

MERCY HEALTH

SUBMISSION TO THE SENATE SELECT COMMITTEE ON WOMEN'S HEALTH

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Title: wabung-ngetel
Call of Country, Gunnai Language

Artist: Dixon Patten
Bayila Creative, Gunnai and Yorta Yorta

Acknowledgement of Country

Mercy Health acknowledges Aboriginal and Torres Strait Islander Peoples as the First Australians. We acknowledge the diversity of Indigenous Australia. We respectfully recognise Elders past and present. This report was produced on Wurundjeri Country.

Recognition of Heritage

As part of our reflection practices, we stop to consider all that we have learnt from those who have come before us to make Mercy Health the ministry it is today. We acknowledge Mercy Ministry Companions, which stewards the ministry of Mercy Health and the Mercy spirit so that they can continue to flourish into the future. We give thanks and acknowledge the Sisters of Mercy and their Founder, the Venerable Catherine McAuley, as well as the Family Care Sisters, the Good Shepherd Sisters, the Holy Spirit Missionary Sisters and the Knights of the Southern Cross.

Contents

Mercy Health - Caring for women across the life course	4
Executive summary	5
Priority 1	
Fund recovery after birth.....	6
Priority 2	
Ensure timely mental healthcare and support after loss.....	7
Case study 1	
<i>Compassionate care after the loss of a baby</i>	<i>9</i>
Priority 3	
Provide active care for pain and pelvic health conditions.....	10
Priority 4	
Connect care around women and families	14
Case study 2	
<i>Supporting continuity, choice and connection to Country</i>	<i>15</i>
Case study 3	
<i>Connected care for women and families through early parenting services</i>	<i>17</i>
Priority 5	
Invest in the systems that make better care possible	19
References	21

Mercy Health - Caring for women across the life course

Mercy Health welcomes the opportunity to contribute to the Senate Select Committee on Women's Health.

Women should not be left to navigate fragmented services while recovering, caring for a baby, living with pain or managing serious illness. Women need timely, connected and affordable care throughout the entirety of their lives.

Mercy Health asks the Committee to place continuity, equity and long-term recovery at the centre of its recommendations, backed by the digital infrastructure, workforce and research investment needed to support women through changing needs and service settings throughout their lives.

Mercy Health is one of Australia's largest Catholic not-for-profit health, aged care and community service organisations. More than 10,000 staff deliver care across Victoria, southern New South Wales, northern Queensland, Western Australia and the Australian Capital Territory. Our footprint includes four public hospitals, specialist women's and newborn health services, inpatient and community-based mental health and palliative care, including Australia's largest 24-hour multidisciplinary community palliative care service, supporting around 540 patients at any one time, two early parenting centres, 30 residential aged care homes, support at home services, and a network of ten retirement villages. Together, these services provide care across metropolitan, regional and rural communities and through every stage of life connecting specialist women's health expertise with a whole-of-life perspective.

As a Catholic health organisation Mercy Health's approach is grounded in the inherent dignity of every person and a commitment to justice, compassion and the common good. Healthcare should be safe, connected, personal, attend to the whole person including the provision of spiritual, pastoral and bereavement support, respond to those facing the greatest barriers, and enable women and families to participate meaningfully in decisions about their care. This requires us to address the structures that leave women without timely treatment, continuity or practical support.

Our contribution draws on the following service and research expertise:

Pregnancy, birth and newborn care: tertiary maternity, neonatal intensive care and special care at Mercy Hospital for Women, and maternity and special care nursery services at Werribee Mercy Hospital, including care for women and babies referred from other services.

Recovery, mental health and early parenting: maternity and feeding support; the Mother Baby Unit at Werribee Mercy Hospital; and the O'Connell Family Centre and Woi-wurrung-yagila-wulumperi, Whittlesea Early Parenting Centre, supporting parental wellbeing, feeding, sleep and parent-child relationships

Bereavement and subsequent pregnancy care: Bereavement Care Coordinators and the STAR (Stillbirth and Reproductive Loss) Clinic, connecting support after pregnancy or infant loss with follow-up and future pregnancy care.

Pelvic health and persistent pain: specialist gynaecology, urogynaecology, continence care, pelvic health physiotherapy and multidisciplinary perineal care.

Later life and serious illness: Healthy Ageing, home and community care, and palliative care, informing our recommendations on pain, independence and practical support.

Research and education: expertise in maternal and infant outcomes, perinatal research, pelvic health and evaluation of care models, linking evidence with clinical practice.

This submission focuses on areas where Mercy Health has direct clinical, service-delivery and research experience. Across these settings, effective care must follow women over time and respond to their physical, psychological, social and spiritual needs.

Executive summary

Mercy Health's clinical and research teams identify a consistent challenge: women's needs extend across services and over time, but funding, workforce capacity and care arrangements do not consistently support that continuity.

Mercy Health calls for coordinated Commonwealth, state and territory action across five priorities, with 12 recommendations embedded across these.

Priority	Focus	Recommendations
1. Fund recovery after birth	A funded pathway for physical and psychological recovery, extending beyond six weeks according to need	1
2. Ensure timely mental healthcare and support after loss	Early identification linked to treatment and continuing support after pregnancy or infant loss	2–3
3. Provide active care for pain and pelvic health conditions	Treatment while awaiting specialist care, lifelong pelvic healthcare and pain recognition in older women	4–6
4. Connect care around women and families	Maternity continuity, coordinated neonatal care and practical support to overcome barriers to access	7–10
5. Invest in the systems that make better care possible	Connected information, research capacity and accountability	11–12

Women may leave maternity care before their physical or psychological recovery is complete. Screening can identify mental health concerns without securing timely treatment. Women with pelvic pain, incontinence or prolapse may face prolonged waits with limited support while they wait. During neonatal admission, a mother's recovery and wellbeing can become separated from her baby's care. Women living with serious illness may struggle to access treatment while continuing to care for others.

Mercy Health's experience also identifies practical opportunities for improvement. Midwifery continuity models, coordinated bereavement and subsequent pregnancy care, neonatal Hospital in the Home, multidisciplinary pelvic healthcare and integrated parent–infant services provide approaches to strengthen, expand or evaluate. Their delivery requires sustained funding for treatment, coordination, follow-up and practical family support.

Women should be able to move between services without repeatedly explaining their history, losing visibility of referrals or being left uncertain about follow-up. Achieving this requires investment in the workforce, information systems and research that support connected care. Mercy Health's Health Services does not currently have an electronic medical record, illustrating the need to establish essential digital infrastructure as well as connect existing systems. Research funding must also reach the health services bearing the infrastructure, governance and delivery costs.

Success should be measured by timely treatment, continuity and respect, and sustained improvements in health, function and quality of life. Women with lived experience, including those facing the greatest barriers to care, should be funded and supported as partners in service design, governance, research and evaluation, with payment for their time and practical support to participate.

The following sections set out the current gaps in care, Mercy Health's experience and the specific actions required.

Priority 1: Fund recovery after birth

Terms of reference alignment: best practice pregnancy and postpartum care models; cost and accessibility of postpartum healthcare.

The gap

Women need a clear pathway for recovery when they leave hospital. Mercy Health clinicians describe gaps in antenatal preparation, feeding support, access to a regular general practitioner, timely transfer of birth information and support after a traumatic birth. Emergency departments may become the default when women cannot find appropriate non-emergency advice or follow-up. Women without Medicare eligibility face additional financial barriers.

Discharge should mark a planned transition in care. It should not leave women responsible for coordinating multiple services while recovering and caring for a newborn. Follow-up must reflect clinical and social need, including circumstances in which problems emerge after the conventional six-week postnatal review.

Mercy Health's experience

Mercy Health's maternity teams identify the need to connect antenatal preparation, feeding support and postnatal follow-up with assessment of physical and psychological recovery. Our midwifery continuity models provide examples of care spanning pregnancy, birth and the postnatal period; these models and their service data are described under Priority 4.



Call to action

Recommendation 1: Establish a funded postpartum care pathway.

The Commonwealth and states and territories should jointly fund a minimum offer of coordinated postpartum care, with additional intensity and duration according to need. It should include:

- » a discharge plan shared with the woman and receiving clinicians, identifying the team responsible for follow-up, booked contacts and escalation arrangements;
- » accessible antenatal preparation and postnatal education on recovery, feeding, infant care and when to seek help;
- » timely home or community review, lactation support, physical recovery assessment and access to pelvic health and mental health care;
- » opportunities to discuss the birth and obtain answers, with trauma-informed treatment where required; and
- » continued access beyond six weeks for unresolved or emerging needs, including a pathway for women without an established GP.

Priority 2: Ensure timely mental healthcare and support after loss

Terms of reference alignment: best practice approaches to postpartum healthcare, including the delivery of physical and mental health support and services for mothers and their partners including those who have experienced infant loss; research, education and training on pregnancy and postpartum care for healthcare professionals.

The gap

A key gap is identifying women at greatest risk of postpartum mental illness early enough to offer preventive support and timely care. Better evidence is needed on how risk factors identified during pregnancy, at birth and postnatally can inform assessment and triage alongside screening for current symptoms. Emerging research from our teams, has identified associations between women experiencing severe medical complications at birth and subsequent risk of adverse mental health outcomes. This supports further investigation of targeted follow-up.

Identification must be matched by access to care. Mercy Health's perinatal mental health team reports that psychiatry appointments are booked four to eight weeks ahead and psychology capacity does not consistently allow a sustained course of therapy. Transfers between maternity, mental health, early parenting, general practice and community services can leave responsibility for follow-up unclear. Some women disclose distress only after repeated contact, while caring responsibilities, employment, travel, neurodivergence, substance use and housing instability can make standard appointment or residential models difficult to access.

Women need ongoing assessment, clear referral pathways and coordinated support that responds to overlapping experiences of birth trauma, feeding difficulties, infant illness, pregnancy and infant loss, and mental illness. Consistent with the RANZCOG birth trauma report [1], care should recognise the importance of communication, consent and each woman's experience, without assuming that mode of birth determines trauma. Assessment and treatment should also recognise family violence as a potential contributor to psychological distress, with access to specialist family violence support and safety planning alongside mental healthcare. Partners may also need support, while the woman's preferences, privacy and safety remain central.

Mercy Health's experience

Mother-baby and early parenting models allow assessment of the parent's mental health, the infant's needs and their relationship together. Mercy Health's Mother Baby Unit at Werribee Mercy Hospital provides specialist inpatient psychiatric care for women during their baby's first year, enabling babies to remain with their mothers during treatment and supporting mothers to care for them.

Mercy Health also operates two Early Parenting Centres: O'Connell Family Centre in Canterbury and Woi-wurrung-yagila-wulumperi, Whittlesea Early Parenting Centre. These services offer residential and day-stay programs for families with children aged up to four years, providing support with sleep and settling, child behaviour, parental wellbeing and strengthening parent-child relationships. Teams work with families to identify their needs and connect them with community services for ongoing support.

Mercy Health teams identify opportunities to extend this approach through outpatient, outreach and day services, alongside inpatient care. Consultation-liaison nurses can support active handovers and follow-up between specialist appointments. Our research also highlights opportunities to investigate how mental health history and pregnancy and birth complications can inform earlier risk identification and targeted support.

Mercy Hospital for Women's Pastoral Care team provides support to families experiencing perinatal loss. Service review identified gaps in continuity and practical assistance as families moved through hospital care and returned home, including help with legal requirements, post-mortem options, burial information, emotional support, mementos and connections to resources after discharge.

A dedicated Bereavement Coordinator role was established in late 2025 to address these gaps and provide continuity for women and families. The role complements pastoral care by coordinating practical and emotional support throughout the bereavement journey. The STAR (Stillbirth and Reproductive Loss) Clinic connects this support with specialist obstetric care after loss and during subsequent pregnancies.

In a 12-month period Mercy Hospital for Women cared for and coordinated bereavement support for at least 550 families. This included approximately 40 stillbirths, 19 neonatal deaths and families experiencing miscarriage. These service-reported figures illustrate the breadth of bereavement care required across different forms of pregnancy and infant loss.

Staff wellbeing is also part of sustaining this care. Staff feedback in 2025 similarly identified a need for stronger support for those caring for bereaved families. Sustaining compassionate bereavement care requires training, supervision and access to timely peer and professional support/ supervision for staff.

Calls to action

Recommendation 2: Strengthen early identification, prevention and treatment of perinatal mental illness.

Joint Commonwealth and state investment is needed to:

- » evaluate approaches to risk assessment, triage and preventive support
- » expand perinatal psychiatry, psychology, consultation-liaison nursing, infant mental health, social work and relevant allied health capacity
- » link repeated screening to assessment and treatment within clinically appropriate timeframes, including an urgent escalation pathway
- » fund shared care and treatment at the frequency and duration required, including continuity beyond time-limited perinatal eligibility
- » provide consistent entry points to outpatient, outreach, day and inpatient parent–infant care, and
- » support partners through assessment or referral, involving them in family care where the woman wishes and it is safe.

CASE STUDY 1

Compassionate care after the loss of a baby

In January 2026, a parent shared their experience of care at Mercy Hospital for Women following the stillbirth of their son. Their words illustrate how compassionate communication, respect for parents' choices and sensitive care can shape a family's experience of profound loss.

The parent described the midwife's calm, affirming presence as allowing the family to meet their son "in peace and togetherness":

"She didn't make me feel pitied or that our situation was unimaginable. Instead, she bravely witnessed our love and pain without any judgement."

The midwife's tenderness towards their baby was deeply meaningful:

"I will always treasure the way we were able to say hello and goodbye to A."

The parent also thanked the doctors for listening to their needs and honouring their choices, and the nursing and support staff for providing gentle care, privacy and space to grieve.

Their feedback extended to concern for the midwife: "I'm sure it would have been hard for M too, and I hope the hospital looks after her."

This experience highlights the importance of skilled, compassionate bereavement care that respects each family's wishes, alongside support for the staff who provide it.

Parent feedback, January 2026. Names withheld; initials retained in quoted feedback.

Recommendation 3: Provide continuity after pregnancy and infant loss.

Fund dedicated bereavement coordination across hospital care, discharge and subsequent pregnancy, with timely follow-up, access to results discussions, psychological support and a named pathway into subsequent pregnancy care. Services should aid with legal requirements, post-mortem options, burial information and community support, alongside culturally appropriate information, private spaces, memory-making choices and access to pastoral and spiritual care according to each family's preferences and beliefs. Investment is also needed to support training, supervision and timely peer and professional support for staff caring for bereaved families.

Priority 3: Provide active care for pain and pelvic health conditions

3.1 Timely, active care for pelvic pain

Terms of reference alignment: persistent pain, responses to women's pain, treatment access and affordability.

The gap

Women with persistent pelvic pain can face prolonged waits for specialist assessment and treatment, with limited access to care while they wait. Outpatient and surgical prioritisation may not adequately capture the effect of pain on employment, education, caring responsibilities, sexual function and daily life. Women can remain between primary and specialist services without a clear treatment plan or a clinician responsible for coordinating their care.

Access to pelvic health physiotherapy, psychological support and structured pain education is also limited by service capacity and affordability. Women unable to pay for private treatment may have few options while awaiting public specialist care.

Effective care requires clinicians to listen to women, assess both symptoms and functional impact, and provide appropriate investigation and treatment. Recognising psychological and social influences on pain must never become a reason to dismiss symptoms or delay care. Addressing medical misogyny requires services to take women's accounts seriously and respond when women report that their pain or functional impairment has been discounted.

Mercy Health's experience

Mercy Health's gynaecology and allied health teams report that demand for pelvic pain care greatly exceeds available capacity. Clinicians describe gaps between hospital and community services, limited funding for structured pain education and insufficient access to pelvic health physiotherapy while women await specialist appointments or surgery. Local allied health reports also identify increasing referrals for persistent pelvic pain, alongside greater complexity and chronicity of symptoms.

Drawing on this experience, our teams propose a coordinated pathway combining nurse-led assessment and navigation, early education, pelvic health physiotherapy and shared care with GPs. This would allow treatment to begin while women await specialist review, with reassessment and escalation when symptoms or clinical needs change. These are proposed service improvements requiring resourcing and evaluation.

Calls to action

Recommendation 4: Replace passive pelvic pain waiting lists with active care.

The Commonwealth and states and territories should jointly fund connected hospital and community pathways that provide:

- » structured triage incorporating pain severity, functional impairment, treatment history, emergency presentations and clinical warning signs
- » early access to pain education, pelvic health physiotherapy, psychological support and appropriate medical treatment
- » a named care coordinator and shared treatment plan linking general practice, community pelvic pain services and hospital specialists
- » reassessment when women's symptoms or function deteriorate, with timely specialist review and surgery where clinically indicated
- » funded education, supervision and competency development for specialist pelvic pain nurses, and
- » routine measurement of pain, function, quality of life, out-of-pocket costs and time to treatment.

The Commonwealth should review whether Medicare funding adequately recognises the time and expertise required for complex gynaecological imaging and multidisciplinary care, informed by current service and cost evidence.

Services should also require respectful communication, shared decision-making and accessible feedback pathways, with clear processes for responding when women report that their pain has been dismissed.

3.2 Pelvic health from prevention to later life

Terms of reference alignment: best practice approaches to postpartum healthcare; physiotherapy services, including pelvic health services; barriers to effective pain management, including the range and affordability of available treatments

The gap

Incontinence, prolapse, perineal injury and pelvic floor dysfunction can affect women's health, independence and quality of life well beyond pregnancy [2]. Access to assessment and treatment should extend across the life course, including for women who have never given birth.

Publicly funded pelvic healthcare can involve successive waits for specialist assessment, physiotherapy, investigation and surgery. Women unable to afford private treatment may have limited access to early intervention or ongoing care. Even when treatment is available, insufficient appointment frequency can prevent women from receiving a complete course of therapy. Cultural stigma and language barriers can further discourage women from discussing pelvic health symptoms and seeking care. [3]

Preventive care also requires greater attention. Evidence supports antenatal pelvic floor muscle training to reduce urinary incontinence, and economic evaluation supports the potential value of group-based antenatal training. Access requires funding for assessment, instruction and follow-up.[4,5] The 2026 FIUGA/IUGA white paper similarly calls for greater public health attention to the lasting consequences of pelvic morbidity after childbirth.[6]

Mercy Health's experience

Mercy Health's urogynaecology team estimates that newly referred women face waits of 24–36 months to access specialist assessment for urinary incontinence and pelvic organ prolapse. Allied health teams describe increasing demand, limited capacity for preventive services and appointment frequency that does not consistently allow delivery of the recommended course of treatment.

Our experience also demonstrates variation in access between sites. Women's access to coordinated follow-up after significant birth injury can therefore depend on where they receive care.

Our teams identify opportunities to improve access through earlier pelvic health physiotherapy, community continence services and advanced practice physiotherapy linked to specialist care. Published evaluation of advanced practice models supports their consideration as part of a broader response to demand, with appropriate clinical supervision and ongoing evaluation [7].

Calls to action

Recommendation 5: Make pelvic healthcare accessible throughout life.

The Commonwealth and states and territories should:

- » fund preventive pelvic health education and appropriate pelvic floor muscle training during pregnancy
- » provide assessment and treatment after childbirth, with continued access beyond six weeks according to symptoms and need
- » establish equitable multidisciplinary pathways after significant perineal injury across maternity sites
- » fund sufficient appointments to deliver an evidence-based course of treatment
- » expand advanced practice pelvic health physiotherapy and community continence nursing, with clear pathways to specialist care, and
- » provide coordinated continence and prolapse assessment, conservative treatment and timely specialist care for women in the community, home care and residential aged care.

Services should accommodate communication, cognitive, mobility and transport needs and support women to participate in decisions. Evaluation should measure symptom improvement, function, participation and independence alongside waiting times and treatment activity.

3.3 Pain recognition and management for older women

Terms of reference alignment: barriers to effective pain management, responses to women's pain and related matters.

The gap

Older women with dementia or communication difficulties face additional barriers to having pain recognised and treated. For some women from migrant communities, cultural norms around expressing pain and seeking help, alongside language barriers, may further limit access to assessment and care. Pain may present as agitation, withdrawal, resistance to care or disturbed sleep [7]. These changes can be attributed to dementia or ageing without adequate investigation of underlying pain. Timely care requires appropriate assessment tools, staff who can recognise changes in a woman's usual presentation, and clear pathways to clinical review and treatment.

Mercy Health's experience

Mercy Health's residential aged care teams identify earlier pain recognition and referral as priorities, alongside improved access to pain specialists and geriatricians. Teams report limited access to pain clinics and infrequent face-to-face geriatrician visits within residential care. These observations reflect service experience; women-specific data on pain recognition, treatment and outcomes would strengthen evaluation.

Our established allied health partnership provides an opportunity to strengthen earlier pain assessment and intervention. Staff need structured training in validated observational pain-assessment tools, supported by clear escalation pathways when changes in behaviour, sleep or function suggest pain.



Calls to action

Recommendation 6: Improve pain recognition and management for older women with dementia or communication difficulties.

The Commonwealth should:

- » develop and introduce a dedicated pain-recognition and response indicator within the National Aged Care Mandatory Quality Indicator Program, incorporating validated observational tools for residents unable to self-report
- » fund structured training for direct care staff in observational pain assessment, including recognising when changes in behaviour may indicate pain
- » establish clear pathways for clinical assessment, treatment and reassessment when pain is suspected, and
- » subsidise access to geriatrician and pain-specialist consultation for residential aged care residents, including outreach and telehealth, connected with primary care and allied health services.

Priority 4: Connect care around women and families

4.1 Continuity of maternity care, including culturally responsive models

Terms of reference alignment: best practice approaches to postpartum healthcare; best practice pregnancy and postpartum care models to support long-term maternal physical and mental health; barriers to effective pain management.

The gap

Demand for continuity of maternity care exceeds available capacity. Sustained investment is needed to support trusted relationships across pregnancy, birth and the postnatal period, including culturally responsive care for First Nations women and families.

Mercy Health's experience

Midwifery Group Practice (MGP) offers continuity across pregnancy, birth and the postnatal period. Mercy Hospital for Women's 2025 service figures record 784 families receiving MGP care, accounting for 15% of births at the hospital. A known MGP midwife attended 95% of births. The service reports demand exceeding capacity, with an average of 35 additional requests for MGP care each month.

Women's feedback illustrates how continuity supports trust, advocacy and confidence in care during birth and after discharge. One woman described:

"Loved having my midwife there through the whole labour and delivery, it was amazing to have someone there just for me who knew me and could strongly advocate for the type of birth I wanted."

Another highlighted the importance of an established relationship when receiving care at home:

"I felt that my baby and I were guided with compassion and genuine care. The care I received at home is unbelievable and having built a foundational relationship with the MGP team meant that I was comfortable and knew the advice provided was sound."

Mercy Hospital for Women's Nangnak Baban Murrup Maternity Group Practice, meaning 'Nurturing Mothers Spirit', provides culturally responsive care for women pregnant with an Aboriginal or Torres Strait Islander baby. Women receive care from a primary midwife, supported by a small team, throughout pregnancy, labour, birth and the postnatal period. Aboriginal Hospital Liaison Officers provide cultural support and advocacy, and midwives maintain continuity alongside specialist medical care when complications arise. This model supports trusted relationships and coordinated care for women and their families. Sustaining and expanding it requires funding for relationship-building, flexible caseloads, Aboriginal workforce participation and partnerships with Aboriginal communities, alongside clinical staffing.

CASE STUDY 2

Supporting continuity, choice and connection to Country

In 2025, 110 women received care through Nangnak Baban Murrup Midwifery Group Practice. The program expanded to include home birth as an option, and during 2025–26, two First Nations babies were born on Country in their family homes through the model. This expansion supported families' choices and connection to culture and Country while maintaining continuity with their maternity care team.

In 2025–26, 96 per cent of babies born through the program weighed more than 2.5 kilograms, contributing to Mercy Hospital for Women achieving the healthy birth weight target under the National Agreement on Closing the Gap for the second consecutive year. The program also recorded a 30 per cent smoking cessation rate among participating women.

This experience highlights the value of culturally responsive continuity of care that supports women's health alongside their family and cultural connections. Sustained investment in relationship-based care, Aboriginal workforce participation, flexible caseloads and partnerships with First Nations communities is essential to support and expand these models.

Calls to action

Recommendation 7: Expand continuity of maternity care, including culturally responsive models for First Nations women and families.

Fund staged expansion of MGP and comparable continuity models, including models co-designed with First Nations communities. Funding should support relationship-based care, Aboriginal workforce participation, on-call work, care coordination, community visits and flexible, complexity-adjusted caseloads, with access to specialist services while maintaining continuity of care.

4.2: Infant and early parenting care that supports women and families

Terms of reference alignment: postpartum physical and mental health, infant feeding, allied health and models of care.

The gap

A baby's admission to a health service does not remove the mother's need for postpartum care. Recovery, feeding, emotional wellbeing and practical support must remain visible throughout the baby's admission and transition home.

Supporting early parent–infant relationships also matters for children's ongoing health and development [9]. Responsive caregiving, recognising and responding to a baby's cues, supports healthy development [10,11]. Neonatal services should enable parents to spend time with their baby, participate in daily care, including feeding, and build confidence, with support tailored to the baby's clinical needs and the family's circumstances.

Mercy Health's neonatal and paediatric teams describe limited facilities for parents to stay overnight beside their babies, inconsistent access to parental mental health support and gaps in social work availability after discharge. These limitations can make it harder for families to remain together and receive coordinated support during a demanding period.

Travel, accommodation costs, employment and responsibilities for other children can further restrict parents' ability to participate in their baby's care. Addressing these barriers requires investment in family accommodation, practical assistance and coordinated maternal and infant support during admission and after discharge.

Mercy Health's experience

Mercy Health provides neonatal intensive care and special care at Mercy Hospital for Women, and special care at Werribee Mercy Hospital. These services care for sick and premature babies, including babies who remain in hospital after their mothers have been discharged. This gives Mercy Health direct experience of the need to coordinate women's postpartum recovery with their babies' ongoing care.

Mercy Health's neonatal Hospital in the Home (HITH) programs provide eligible babies with continued hospital-level care at home, including clinical monitoring and feeding support. At Werribee Mercy Hospital, a retrospective evaluation covering February 2022 to June 2024 included 896 babies receiving HITH care. Babies receiving HITH care gained an average of 4.74 grams more per day than those receiving inpatient special care, with no difference in readmission rates reported.

Beyond the neonatal period, Mercy Health's O'Connell Family Centre and Whittlesea Early Parenting Centre support families with sleep, feeding, parental wellbeing and parent-child relationships. Early parenting care also provides opportunities to identify broader needs and connect families with ongoing support. The following case study illustrates how developmental concerns identified during a residential admission prompted assessment, coordinated referrals and communication with primary care and Maternal and Child Health services, helping the family leave with a clear plan for follow-up.

Our experience highlights complementary priorities: enabling families to remain close during hospital admission, supporting care at home when clinically appropriate and consistent with family preferences, and maintaining coordinated support as women's and children's needs change through early parenthood. Expansion of neonatal HITH should include evaluation of maternal wellbeing, feeding, infant safety, family care burden and longer-term child development. Early parenting services similarly require capacity for care coordination and active handover to community services, so families receive support beyond their residential stay.

Calls to action

Recommendation 8: Connect infant care with maternal recovery.

State and territory governments, supported by Commonwealth investment and national collaboration, should:

- » expand and evaluate neonatal HITH with explicit eligibility, family choice, clinical oversight and rapid hospital reassessment arrangements
- » include maternal recovery, feeding, parental mental health and family practical needs in infant care and discharge plans
- » provide lactation and feeding expertise throughout admission and after discharge, with non-judgemental support for informed feeding decisions
- » fund mental health assessment and treatment within infant services, with continuing pathways after discharge
- » provide social work access in neonatal follow-up and outpatient care
- » improve accommodation and facilities that enable parents to stay with their baby. Beyond neonatal care, governments should fund care coordination within early parenting services, including assessment of parental wellbeing and child development, active referrals and planned follow-up with primary care and community services.

CASE STUDY 3

Connected care for women and families through early parenting services

A family attending Mercy Health's O'Connell Family Centre for a four-night residential program sought support with their toddler's sleep. During a routine child health check, staff identified possible developmental delays, including language and gross motor concerns.

With the family's consent, an educator completed a developmental assessment, explaining the findings sensitively and recognising the child's strengths alongside areas needing support. The parent described feeling nervous initially, but said the clinician's warmth and clear communication made the experience reassuring:

"She was genuinely invested in my child as a little person, not just as a child being assessed."

The team coordinated referrals to NDIS early childhood supports, liaised with the family's community Maternal and Child Health nurse, and provided correspondence to the GP to support ongoing care and referral to a paediatrician. The family left with information to support their child's development, a clear plan for follow-up and an offer of further support with the NDIS application.

This case highlights the importance of connecting care around women and their families. A child's sleep and developmental needs are closely intertwined with a mother's wellbeing and the family's capacity to manage everyday life. The residential admission provided an opportunity to recognise these broader needs and establish support that would continue after discharge. Active communication between the early parenting service, Maternal and Child Health nurse and GP helped connect the family's care across services, rather than leaving them to navigate each referral alone.

This experience supports investment in early parenting services as a point of connection between women's health, child health and community support, with funded care coordination and clear referral pathways that respond to the needs of the whole family.

4.3 Equitable access and support during serious illness

Terms of reference alignment: barriers to effective pain management, the ways in which women and girls experience recurrent, severe, or long-lasting pain conditions; experience in seeking appropriate healthcare responses to pain, related matters.

The gap

Women's ability to access healthcare is shaped by income, disability, language, cultural safety, housing and caring responsibilities [12]. A service may be available but remain inaccessible if a woman cannot afford transport, arrange care for her dependants, communicate her needs or navigate referrals.

These barriers can persist or intensify as women age or develop serious illness. Women need coordinated access to primary care, specialist services, allied health, home care and residential aged care. Their history, preferences and treatment plans should follow them between settings. Family violence can further restrict women's ability to access and continue healthcare. Coercive control, financial abuse and concerns about safety or privacy may prevent women from attending appointments, communicating freely with clinicians or following treatment plans. Healthcare responses must provide opportunities for women to speak privately, support safe identification and disclosure, and connect women with specialist assistance. Care coordination, family involvement and discharge planning must be guided by the woman's safety, preferences and circumstances.

Women living with advanced illness may continue to care for children or other dependants while managing symptoms and treatment. Without practical assistance, they may struggle to attend appointments or follow a care plan. Eligibility rules based primarily on age can leave women without support that reflects their functional and family needs.

Mercy Health's experience

Mercy Health's Family Violence Safeguarding Program supports staff to identify and respond to family violence through training, secondary consultation, policy development and coordination with specialist services. This includes supporting the application of Victoria's Multi-Agency Risk Assessment and Management (MARAM) Framework. Our experience highlights that an effective response requires protected clinical time, social work and specialist safeguarding capacity, safe information sharing and established referral pathways. These functions require sustained resourcing alongside frontline clinical care.

Mercy Palliative Care reports that some women remain responsible for children or other dependants while living with advanced illness, with limited access to childcare and household assistance. Financial pressures can prevent families from purchasing help privately. Clinicians also describe how concerns about maintaining employment, driving or caring responsibilities may influence women's reporting of pain and decisions about treatment.

This experience highlights the need to assess communication, practical and family circumstances alongside clinical symptoms. Earlier multidisciplinary care and stronger connections between services can help ensure that pain is recognised and that women and their families can follow the care plans developed with them.

Calls to action

Recommendation 9: Remove practical and structural barriers to care.

Governments should:

- » fund health services to identify and respond safely to family violence, including protected clinical time, workforce training, social work and specialist safeguarding capacity, safety planning and coordinated referral pathways to specialist family violence, housing and legal services
- » increase funding for interpreters, accessible information, care navigation, transport and outreach as core elements of women's healthcare
- » support culturally safe services developed with First Nations communities
- » provide disability access, flexible appointments and care arrangements that recognise caring responsibilities
- » establish pathways for women facing financial exclusion, including those without Medicare eligibility, and
- » fund and support women with lived experience as partners in service design, governance and evaluation, including First Nations women, older women, women with disability or cognitive or communication impairments, and women receiving home or residential care. Payment for time, interpreters, accessible participation formats and support with travel and caring costs should be included.

Recommendation 10: Support women with serious illness and caring responsibilities.

The Commonwealth and states and territories should:

- » establish needs-based access to practical family support, including assistance with dependent care, transport and household tasks
- » ensure eligibility reflects functional and family circumstances, avoiding gaps based solely on the woman's age
- » fund multidisciplinary models that integrate palliative care earlier within disease-specific pathways, and
- » strengthen connections with culturally appropriate community services, including access to pastoral and spiritual care.

Priority 5: Invest in the systems that make better care possible

Terms of reference alignment: data collection, reporting, monitoring, research allocation, education and care models.

The gap

Women move between maternity, emergency, mental health, early parenting, primary care and community services. Fragmented clinical information can make it difficult to establish what care has occurred, who is responsible for follow-up and whether referrals have resulted in treatment. These gaps can interrupt care and make women responsible for repeatedly explaining their history.

The same fragmentation limits the ability to evaluate care across services and over time. Measures focused on individual admissions or appointments do not adequately capture women's recovery, ongoing symptoms, unmet need or longer-term outcomes.

Medical research has historically treated men as the default, with women excluded or underrepresented in many areas of research. Pregnant and breastfeeding women remain frequently excluded from clinical trials, leaving significant gaps in the evidence available to guide safe and effective treatment. [13]

These gaps are compounded when women from culturally and linguistically diverse communities face language barriers, concerns about research, culturally inappropriate recruitment and practical barriers. Underrepresentation limits understanding of women's needs and confidence that research findings apply to them, potentially widening inequities in care. Addressing this requires inclusive study design, trusted community partnerships, accessible information and practical support for informed participation. [14]

Research is conducted within health services, yet research funding does not consistently flow to the services responsible for delivering it. Health services must therefore absorb infrastructure, governance, workforce and study coordination costs within already constrained clinical budgets.

Health services delivering clinical trials are also assessed against the National Clinical Trials Governance Framework as part of accreditation. Meeting these requirements depends on dedicated staff, training, data systems, safety monitoring and quality assurance. Mercy Health supports these standards, but the infrastructure needed to meet them requires sustainable funding. Governments must align health services' research and accreditation responsibilities with direct investment in the capacity to deliver safe, high-quality research and translate findings into better patient care.

Mercy Health's experience

Mercy Health's Health Services does not currently have an electronic medical record (EMR). This is a significant infrastructure gap for coordinating care and following women through antenatal, birth and postnatal services, including subsequent admissions to mental health, mother-baby and early parenting services. Investment is needed to establish an EMR that supports information sharing across services, coordinated follow-up and appropriate connections between maternal and child records.

An EMR would also strengthen the infrastructure available for research, including identifying eligible participants, following outcomes over time and evaluating care across services. These functions require appropriate governance, privacy protection and clear permissions for clinical and research uses.

Across this submission, Mercy Health teams identify practical questions about how best to deliver continuity of care, neonatal HITH, perinatal mental health, pelvic pain and pelvic health services. Answering these questions requires investment in digital infrastructure alongside research capacity, consumer participation and access to reliable data. Mercy Health therefore advocates a defined research component within teaching, training and research funding that flows directly to health services and supports the infrastructure, workforce and governance required to generate and implement evidence.

Calls to action

Recommendation 11: Enable women's care information and follow-up plans to move safely between services.

The Commonwealth and states and territories should fund interoperable electronic medical records and secure information exchange across hospitals, primary care, mental health, community services and aged care, including implementation in services that lack an EMR. Investment should cover workforce training, ongoing maintenance, privacy and access controls, as well as implementation and interoperability. Priorities should include:

- » timely access to clinical histories, discharge information and shared care plans
- » visible referral status and clear responsibility for follow-up
- » active handover between services, and
- » capacity to support service evaluation and approved research through reliable data collection and follow-up.

Recommendation 12: Embed research and accountability in service delivery.

Governments should:

- » establish a defined research component within teaching, training and research funding that flows directly to health services and supports research infrastructure, workforce, governance and delivery costs
- » fund pragmatic and implementation studies comparing continuity, postpartum, neonatal HITH, parent–infant, pelvic pain and pelvic health models
- » support secure longitudinal linkage of clinical and administrative data to assess women's and children's outcomes beyond the birth admission
- » resource data custodians and establish transparent application processes and timeframes for approved research, with privacy protection and appropriate Indigenous data governance
- » fund consumer participation in setting priorities, designing studies, interpreting findings and evaluating implementation, with payment and practical supports for equitable participation, including women from culturally and linguistically diverse and other underrepresented communities
- » resource interpreters, translated materials, culturally responsive recruitment, flexible appointments and assistance with transport and caring responsibilities to reduce practical barriers to research participation
- » include evaluation and implementation funding within major service reforms so effective approaches can become part of routine care.

Governments should also support a nationally agreed set of measures, co-designed with women and clinicians, and resource health services to collect and report them. These should include time to treatment, continuity, unmet need, pain and function, pelvic health, mental health, feeding support, readmission, family experience and out-of-pocket costs. Longer-term outcomes and appropriate risk adjustment should inform comparisons between services.

Research priorities should encompass service models and emerging treatments, with assessment of safety, effectiveness, acceptability, cost-effectiveness and sustained benefit.

References

1. Royal Australian and New Zealand College of Obstetricians and Gynaecologists. *Birth Trauma Roundtable: Final Report*. July 2026.
2. Fritel X, Varnoux N, Zins M, Breart G, Ringa V. Symptomatic pelvic organ prolapse at midlife, quality of life, and risk factors. *Obstet Gynecol*. Mar 2009;113(3):609-616. doi:10.1097/AOG.0b013e3181985312
3. Jouanny C, Abhyankar P, Maxwell M. A mixed methods systematic literature review of barriers and facilitators to help-seeking among women with stigmatised pelvic health symptoms. *BMC Women's Health*. 2024;24:217.
4. Zhang D, Bo K, Montejo R, et al. Influence of pelvic floor muscle training alone or as part of a general physical activity program during pregnancy on urinary incontinence, episiotomy and third-or fourth-degree perineal tear: Systematic review and meta-analysis of randomized clinical trials. *Acta Obstetrica et Gynecologica Scandinavica*. 2024;103(6):1015-1027.
5. Brennen R, Frawley HC, Martin J, Haines TP. Group-based pelvic floor muscle training for all women during pregnancy is more cost-effective than postnatal training for women with urinary incontinence: cost-effectiveness analysis of a systematic review. *Journal of physiotherapy*. 2021;67(2):105-114.
6. Hegde A, Goh J, Kearney R, et al. Chronic Maternal Pelvic Morbidity: A Neglected Tragedy: Where is Pelvic Maternal Morbidity in Maternal and Child Health? Advocating for a Public Health Approach to Pelvic Floor Disorders Resulting from Pregnancy and Childbirth Trauma. *International Urogynecology Journal*. 2026;37(5):1207-1220.
7. Brennen R, Sherburn M, Rosamilia A. Development, implementation and evaluation of an advanced practice in continence and women's health physiotherapy model of care. *Australian and New Zealand Journal of Obstetrics and Gynaecology*. 2019;59(3):450-456.
8. Achterberg WP, Pieper MJ, van Dalen-Kok AH, et al. Pain management in patients with dementia. *Clinical interventions in aging*. 2013;1471-1482.
9. Yui Y, Pazandak CC, Barbeau DY, Spencer M, Scala M, Givrad S. Promoting bonding and secure attachment in the NICU to improve parent-infant mental health: recommendations for clinical practice. *J Perinatol*. Apr 2026;46(4):664-671. doi:10.1038/s41372-025-02526-4
10. Feldman R. PARENT-INFANT SYNCHRONY: A BIOBEHAVIORAL MODEL OF MUTUAL INFLUENCES IN THE FORMATION OF AFFILIATIVE BONDS. *Monographs of the Society for Research in Child Development*. 2012;77(2):42-51. doi:10.1111/j.1540-5834.2011.00660.x
11. World Health Organization, United Nations Children's Fund, World Bank Group. *Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential*. Geneva: World Health Organization; 2018. <https://www.who.int/publications/i/item/9789241514064>
12. Australian Government Department of Health. *National Women's Health Strategy 2020-2030*. 2019. https://www.health.gov.au/sites/default/files/documents/2021/05/national-women-s-health-strategy-2020-2030_0.pdf
13. National Health and Medical Research Council, Australian Government Department of Health, Disability and Ageing. *Statement on sex, gender, variations of sex characteristics and sexual orientation in health and medical research*. Canberra: NHMRC; 2025
14. Watson E, Gulline H, Jane SM, Woollett A, Ayton D. Improving participation of culturally and linguistically diverse participants in clinical trials: an expert consultation. *Trials*. 2025;26:105.



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