactation medicine**
   Establish national recognition, education, credentialing, clinical guidance and appropriate funding for breastfeeding and lactation medicine.

5. **Maternal mental health**
   Integrate maternal mental health assessment and treatment into routine postnatal medical care and improve access to affordable perinatal psychological and psychiatric services.

6. **Pelvic health**

   Establish funded access to postnatal women's-health physiotherapy and routine pelvic-health assessment.

7. **Postnatal day stay services**
   Fund and evaluate community-based postnatal day-stay services for women and babies requiring intensive support without hospital admission.

8. **Antenatal preparation**

   Strengthen antenatal preparation for the first year after birth, including realistic education about feeding, sleep, infant behaviour, maternal recovery, mental health, pelvic health and support needs.

9. **Education and clinical guidelines**

   Develop nationally consistent education and evidence-based clinical guidelines for postnatal, breastfeeding and infant-feeding care across relevant health professions.

10. **Data and research**

    Establish national postnatal and infant-feeding data collection and increase Australian research funding in breastfeeding, lactation, postnatal physical health and maternal mental health.

11. **Equity**

    Ensure postnatal services are accessible regardless of socioeconomic status, geography, health literacy, disability, culture or family circumstances.

12. **Workforce**

    Review remuneration, training and workforce arrangements necessary to sustain a skilled postnatal healthcare workforce, particularly within general practice.

Conclusion

Our patients have given us a clear message. The postnatal period is not simply a short episode after birth. It is a period of significant healthcare need. Women have told us that they need time. They need continuity. They need appropriately trained clinicians. They need evidence-based information. They need mental-health support. They need pelvic-health care. They need breastfeeding and infant-feeding support.

They need someone who can look at the mother and baby together. And they need these services to be accessible without requiring substantial private expenditure.

One respondent described the current experience as:

"but once you give birth, you're on your own and then overwhelm is huge."

Survey respondent | Q10, response 123, pp. 38–39. Excerpt; original wording retained.

Another wrote:

"A woman's postpartum challenges don't end after her 6 week checkup."

Survey respondent | Q10, response 71 p. 32. Excerpt; original wording retained.

We believe the healthcare system should reflect this reality. Women should not need to be unusually knowledgeable, financially privileged or persistent to obtain appropriate postnatal care. They should not have to become their own care coordinators. They should not have to choose between their own health and the health of their baby. Australia has a highly skilled maternity and primary healthcare workforce.

The opportunity now is to build a system that connects that workforce around women and their babies. Women experience the postnatal period as one life. Our healthcare system should do the same. Postnatal care is not an optional extra after maternity care. It is maternity care. And it is preventive healthcare.

Significant and sustained government investment is required to make comprehensive postnatal care affordable for families, viable for services and sustainable for the workforce. Existing models such as AMBC provide a practical foundation on which to build.

Dr Briony Andrew and Dr Rhiannon Smith

Adelaide Mums and Babies Clinic



Appendix 1: Patient survey methodology

In September 2026, Adelaide Mums and Babies Clinic conducted a voluntary survey of patients and families about experiences during the first 12 months after having a baby. The survey received 338 responses to the principal postnatal-challenges question. Individual questions had slightly different response numbers. The final open-ended question asking respondents what they wanted the Australian Senate inquiry to understand received 227 responses.

The survey was conducted among the AMBC patient community and was not designed to be nationally representative. The findings should therefore be interpreted as patient-experience evidence rather than population prevalence estimates. The survey nevertheless provides a valuable source of lived-experience evidence and identifies consistent themes around:

- breastfeeding and infant feeding;
- infant sleep and behaviour;
- maternal mental health;
- exhaustion;
- cost;
- access to expertise;
- conflicting advice;
- fragmentation;
- inadequate preparation; and
- the value of longer, coordinated consultations.

Q10 records 227 responses and 113 skips, indicating 340 survey records in the export; this does not mean 340 people answered every question. Denominators used here are Q1 338, Q3 334, Q4 337, Q6 329 and Q9 334. Multiple selections were allowed. Q9 selections exceed five per respondent overall despite its top-five instruction, so results are reported as selections rather than a strict ranking.

The Q7 and Q8 charts do not provide printed exact category counts. No numerical outcome percentages have been inferred from those charts. Findings describe patient-reported experience, not causal clinical effects or proven cost savings. Quotations are de-identified excerpts checked against the final report; original wording is retained. Some respondents describe care outside AMBC. The companion patient submission explores these experiences in greater detail.

Appendix 2: Selected patient experiences

> *"If there is one thing I would want the Senate inquiry to understand, it is that time is healthcare."*

Survey respondent | Q10, response 54, pp. 30–31. Excerpt; original wording retained.

> *"It felt less like a network of support and more just overwhelming."*

Survey respondent | Q1, other response 18, p. 3. Excerpt; original wording retained.

> *"But some days it feels like I am drowning in appointments (particularly add the needs of an older child)."*

Survey respondent | Q10, response 115, p. 37. Excerpt; original wording retained.

> *"Womens healthcare is EXPENSIVE - it's such a shame when you have to choose whether to continue follow up with a physio or lactation consultant because you simply can't afford it!"*

Survey respondent | Q10, response 64, p. 32. Excerpt; original wording retained.

> *"A woman's postpartum challenges don't end after her 6 week checkup."*

Survey respondent | Q10, response 71, p. 32. Excerpt; original wording retained.

> *"Postpartum is more than the first 6 weeks"*

Survey respondent | Q10, response 113, p. 37. Excerpt; original wording retained.

"The right support from people who know exactly what they're doing in the space is vital."

Survey respondent | Q10, response 95, p. 35. Excerpt; original wording retained.

"Not one practitioner to look at the big picture for my sons feeding challenges"

Survey respondent | Q1, other response 13, p. 3. Excerpt; original wording retained.

"Every baby and birth is different. Practical hands on support and trusted advice is invaluable."

Survey respondent | Q10, response 151, p. 41. Excerpt; original wording retained.

"Continuity is so valuable, both in the perspective of being able to see one GP for myself, as well as my baby and older children and in the perspective of seeing other GP's and health care professionals who share the same view point and give the same information."

Survey respondent | Q10, response 69, p. 32. Excerpt; original wording retained.

"Good care has to cover all these issues together. Treating each issue with a separate provider makes no sense and means ineffective, inaccessible and expensive care."

Survey respondent | Q10, response 114, p. 37. Excerpt; original wording retained.

References

[1] AMBC final survey. SurveyMonkey report, September 2026, 48 pages. Question, response and page references accompany findings and verbatim quotations. De-identified use of comments was explained in the survey.

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