FELLOWSHIP REPORT

THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA


To study overseas developments in
maternity care services

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1: Introduction:

In Australia maternity care reform has been on both the state and federal government’s agenda since the Queensland 2005 report by Dr Cherrell Hurst (Re-Birthing Report of the Review of Maternity Services in Queensland) and Improving Maternity Services in Australia: the report of the Maternity Services Review (2010). Both reviews and corresponding action plans recommended providing safe and sustainable primary maternity services as close to home as possible, and by a care provider who is known to the woman, this includes birthing services.

Research has demonstrated that primary local birthing with a trained and skilled health professional known to the woman produces the best clinical and psychosocial outcomes for the mother and baby and is more economical (www.ncbi.nlm.nih.gov/pubmed/240508080).

Despite the wealth of evidence supporting the safety of primary birthing care with a known midwife and demonstrating how closing local primary maternity services is detrimental to the health and wellbeing of the individuals and the community as a whole (www.crhr.ca) many smaller birthing services have been closed, and continuity of midwifery carer models have struggled to become mainstream.

Canada, New Zealand and England have developed innovative models of maternity care where the evidence around place of birth and relationship based care have been put into practice within both new and mainstream traditional services. These relatively new models of care are producing exceptional clinical outcomes along with improving womens satisfaction with care.
2: Executive Summary:

2.1: Contact Details:

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2.2: Project Description:

For my Churchill Fellowship I travelled to England, Canada and New Zealand to look at their maternity care systems from a midwives perspective, and consider how we could use the experience of other systems in similar countries to improve maternity services in Australia.

2.3: Major Highlights:

1. England: Evidence based clinical care with great outcomes for women and babies - The Serenity Birth Centre and St Thomas Maternity Service, along with the research and policy work on place of birth and continuity of carer models being undertaken by the Royal College of Midwives and Kings College.
2. Canada: Evidence based clinical care with great outcomes for women and babies – Hamilton Midwifery Practice and Blessings Way Midwifery Practice, along with the research work being done on rural birthing and First Nations birthing at University of British Columbia, and the midwifery education, regulation and association work in Alberta and Ontario.
3. New Zealand: The support midwives get from the New Zealand College of Midwives to enable them to provide local relationship based continuity of midwifery care and birth in any setting for 85% of women in New Zealand.

2.4: Major Lessons:

The evidence for wide scale introduction of local primary relationship based continuity of maternity care into Australia seems to be so irrefutable that it seems staggering that it has not already occurred, women, babies, families, communities and the economy would all benefit from its introduction.

1. Evidence and practice demonstrates that primary community based care provided as locally as possible and in conjunction with other primary care providers or community based agencies produces the best clinical, social and economic results.
2. The best place of birth for women without complex physical problems is not in acute care hospital settings, but in low key birth centers or at home.
3. Relationship based care where midwives and women are supported to develop positive partnerships increases safe normal birth, increases consumer satisfaction, reduces midwife burn out and reduces cost.
4. Birthing on country is an important cultural safety issue for Indigenous Australians. First Nations women in very remote areas in Canada and rural areas in New Zealand are safely giving birth on their homelands in low key birth centers or at home.
5. Midwives need to be regulated separate from nursing, educated, and required to provide safe evidence based continuity of midwifery care to their full scope of practice in both public and private settings.

2.5: Planned Dissemination:

Dissemination of findings will be at local, state, national and international levels.

1. Through local work on improving models of maternity care at Gold Coast Health and through midwifery student preparation through Griffith University.
2. Through state, national and international conference presentations, and articles for professional journals.
3. Through state and national influencing of Department of Health and political influencers by work undertaken by the Midwifery and Maternity Provider Organization of Australia.
3: Overseas Contributors:

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Findings and Lessons Learned:

4.1 England:

4.1.1: Policy and Evidence:

Approximately 750,000 babies are born in England each year with billions of pounds spent on providing maternity services. The provision of care is set in a challenging environment with rising demand for services and increasing consumer expectations against a background of fiscal restraint and an expectation of improved performance. The Marmot review (2010) highlighted the importance of ensuring that pre-natal and maternity services achieve the best outcomes so that every child has the best start in life. The Marmot review gives the recommendations around best start the highest priority. [www.instituteofhealthequality.org](http://www.instituteofhealthequality.org)

Since the Changing Childbirth report back in 1993 maternity services in England and the bodies that fund them have been charged with changing the way maternity services are provided. Improving safety by providing primary care locally, using the available evidence for practice, giving women a real choice of care provider and place of birth and improving access to continuity of carer were key elements of the report. Care providers appear to have responded to these recommendations in a variety of ways, some have changed very little, whilst others have embraced the recommendations and have changed their whole system in order to try to meet the spirit of the report.

The 2012 Health and Social Care Act introduced a clinically led commissioning system, which, as Professor Malcolm Grant Chair of the NHS Commissioning Board says, has been designed to “reduce centrally determined processes and day to day political control and refocus it exclusively – and obsessively – upon the interests of patients”.

Local Clinical Commissioning Groups have been set up to respond to the needs and wishes of their community with regard to performance based health care funding. These commissioning groups are independent from the actual care providers or employers; this separation and results based commissioning has opened the way for providers other than NHS Trusts to compete for funding [www.england.nhs/wp-content/uploads/2012/07/comm-maternity-services.pdf](http://www.england.nhs/wp-content/uploads/2012/07/comm-maternity-services.pdf).

This year (2015) the English Government has commissioned a new maternity services review led again by Baroness Cumberledge. [www.england.nhs.uk/ourwork/futurenhs/matreview/](http://www.england.nhs.uk/ourwork/futurenhs/matreview/)

Place of Birth:

Although there is an increasing body of evidence regarding the safety of birth in primary care units which were set up following the recommendations from the Changing Childbirth review, according to midwifery researchers, there has been a move in the last 5 yrs to close many of these units down in favour of centralisation. For example around the Manchester area at least 5 units have been closed despite public pressure from consumers, those that have remained open are gradually being reduced as more and more restrictions are placed on women allowed to birth in these units.

The Birthplace Cohort Study conducted in England and reported in 2014 [www.npeu.ox.ac.uk](http://www.npeu.ox.ac.uk) studied 64,000 low risk births and showed that midwifery units, both freestanding and alongside, are safe for babies and offered
benefits such as reduced intervention rates for the mother. The benefits for multiparous women were particularly significant and have led to the production of NICE guidelines recommending that low risk multiparous women should be informed that the safest place for them to give birth is in a non-hospital setting. www.nice.org.uk/guidance/cg190/chapter/key-priorities-for-implementation

The Royal College of Midwives has been given Government funding to run the Better Births Initiative in partnership with the Design Council www.rcm.org.uk/betterbirths. The key themes of the initiative are continuity of carer, maintaining normality and ensuring equity, with a sub theme of dignity and human rights. The key activities support the mobilization of grass roots improvement initiatives and the dissemination of successful changes. Getting information out on what worked and how it was achieved in an effort to reach untapped potential and get sustained buy into change at the local care delivery level. Rather than the top down approach, used following Changing Childbirth which appears to have lacked sustaining power in the face of pressure.

Continuity of Carer:

Continuity of carer for childbearing women and their families is a constant theme throughout the policy documents in England. The most recent continuity of midwifery care research was published in September 2015 www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-versus-other-models with over 17,500 women. The report authored by Professor Jane Sandall confirms the outcomes from previous studies regarding a reduction in intervention, increased satisfaction with care and identifies a possible new benefit of fewer preterm births.

When I met with Professor Sandall she identified that national maternity policy supported the concept of continuity of midwifery carer and choice for place of birth. However, there continues to be resistance from Trusts who faced financial pressures, and from midwives and midwifery leaders who failed to see how they could change the way they work without causing disruption to their local service or the midwives lives. In some instances this fear has been based on services who have attempted to make changes in a piecemeal way and have not controlled the midwives caseloads or provided adequate back up.

Professor Sandall reported that a how to guide is being developed to assist commissioning authorities, Trusts and clinicians to implement safe and sustainable continuity of midwifery carer models. Professor Sandall is also looking at ways to reduce midwives fear of the on call associated with continuity of care models by trialing different models of caseload supplemented by shifts on birth suite, testing the feasibility of these models to achieve clinical outcomes and womens satisfaction to the standard set by caseload models.

4.1.2: Practice Reality:

Note that the midwives interviewed are not representatives of their employer and the information provided is from their own personal professional experience.

Community Midwifery Practice:

Amanda is a community midwife who works part time in a semi-rural practice based at a local General Practice (GP) center. Amanda is an experienced community midwife who, regardless of risk profile, provides mainly antenatal and postnatal care for all the women in the village. Amanda is on call, based on a rota system, for all home births not only in her own area, but for the other 12 midwives who make up the community team. Amanda believes that she practices a fairly traditional model which is replicated in most parts of England.

Antenatal:
Most women self-refer and access Amanda when they find out they are pregnant. Amanda meets with the woman and together they explore the options for care. Provided there are no contraindications Amanda will provide the womens entire antenatal care at the local clinic and book the woman into the local maternity unit or plan for a home birth. If the woman has medical complications, had complications in a previous pregnancy, or develops complications in this pregnancy Amanda will refer the woman to the Obstetric consultant clinic at the
local hospital, and she will discuss the case with the woman’s GP. Usually the Obstetrician will share care with Amanda. Amanda also provides parent craft antenatal classes from the local Children’s Centre which provides free crèche facilities and gets the women used to using the Center which provides lots of support activities for mums and babies/children.

Intrapartum:
Amanda does not provide intrapartum care to women in hospital, the previous continuity of midwifery care - the DOMINO scheme (community midwives providing birthing care for their low risk women in hospital) has died out. All hospital care is provided by hospital midwives who work shifts, these midwives have never met Amanda’s clients until they arrive either in labour or with an acute pregnancy related problem. There are approximately 4,000 births at the local hospital where most of Amanda’s clients birth. Amanda provides home birth care when she is on call for the whole area, but this may be to women she has never met before and in surroundings with which she is unfamiliar. Amanda is also on call as the back-up (second) midwife called in later in the labour to ensure that two midwives are at each home birth. On average Amanda provides home birth care about twice per year. The home birth rate in Amanda’s community team is approximately 3% (consistent with the national average). Amanda is aware of the latest evidence regarding the safety of home birth and the policy directive to offer select low risk women home birth. Amanda believes that the rate of home birth is low due to the slow pace of culture change combined with workload pressure.

Amanda said “We spent the 70s, 80s and 90s telling women hospital was safer and now we wonder why the women and many midwives believe it. Some community midwives have big caseloads of up to 200 women with lots of safeguard issues (child protection), the midwives can’t see how they will manage more home births, so it tends to be only those women who directly ask for home birth who get it.”

Postnatal:
Amanda provides home based postnatal care to her antenatal clients for up to 6 weeks. In reality Amanda says this is 2 weeks, with most women getting approximately 5 visits based on clinical need. Amanda tried extending the number of visits she could provide by trialing a postnatal clinic, but women did not like it or use it. Amanda is assisted with postnatal care by a Maternity Support Worker; Amanda uses the support worker service for women needing intensive breast feeding support.

Amanda identified that “The breast feeding support worker can spend up to 2 hrs each day with a woman who needs lots of help; I don’t have that kind of time to spend with one person.”

Policy:
Amanda thinks that Changing Childbirth helped to change from a heavily medicalised system to a community based system, but other factors influence practice such as the fear of litigation and workload issues. Amanda says she feels supported in doing home birth, the supervisor of midwives is always available for help and advice, and her manager helps with workload issues. Policies at her local hospital are geared to normal birth and the Obstetricians in her local hospital are supportive of normal birth.

Amanda feels that the attitude of the obstetricians is highly influential “so the women don’t get induced for post maturity until 14 days post, the LSCS rate is low (22%), epidural rate is low, and the VBAC rate is high with a midwife led choices clinic”.

Amanda is aware (through her contacts) that other hospitals do not follow the NICE guidelines or support the midwives with home birth and probably have a higher LSCS rate as a consequence.

The Along Side Birth Centre:
Birmingham is a large city with 3 hospitals offering maternity care within a small geographical area and approximately 25,000 women per year give birth.

Opened in 2010 Serenity Birth Centre in Birmingham is attached to Birmingham City Hospital, but separate from the hospitals birth suite. All the women who book for birth at Birmingham City Hospital and are uncomplicated will give birth in the Birth Centre. The environment in each room is set up to be home like with blond wood
furniture, a big floor birthing mattress, a fold down bed hidden in a cupboard and all the medical equipment in cupboards out of sight, but ready on hand if needed. The reception area is open and more like a hotel than a hospital, with a visitor book full of praise and a welcome pack full of useful information for mums and their supporters.

The birthing women come from an area of high social deprivation; they are younger than the average birthing woman and more likely to be from non-English speaking backgrounds. The driving force behind the setting up of Serenity is Kathryn Gutteridge the current Midwifery Director and the services Obstetric (MFM) Clinical Director; together they have developed the pathway of care.

Antenatal:
Women choosing to birth at Birmingham City Hospital are all risk assessed in the early antenatal period and streamed into separate pathways of care depending upon their risk assessment. For low risk women Birmingham City Hospital operates an opt out system where the normal pathway of care for low risk women is to attend the Serenity Birth Centre or home birth for their birth. Antenatal care is provided by the usual community midwives (as per 2.1 Amanda). Women are reassessed at 36 weeks and a low risk birth plan developed for birth in Serenity, at home, or transferred to the high risk pathway and birthing in the hospital birth suite.

Intrapartum:
Serenity operates a Continuity of Care (not carer) model. The midwives work shifts in the birth centre and care for which ever women arrive in labour, rather than for women they know and have provided antenatal care for. There is no continuous fetal monitoring, no pain relieving drugs or interventions (induction, epidural, augmentation) practiced at Serenity. Water, aromatherapy and hypno-birthing are used along with doulas (doulas only funded for refugees and asylum seekers) 60% of women have a water birth. Community midwives are encouraged to attend births for their women and maintain their skills for home births. Health care support workers are used at Serenity to assist the midwives and women.

Kathryn said “I have been careful in the selection process and employed women who were either doulas or who wanted to become midwives, so that the philosophy of care is not undermined”.

The support workers undertake tasks relevant to their level of training, such as stocking, cleaning, answering the phone, preparing equipment, assisting with basic observations of the mother and baby, feeding support, and basic education of the mother on baby care.

Kathryn identified that the clinical outcomes for Serenity are very good with 3% LSCS rate, 5% PPH rate and 94% success rate for women birthing post previous section (VBAC). VBAC is not usually classified as low risk, but Kathryn said they could not get traction on increasing VBAC rates until it was moved to the birth centre as a trial. VBAC has special protocols including attendance at VBAC clinic, careful selection, no induction, no augmentation, plus 15 min fetal heart and maternal pulse monitoring by the same midwife who remains in the room at all times with the woman.

Postpartum:
The women are not transferred to the postnatal ward unless clinically indicated, they go home and post-natal care is provided by their community midwife (as per 2.1).

Policy:
Kathryn identified that the policy framework set by the government has helped to provide the platform for changing the pathways of care from a one size fits all to a more woman centered approach. However, Kathryn felt that without the support from the obstetricians, particularly those in leadership positions the changes would be difficult, and this may be why other areas have been unable to change from traditional fragmented models. Kathryn said that at Birmingham City Hospital the Clinical Director for Maternity (lead medical position) is supportive of normal birth and of the streaming to pathways of care.
Kathryn said "it was a big cultural change for staff when the reason for intervention started to be questioned and cases reviewed for lessons that could be learned, and protocols supporting normal birth were introduced”.

Junior doctors now spend a 5 day placement working alongside a Serenity midwife; they have to complete normal birth competencies which are over seen by Kathryn who works with the training lead obstetrician to ensure RCOG standards are met. Kathryn feels that there has been a culture shift resulting in greater respectful behaviors from the staff towards the women and their families and that this is evidenced through the positive comments in the Serenity visitor’s book, satisfaction surveys and the low level of complaints.

**The Stand Alone Birth Centre:**

Helme Chase Midwifery Unit in Kendal is classified as a stand-alone birth centre although it is attached to Westmorland General Hospital. It is classified as stand-alone because Westmorland Hospital does not employ specialist obstetricians or paediatricians, and therefore has no caesarean facility; all these services are available at either Lancaster (22 miles) or Furness (32 miles) Hospitals. Helme Chase changed from a GP/Obstetric unit to a midwifery unit in 2001. Sharon Walker is the midwifery manager at Helme Chase.

**Antenatal:**
Helme Chase midwives book approximately 900 women in the surrounding catchment area and provides all the antenatal care. Each full time midwife carries a caseload of approximately 80 -100 antenatal/postnatal women. The community midwives provide standard antenatal care as per 2.1. A consultant obstetrician provides an on-site antenatal clinic at Helme Chase for higher risk women and specialist consultation three times per week.

**Intrapartum:**
Helme Chase is staffed with shift midwives from 8am to 8pm, after this time there is a midwife on call system which ensures there are 2 midwives in the unit for all births. The midwives are on call for home births and another on call midwife provides back up. Midwives are on call approximately twice per week. There is also a maternity care assistant on shift in the unit from 8am - 8pm. It is unclear how many women birth with their primary caseload midwife. Of the 900 women who book with the antenatal service approximately 200 actually birth at Helme Chase. The case load midwives do not attend their woman’s birth if they birth elsewhere.

**Postnatal:**
Women go home 4-6 hrs after birth and their community caseload midwife provides home based postnatal care as per 2.1. Women usually get 3 visits (2 from a midwife and 1 from a maternity care assistant).

**Policy:**
There has been a centralization movement in the NHS, with Trusts closing smaller birthing units and consolidating units into larger centers in the belief that this will provide a financial advantage for the Trust, and reports of safety concerns about maintaining the skills of the staff in the smaller units (Sarah Davies, Salford University). Sharon identified that consumer pressure prevented the Helme Chase unit from being closed completely in 2001; instead it was changed from a GP unit to a midwife unit. However, the number of women birthing at the unit has been steadily declining from an average of 300 births per year to approximately 200 births per year. There are concerns that the unit will not be financially viable if more women do not use the service. The original friends of Helme Chase group who campaigned to keep the unit open have disbanded and there is currently little consumer input. Sharon said it is unclear why women are not choosing to use the service; however, changes to the clinical guidelines such as high BMI and older women have reduced the number of women deemed to meet the low risk criteria for birth at Helme Chase.

Sharon spoke about the midwifery staffing with 14 FTE case loading midwives and maternity support workers the unit also has 1 FTE Supervisor of Midwives, 1 FTE Manager, and 1 FTE Educator. Midwives are required to complete 90 hours of mandatory training each year. Sharon has concerns about the ongoing sustainability of the midwifery staffing because “the midwives are predominantly older than average, and although we provide 2 graduate midwife positions the unit is having difficulty attracting other experienced midwives.”
Non-Tertiary Maternity Service:

Sunderland Maternity Unit in the north of England provides non tertiary birthing and neonatal services for approximately 3100 women per year. The service caters for women with a predominately socially deprived background. Jackie Dyson is the Midwifery Director who manages a midwifery team based service. Midwives are grouped into large geographic teams and work shifts rather than caseload. Core midwives are not assigned to the teams, but provide care to any women who are not in a team model, usually high risk women.

Jackie highlighted the Units safety record and described their clinical governance system. The unit uses NICE and Green top guidelines and audits their use. There is a rigorous risk management program which is overseen by a multidisciplinary group with case review each morning of the births for the previous day, and incidents and any high risk women of concern. There is a weekly meeting of all staff where incidents both actual and near miss are discussed and action plans developed. There are 12 supervisors of midwives who are available 24/7 on an on call roster. Staff are required to attend 3 days of mandatory training each year included obstetric emergencies, midwife competencies and Trust HR mandatory training. New midwives are assigned a preceptor for their first year of practice.

Antenatal:
Care is provided for low risk women in community locations by midwives from the teams, or in the consultant obstetric clinics for those women deemed high risk. A day unit is staffed with core midwives and a consultant obstetrician is available.

Intrapartum:
99% of women give birth in the birth unit 1% at home. The women who give birth in the unit are streamed into high and low risk. Low risk women are cared for by the team midwife from their team who is rostered to the birth unit, and the high risk women cared for by the birth suite core midwives. The women who birth at home are cared for by a team midwife who is on call with a second midwife at the birth. All women have 1:1 care unless there are exceptional circumstances. The 1:1 in labour care is audited and there is high compliance.

Postnatal:
Low risk women go home 4-6 hrs after birth, only those women with ongoing high risk or are postoperative are admitted to the 13 bed postnatal area.

Jackie identified that “We are very proud of the changes we have been able to make, ongoing breast feeding rates were very low (27%), but this has increased to 60% with the introduction of a breast feeding support team of midwives and maternity care workers.”

All women have an average of 3 face to face visits by the team midwives, including those women whose antenatal and intrapartum care was provided by the core midwives.

Policy:
When changing childbirth funded units to change their model of care to increase access to primary care Sunderland changed to rostering their midwives into teams. The teams (9) provided caseload care for all the women assigned to their team. This was achieved through rostering midwives from each team to antenatal clinics; birth suite and postnatal ward, there were approximately 10 FFTE midwives per team. In addition to the team midwives there are a number of core midwives who work shifts and provide care to the higher risk women who are in the consultant care stream.

Jackie said “The unit has trialed varying the numbers in the teams in order to improve continuity of carer rates. Antenatal and postnatal continuity has been high, but without great success for intrapartum care. We are now ready to implement the next phase of our development with a change to caseload”
Tertiary Maternity Service:

St Thomas in London provides services for approximately 7,000 women per year. The catchment area is very diverse with areas of social housing and areas of great affluence. Over 200 languages are spoken and while 60% are primiparous over 30% are aged over 40. Lyn Pacanowski is the Midwifery Director.

Antenatal:
St Thomas offers several different models of care, from primary to tertiary and from private obstetrics to caseload midwifery care. Caseload midwifery care is offered for vulnerable families by geographically located teams of midwives; each midwife has a caseload of 40 women as primary midwife and 40 women for which she is back up. The midwives work in pairs and are on call for their primary women unless on days off. Two of the teams have very high home birth rates (20%) with midwives skilled and confident with home birth. Standard antenatal care as per 2.1 is also offered. The group practice midwives also provide care for very high risk women developing plans of care collaboratively with the woman, her obstetrician and physician. Approximately 35% of women who birth at St Thomas have known midwife continuity of care.

Intrapartum:
Core midwives provide care to those women who do not have a caseload midwife.

Postnatal:
The traditional model midwives provide 55,000 post natal home visits per year, with 86% of women seen at home within 24hrs of discharge. Lyn identified that for those women who do not receive case load care ongoing postnatal care is very poor. In order to improve care Lyn has introduced postnatal clinics, these clinics are run by the maternity care workers at community locations and are well utilized. Women in caseload care go home 4-6 hrs following birth and are provided care by their caseload midwife for up to 6 weeks postnatal, the number of visits is determined by clinical/social need.

Policy:
The maternity service at St Thomas has embraced the concepts outlined in government policy, and is a leader in providing best practice maternity care. Lyn identified that their current success is related to the opportunity to build upon the history of strong midwifery leadership and ongoing close association with the RCM and the midwifery researchers/educators at Kings College.

Private Practice Midwifery:

One to One Midwifery Service started in 2010; it is a private business that employs midwives to provide continuity of care midwifery home birth services across several different Trusts in the north and south of England. The business is paid for the care provided to women by the local commissioners of maternity care at the same rate as all other publically funded maternity services, using the payment by results system. Contracts are currently in place with the commissioners from Wirral, Liverpool, Cheshire, West Cheshire, and Warrington. Simon Mehan is a One to One Director and supervisor of midwives.

Antenatal, postnatal and home birth is offered with plans to expand to hospital birth and to open a free standing private birth centre. One to One currently provides care for approximately 2,500 all-risk women per year with a 30% home birth rate. There are 64 midwives employed, midwives are allocated a caseload of 4 women per month (40/year) and work in pairs within a team of 6 or 12 midwives. Each team has a midwife coordinator who takes a smaller caseload (25). Three consultant midwives (CM) are also employed on a smaller caseload (10), the CMs support the local coordinators with education, clinical issues and are the second midwife for intermediate risk home births. One to One is trialing smaller caseloads (32) and Simon said they will continue to expand this trial provided it is financially viable. There is also an admin team who organize billing, finance, data and marketing.

Simon said “One to One is about providing the best care (caseload) based on the evidence, and showing that this can be done for the same or less money that is currently spent on maternity care and doesn’t need big institutions.”
In order to remain workforce sustainable Simon outlined how student midwives in 1st and 3rd year are provided with clinical placements with the One to One midwives. Newly qualified midwives are employed with a smaller caseload and mentorship. All newly appointed midwives are required to complete a nine month mentored program.

Antenatal:
Women self-refer and if planning a home birth women are allocated a midwife who lives within 30 mins of their home. One to One has several shop front premises where clinics, including non-tertiary scans, are run. Where clinic space is not available care is provided in the woman’s home. The service provides care to all women regardless of their risk profile. The woman is not required to make any contribution to payment; standard antenatal care is paid by the commissioning authority at 1,000 pounds, intermediate at 1,500 and intensive at 3,000. Pathology is also paid by One to One from the payment received for care. Approximately 40% of the caseload is intermediate (twins, social issues) with the remainder standard. If a woman develops complications a referral is made to a public hospital obstetric clinic and One to One is billed for the appointment. One to One midwives are required to work with women to develop a robust care plan based on NICE guidelines, including plans for transfer if required. Midwives are required to complete a database for all episodes of care.

Intrapartum:
Currently all women are birthed at home, but negotiations are underway with several trusts regarding access to hospitals and payments for using hospital resources. Simon identified that One to One achieves a home birth rate of 33% of all women provided with antenatal care (UK rate 2.8%). 63% of women have their primary midwife at the home birth. The transfer rate from planned home birth is 12%, the LSCS rate for all births (both planned hospital and home) is 16%.

Intrapartum payments are currently 2,600 pounds with complications and 1,500 without. If women choose hospital birth or are transferred to hospital intrapartum the One to One midwife does not provide ongoing intrapartum care in hospital.

Postnatal:
Postnatal care is provided by the caseload midwife for up to 6 weeks post birth, the average number of visits is 7. Simon reported that One to One midwives have developed good relationships with Health Visitors (Child Health Nurses), with subsequent good handover of care with 91% of women breast feeding their babies on handover of care.

Simon said “Payment for postnatal care is 230 pounds, this is completely inadequate and baby’s PKU is also paid from this amount, it is an indication of the low value placed on postnatal care in this country.”

Policy:
One of the Government’s policy elements is to increase women’s access to different choice of care provider by ensuring that payment for maternity services follows the woman and is made to the organization that provides her care.

However, Simon said “Not all commissioning authorities have honored this interpretation of the funding model, with One to One currently in dispute with a commissioning authority over payment for care provided to women residing in their area.”

Simon also identified that “The payment system can also make the relationships with the hospitals problematic as One to One is seen as a competitor for funding, with some hospitals expressing concerns about their financial viability if their birthing numbers fall.”

Simon acknowledged that One to One has been challenged on safety due to providing home birth services for breech, twins and VBAC if requested by women, and that this different ethos of woman centered, informed choice care also affects relationships with some obstetricians. Simon said that One to One clinical outcomes were better than national average, but the small numbers made it hard to compare.
One to One is insured in the same way that all public maternity providers are insured – through the NHS Local Authorities. Simon said One to One is required to provide an annual quality report to the commissioners which demonstrates their results, staff training (6 days mandatory plus 4 for CPD), mitigation for fatigue (midwives get 9 weeks leave/year) and incident management. In addition One to One is required to demonstrate that it meets the requirements of the contract with the commissioners which include: care closer to home, choice of place of birth, improved breast feeding rates and decreased smoking and obesity. A midwife is employed full time to ensure audit, data integrity and compliance with national and contractual key performance indicators.

Simon said “The NHS is gradually changing risk assessment requirements to include not only physical clinical outcomes, but women’s choice/preference and psychosocial risk.”

4.1.3: Relevance for Australian Maternity Care:

Although the Australian health care system is not exactly the same as the English system there are many commonalities. At its core the Australian system, like the English, offers its citizens free access to publicly funded health care. And much of the private health care system in Australia is actually funded by the public purse through Medicare and rebates to private health funds.

Both the Commonwealth and State/Territory governments have long identified the need for widespread system change in maternity care. The key tenants for change are improved access, choice, consumer control and safety within an economically sustainable system. Change is proving to be very slow and piecemeal at best, with high profile influential advocates who benefit from the status quo receiving disproportional air time.

The English experience and the available research evidence highlights that the best place of birth for women without complex physical problems is not in acute care hospital settings, but in low key birth centers or at home. This may seem simplistic (the best ideas often are simple) and undoubtedly will challenge the preconceived prejudices that surround maternity care in Australia. Many will cite the tyranny of distance as the reason this type of fundamental change cannot occur in Australia, but this will be addressed in the Canadian section of this report. The reality for Australians is that most live a suburban life close to major hubs where distance is irrelevant to any decisions regarding maternity care. The evidence around safety in birth centers or at home has been well researched with large cohorts showing that it’s safer for many women to birth at home rather than in hospital, this turns our preconceived notion of hospitals being safer places to birth our babies on its head.

The English maternity system is based upon primary community based care provided as locally as possible and in conjunction with other primary care providers or community based agencies. This way of providing services and recognizes that maternity care is not isolated from family/community, but is part of community building. This is an important lesson for Australian maternity care which is often very fragmented and divorced from the psychosocial aspects of family life. Providing geographically based primary maternity care co-located with other women and children/family services improves access to care and ongoing access to support.

Caseload continuity of midwifery care has been slow to gain a foot hold in England, but those places where it has report results consistent with the research evidence. Relationship based care where midwives and women are supported to develop positive partnerships has demonstrated increased safe normal birth, increased consumer satisfaction, reduced midwife burn out and reduced cost. Researchers are currently studying some of the finer nuances of this model and discovering links to reduced still birth, preterm birth and admissions to neonatal intensive care for babies.

The evidence for wide scale introduction of local primary relationship based continuity of maternity care into Australia seems to be so irrefutable that it seems staggering that it has not already occurred, women, babies, families, midwives and the economy would all benefit from its introduction. Other interventions (such as CTG and withdrawal of vaginal breech birth) have been quickly introduced (almost overnight) and mainstreamed with significantly less initial and ongoing efficacy evidence. The conclusion drawn from this state of affairs is that it’s unlikely to be about the evidence and more likely to be about who benefits from the status quo, entrenched attitudes and fear of change.
4.2: Canada:

4.2.1: Policy and Evidence:

Like Australia Canada is a vast country with a relatively small population in comparison to land mass. Most of the population lives within 350 km of the USA border, with the rest of the population living in rural or remote areas, particularly First Nations communities. Health care is provided free of charge to Canadian citizens and is funded through taxation.

Midwives in Canada have only been a regulated profession for approximately the last 20 years (there remain some smaller provinces where due to small numbers midwives are still not regulated). Ontario was one of the first provinces to regulate midwives (1994) with other provinces following suit over the intervening years. The midwives work as independent practitioners in a business model, but are paid by the Government within their province through varying public health payment methodologies, women are not required to contribute payment. With approximately 360,000 births per year demand for midwifery services is outstripping the supply of midwives. Obstetric care is the predominant model of care with obstetric nurses providing most of the care under the direction of a doctor with obstetric qualifications.

Interviewees identified that the Canadian Government was motivated to improve access to midwifery care by a shortage of medical practitioners with maternity skills particularly in rural and remote areas, the need to reduce unnecessary interventions, and provide 24/7 maternity care close to home within an economically sustainable model.

The province government sets controls on the number of midwives in practice by determining the number of contracts/courses of care provided to midwives both in number and location. This is in contrast to medical professionals working in maternity care who are not controlled in number or location. Midwives and their professional organizations have identified that this has led to both a competitive environment between doctors and midwives and a misalignment of medical resources particularly in less popular rural and remote areas.

The Canadian Government has fully implemented the concept of continuity of midwifery care. Called the Canadian Model www.cmrc-ccosf.ca/node/25 midwifery continuity of carer has been adopted by most provinces within Canada with relatively minor differences. The model is fairly prescriptive in that a maximum of 4 midwives may be involved in the woman’s care during the whole pregnancy, birth and post birth period. 40 women per full time midwife per year is considered a maximum caseload, although this has been increased to 60 in some provinces. Two midwives must be at each birth, which means a midwife will also have responsibility to be second midwife at a further 40 births per year, although some provinces will allow another regulated health practitioner such as a nurse to be the second at the birth. The Canadian model is designed to be woman centered, evidence based and relationship focused through continuity of carer.

Midwives remuneration varies from province to province, but is a fairly complicated system of case load payments and grants/incentives (www.aom.on.ca Compensation review of midwifery 2010). The remuneration method is case load based rather than a fee for service model and is designed to ensure that midwives are able to spend time with their clients building the relationships that have been shown to produce tangible clinical and financial benefits.

Midwives practice insurance is paid by the province government, in a similar way to the medical doctors insurance, and is estimated to be approximately $40,000 per year/full time midwife. Insurance is administered by a not for profit insurance agency called Health Insurance Reciprocal of Canada which was established during the global health insurance crisis of the 1980's (www.hiroc.com).

Midwives are regulated as autonomous primary health care practitioners. Midwifery is a growing profession across Canada with a steady increase in the number midwife attended births each year, and an increase in the number of midwives practicing ( www.cmbc.bc.ca/Jurisdictional-Review-Midwifery-Scopes-and-Models.pdf ).
There is a midwifery regulator (not nursing), in participating provinces, with a mandate of protecting the public by ensuring equitable access to high quality midwifery care. Regulation requires that any midwife registering to practice must meet prescriptive practical competencies, risk management performance indicators and a stringent requirement for continuing recent practice. There is reciprocity of regulation between the provinces and arrangements for assessing overseas trained midwives.

In Ontario, for example, there is a College of Midwives (the regulator) council made up of 8 midwife members elected by the 800 Ontario midwives and 7 public members appointed by the Ontario government. A CEO and a staff manage the administration of regulation www.cmo.on.ca. The CEO Kelly Dobbin said that the College is responsible for setting clinical/quality standards and scope of practice, auditing midwives compliance with standards, maintaining the register of midwives, education and reciprocity standards including overseas midwives and managing complaints. Registration costs CAD $1,900 for a practicing midwife and $950 for an inactive midwife.

All midwives who apply to be registered as practicing midwives must prove that they have recent practice experience which is prescribed as 50 births as primary midwife and 50 births as back up midwife within the last 5 years. Midwives in non-practice roles (educators, managers etc…) may enter into an alternative practice agreement with the College Of Midwives (regulator), in this arrangement they are able to remain on the midwifery register, but are not eligible to practice as a midwife without first proving competence.

Kelly identified that in Ontario there were three sites providing initial midwifery training and bridging courses for internationally trained midwives. Midwifery training is a 4 year bachelor level university course. There is a Canadian Midwifery Regulation and Education consortium that set the final exam for midwifery students; however midwifery training programs are not currently required to have standard national accreditation.

New midwifery graduates have limitations on their practice, for the first year the new registrant must work within an established practice and there must be an experienced midwife at each birth the new registrant attends. Upon qualification a new midwife has full prescribing rights and is eligible for full government payment for the care provided.

Michelle Butler (Midwifery Program Director UBC) said incentives are offered by the provinces to encourage midwives to practice in rural areas (debt for university fees waived) and for established practices to take on new midwives. Michelle identified that the midwifery funding model of courses of care is not attractive in areas with low birthing populations. Michelle is working as a member of the Rural Maternity and Surgical Services Committee BC to help expand the midwives scope of practice and developing educational programs to include older infant care, well women care and surgical first assist in order to make rural practice for midwives economically viable.

In Ontario all providers are required to provide outcome data to the Better Outcomes Registry and Network (www.bornontario.ca) and Hospitals are required to meet the quality and safety requirements under the Excellent Care for All Act 2010 (www.health.gov.on.ca/en/pro/programs/ecfa/legislation/act.aaspx ).

Each province has a midwives association, the size and activity of which seems to be dependent upon the length of time midwives have been regulated and the number of midwives in each province who fund the association. For example, the Association of Ontario Midwives (AOM) ( www.aom.on.ca ) is a fairly large organization, with 40 staff, and is very active. Kelly Stadelbauer the CEO said that the AOM represents the approximately 800 midwives practicing in Ontario, the first province to regulate midwives, with approximately 90 new graduates each year. The AOM advocates on behalf of its midwifery members by lobbying government regarding midwives reimbursements for services, insurance cover, benefits (pension, sick pay etc…). The AOM also provides professional practice guidelines, peer support, education, professional development support, and promotes midwifery to the media and general public. Midwives pay approximately CAD $1200 per year and OAM also belongs to the national professional organization called Canadian Association of Midwives (CAM). The OAM has also levied each midwife $1,000 to pay for its human rights gender issues case against the Ontario Government with regard to midwives remuneration www.ontariomidwives.ca. The Ontario Government also funds AOM to
manage the rural and remote midwifery locum scheme and various projects related to improving care for special populations and building midwifery capacity.

Midwifery in Alberta has been regulated and Government funded since 2009. Nicole Mattheson, President of the Alberta Midwives Association, said there are 94 practicing midwives, and midwifery is growing each year with 51 midwifery students, 12 of which are set to graduate soon. Full time midwives are usually contracted by the Government to provide 40 courses of care per year, but the contracts are renewed yearly and no Government guarantees are given from year to year. The Government pays a flat rate of $4300 for each course of care and an additional $300 for each attendance as secondary midwife. The Government pays the midwives indemnity insurance, but expects $1000 contribution from the midwife.

Joanna Nightengale identified that doulas have an expanding role in maternity services in Canada. A doula is someone who provides non clinical support during pregnancy, birth and postnatal. Doulas are not a regulated health profession and are not required to undertake any training, although most do some form of training. Research has shown that continuous support for women during childbirth by other women who are not employed by the hospital is most effective in helping women achieve normal vaginal birth, use less analgesia, have fewer babies with low apgar scores and feel more satisfied (www.ncbi.nlm.nih.gov/pubmed/21328263). Doulas are not remunerated by the government health funding system and are usually paid directly by the woman or health care organization (www.ontariodoulas.org).

The similarities between Australia and Canada are particularly evident in rural and remote communities. Many small rural birthing services have closed amid a preference for centralization, difficulties recruiting health professionals and concerns about the safety of smaller units.

Women in rural and remote communities without access to birthing services are subject to the enforceable Canadian evacuation policy for pregnant women who live on-reservation in rural and remote areas. These women are usually First Nations women who are required to be evacuated to larger urban centers at 36 weeks of their pregnancy until after their immediate postnatal recovery period www.researchgate.net/publication/236271988. In 2013 First Nations Health Authority took over responsibility for health care of First Nations people. A key part of the plan to improve health care is to increase access to maternity care for women in rural and remote areas.

Jude Kornelson, Director for Rural Research at the University of British Columbia (www.crhr.ca) has been working with the First Nations Health Authority and collaborating with researchers in Australia around the issue of actual and perceived safety of birthing outside major metropolitan centers. The main focus is on developing and disseminating enabling strategies for providing safe, accessible birthing in rural and remote areas. A rural birth index planning tool has been developed which has been adapted for the Australian environment. Jude and her team have produced a wide body of research demonstrating the safety of rural care and midwifery care (available at www.crhr.ca). Despite the evidence Jude said that the research on attitudes shows that there remains a perception amongst most obstetricians that home birth is unsafe and amongst specialist surgeons that surgery (including caesarean) by family physicians (Rural Generalist GPs) is unsafe. This perception has reportedly led to lack of collegial support for midwives and rural doctors particularly when transfer of care or specialist support is required, and to fear based advice to women and their families.

Jude reports that there are a growing number of very successful birthing services in Canada run by a combination of midwives with or without collaborating rural physicians and caesarean capacity which are producing outstanding evidence of safe care in rural and very remote (4hr plane journey to caesarean facilities) locations.

4.2.2: Practice Reality:

In Hamilton Ontario midwifery practice is well established. Beth Murray, one of the Hamilton practice midwives, said that in the practice she works in www.communitymidwivesofhamilton.com approximately 18 midwives are contract employed both full time and part time. Midwives contract with the Practice based on the number of courses of care they will provide per year as primary and secondary midwife.
The Hamilton Practice is funded by the Ontario Government for approximately 600 courses of care. Beth said she is paid approximately CAD $2,000 per primary birth (comprised of experience, on call, and secondary care fees) by the government and the practice is paid $750 per birth for operating/administration fees. The practice also claims other available grants for equipment, lease hold and professional development of the midwives contracted to the practice. In addition the government pays all the midwives insurance liability fees.

Beth said the midwives must provide 12 weeks of care or be the primary midwife present the birth to be eligible for payment. Midwives in the practice are able to use all the resources, facilities and administration staff as part of their contract with the practice. Midwives in the practice work in partnerships of two midwives with one of the two on call at all times in a 10 day on and 10 day off call roster arrangement.

Women can request a particular midwife or are allocated a midwife according to an allocation roster in order to ensure that all midwives have a full caseload. Antenatal visits are mainly clinic based with one home visit at 36 weeks. The birth is attended by either the primary or secondary midwife; the second midwife at the birth may not be familiar to the woman as this is determined by a second on call roster. Postnatal care is up to 6 weeks and depends upon the woman’s needs, but is generally 2 weeks of home visits (usually 5) the rest are clinic visits. Births may be at home or in hospital as the midwives have privileges at the local hospitals and collaborate with the local obstetricians as required by the woman/babies condition.

Midwives use the AOM care guidelines and must adhere to the Ontario COM standards for practice. In addition the Hamilton Practice has practice protocols that the midwives are expected to meet and data requirements to ensure compliance with regulation, Ontario maternity statistics and funding.

Midwives are required to complete mandatory training to meet the quality and safety standards set by the COM. In addition the Hamilton Practice expects midwives to provide client survey results, monitors quality and safety data, midwives attendance at peer review meetings 6 monthly and attendance at practice meetings which are held weekly.

After completing a 4 year bachelor level university course new midwives are assigned a practice mentor and must attend 30 primary and 30 back up births in their first year of practice supported by an experienced midwife before they can provide birth care independently. Usually the new midwives are already known to the Hamilton Practice midwives as they completed their student practical placement at the Hamilton Practice.

In Rocky Mountain House (RMH) Alberta, Michelle Matheson, one of the practice midwives and the President of the Association of Alberta Midwives, advised that at their rural midwifery practice 3 midwives provide Canadian Model caseload courses of care for approximately 100 of the 160 women who birth in the area. In addition this practice provides care for the women of the nearby First Nations reservation (www.blessingwaymidwifery.com).

The midwives all have privileging at both Rocky Mountain House and Red Deer Hospitals. The midwives work in collaboration with the physicians at Rocky Mountain House Hospital and the Obstetricians at Red Deer Hospital when women experience complications. Michelle said that only approximately 10% of women in the practice chose home birth. Repeat clients were more likely to choose home birth, but there is still lots of stigma and distrust of home birth from the community so women often feel pressured into hospital birth by the expectations/fears of their families. Michelle said that RMH seems to be an anomaly in this area with midwifery practices in Edmonton and Calgary reporting home birth rates of 50-80%.

Michelle said that some hospitals in Alberta were refusing to give midwives privileging or delaying privileging, and this was likely to be due to obstetrician influence on privileging committees and may be related to concerns about differences of philosophy about birth, gender power, control and income. This issue is not peculiar to Alberta; Michelle Butler in BC also cited this issue as a concern for the viability of midwives practice.

The Rocky Mountain House practice would like to have four midwives in order to work in partnerships, but there are not enough births in the area to allow this. Michelle said the RMH midwives could take more of the births in the area, but they are concerned about how this would impact upon the skills of the local physicians, and how it
may upset the balance of viability of the physician’s practice which could lead to a competitive environment. Currently the midwives and physicians at RMH Hospital have a good collegial working relationship and share on call arrangements.

Michelle talked about the difficulties rural midwives faced with viability of their practice with low birth numbers, but lots of on call, particularly when infrastructure is a long way away eg shopping 45 miles away. Michelle said that acuity was often high with midwives needing to be more skilled and ready to step outside of their scope of practice in emergency situations such as premature birth. Michelle said that the team work between health professionals in rural areas was imperative to successful maternity services. In RMH the midwives mentor the nurses at RMH Hospital so they are skilled to help out at the births. Michelle identified that at first there was some confusion about the roles between midwives and nurses, but this was quickly worked through as the midwives and nurses worked together to produce guidelines for the hospital nurses.

Michelle identified that the working relationships with the obstetricians at Red Deer are generally very respectful until a woman chooses care against their advice, then it can get tricky, advocating for women can lead to difficulties “doctors seem to find assertive women an enigma”. Michelle believes that obstetricians practice in a different environment and are more likely to fear being sued/actually sued more than midwives. Following discussions with the health practitioner’s insurer for both doctors and midwives Michelle believes that the relationship formed between the women and the midwife may explain this difference. Michelle said that the midwives usually use the standard guidelines such as the Society of Obstetricians and Gynaecologists of Canada, or OAM guidelines.

Michelle advised that due to the low numbers, but increased social complexity, the care for the First Nations women on the reserve west of RMH is not based on the Canadian Model, but has been negotiated as the wages for a full time midwife rather than based on the usual contracted courses of care.

Michelle said that the First Nations women in her practice rarely wanted to birth on the reservation, which is not considered to be their native land, but usually wanted hospital birth and some physician involvement. The RMH midwife provides antenatal and postnatal care on the reservation often in a share care arrangement with the RMH physicians, and birth care depends on who is on call. A 24/7 midwife text line is available for the women who often don’t have phone credit.

Kelly Stadelbauer (CEO AOM) explains that in some remote areas, such as Nunavik, First Nations women are working as midwives and work under an exemption from the requirement to be regulated by the College of Midwives; this has led to funding issues for these midwives which are in the process of being rectified. These First Nations midwives have ensured that birthing services can be provided in their communities and this has led to unexpected positive benefits to the whole community, such as reduced domestic violence and child abuse. In addition some regulated midwives are starting to set up in practice in remote areas, Kelly describes how two midwives have set up in practice at Attawapiskat a very remote community with 50 births per year, this midwifery practice now means that low risk women no longer need to evacuate from their community, and higher risk women can have all their antenatal and post-natal care in their community (www.aboriginalmidwives.ca/toolkit/attawapiskat).

In British Columbia other alternatives to the Canadian Model are being trialed – for example in Nelson Appletree Maternity is a collaborative practice model has been implemented where midwives, physicians and allied health work in partnership providing hospital and home birth. The requirement for only 4 care providers is maintained, but caseloads may be as high as 60 women per year per practitioner (www.appletreematernity.com). The South Community Birth Centre provides care for new immigrants from SE Asia and is staffed by shift work midwives. Group antenatal and postnatal care is provided by a mixture of midwives and doulas (www.scbp.ca).

4.2.3: Relevance for Australian Maternity Services:

Relationship based midwifery continuity of care has been adopted and funded by most province governments in Canada. The model is designed be local, including rural and remote, woman centered and provide safe evidence
base maternity care with reduced medical interventions and at lower cost.

**Birthing may be in any setting**, including at home or in hospital with midwives eligible for hospital admitting rights to all Canadian hospitals.

Although midwives work in private practice they provide care for public women and are funded by the Province Government. Midwives practice **insurance is also funded by the Province Government**.

Midwives are regulated as a separate profession from nursing. **Midwives registering to practice demonstrate the quality of their midwifery skills, knowledge and abilities** by meeting stringent practical competencies, risk management performance indicators and proving they have completed recent clinical practice. This is much more rigorous than current Australian requirements.

**New midwifery registrants are able to enter private practice and access Province funding** provided they work within an established practice and an experienced midwife is present for all births. In Australia new midwives cannot access Medicare funding for at least three years.

Incentives are provided by Province Governments to encourage midwives to **set up practice in rural and remote areas**, and to take on new registrants.

**First Nations** communities with **birthing services** have demonstrated unexpected **positive community benefits** over and above cultural safety, such as **reduced domestic violence and child abuse**.

**Attitudinal research** demonstrates that **despite the evidence** many obstetricians believe that birth outside a major hospital is unsafe.

4.3: New Zealand:

4.3.1. Policy and Evidence:

The population of NZ is approximately 4.2 million with approximately 57,000 babies born in NZ each year, and like Australia New Zealand (NZ) has a universal public health system. In 1990 the Health and Public Service Act was changed in order to allow midwives to claim on the Maternity Schedule (section 88), this meant that payment for maternity care was the same for all authorized health professional. The purpose of the change was to promote safe, evidence based, financially sustainable primary maternity services. The woman and her continuity of care provider (lead maternity carer, LMC) work in a partnership, with the LMC responsible for managing care and facilitating the provision of additional (specialist) care as required. An LMC may be a midwife, a general practitioner or a private obstetrician. Primary birthing services may be in the home (5%), a primary birth centre (12%) or a public hospital maternity service, with specialist secondary (48%)/tertiary (35%) birthing services provided in hospital. A greater proportion of women from rural/remote settings gave birth at home or in primary birth centers ([www.health.govt.nz](http://www.health.govt.nz) and NZCOM Report on MMPO Midwives).

Entry to midwifery practice is via a four year university based degree course undertaken over three extended academic years. Midwifery students complete extensive clinical placements across the full range of place of birth, including home, and across the full range of midwifery practice including LMC.

Approximately 85% of NZ women choose a midwife as their LMC. LMC midwives work in private practice, but are paid through the universal public health system and through a national access agreement are authorized to use the public birthing facilities. The LMC is authorized to order the standard maternity care tests, pharmaceuticals and higher level care referrals. Approximately 50% of midwives are employed as core midwives (non LMC’s) in hospitals and 50% are LMC’s.

The approximately 3,000 midwives in NZ are regulated by a Midwifery Council ([www.midwiferycouncil.health.nz](http://www.midwiferycouncil.health.nz)) which is separate to the regulation of nursing; approximately 150 new midwives are admitted to the midwifery register each year 95% of the new midwives are midwife only degree (4 years) qualified. The purpose of the
council is to protect the public by ensuring midwives on the midwifery register are competent to practice by setting midwifery scope of practice and standards (including pre-registration education), assessing competence/compliance with the scope/standards and dealing with complaints. In addition the council works with stakeholders to ensure the sustainability of the midwifery workforce.

There is a rigorous annual re-certification process which involves providing evidence of competent recent clinical practice across all areas of midwifery practice, compulsory attendance at education sessions and completion of practical competency related to maternity emergencies, breast feeding and topical midwifery related issues as set by the council. In addition all midwives must participate in the NZ College of Midwives - Midwifery Standards Review Program. The minimum Midwifery Council competency standard is based on entry to practice level and the fee for ongoing registration is $350.

The NZ College of Midwives (NZCOM) is the professional organization for midwives in NZ. Within its organizational structure NZCOM has several different arms which represent midwives professional, business and industrial interests (www.midwife.org.nz). The College fees range from $700 for a private practice midwife to $350 for a DHB employed midwife, the fees include professional indemnity insurance. Although College membership is voluntary over 90% of midwives in NZ are members. On behalf of LMC midwives NZCOM is currently in dispute with the NZ Government over fair and equitable reimbursement.

For an additional fee the NZCOM subsidiary organization Midwives and Maternity Providers Organization (MMPO) provides LMC midwives with business set up, data management and billing support. The MMPO also manages the rural locum scheme which, along with other rural/area of need incentives, is funded by the NZ Government. The rural locum scheme provides LMC midwives with an at least 50% rural caseload with 9 days/year locum cover.

Another NZ Government strategy to support recruitment and retention of midwives is the First Year of Practice Program. NZCOM administers the program of support for newly qualified midwives, which is fully funded by the NZ Government. Although not compulsory approximately 96% of newly graduated midwives complete the program. The program commenced in 2007 and consists of a formal framework of clinical practice support, mentor support, reflection, professional education and Midwifery Standards Review. A recent review (2014) of the first year of practice program 2007-2010 has demonstrated an improvement in retention rates and improved new graduates confidence.

Approximately 50% of new graduates choose to become private practice LMC midwives on registration. However, allowing new graduates to enter private practice on graduation is not without its critics, with recent very public disagreements between a prominent medical practitioner and the NZCOM about the quality of recently published research which appears to show poorer clinical outcomes for women and babies when cared for by new graduate LMCs.

Unlike Australia, Canada and England the NZ Accident Compensation Scheme (www.acc.co.nz) is a Government backed universal no faults scheme which provides financial compensation and support to sufferers of personal injury. Registered health professionals can only be sued for compensation on narrow grounds; this means that professional indemnity insurance in NZ is affordable and easily available. All health professionals are required to have insurance and the NZCOM includes professional indemnity insurance in its membership fees for private practice midwives.

4.3.2: Practice Reality:

Canterbury District Health Board (DHB) is fairly typical of the NZ public system. There are approximately 515,000 people in the catchment area of 27,000 sq km; there is a tertiary hospital and seven primary/rural services, there is also a private hospital which is contracted for a small number of public births. According to the DHB annual report over 6,000 babies are born each year in the DHB, approximately 88% in hospital, 9% at primary units and 3% at home.
Christchurch Women’s Hospital (CWH) is the DHBs main maternity service, with six of the seven rural/primary services also providing birthing services. There are approximately 240 LMC in the area and 141 FTE DHB employed midwives. Over 80% of women who birth their babies at the hospitals have an LMC. Obstetric specialists provide care for women with complex medical needs, usually in collaboration with the LMC, and there is a Maternal-Fetal medicine specialty service for women and babies with very complex needs. Obstetric specialists are predominantly employed by the DHB, but there are also a small number of private obstetricians with LMC visiting access.

Hospital midwives have their practice license and Midwifery Standard Review fee paid by their employer. In addition to the College and Council requirements the DHB requires employed midwives (core) to complete a number of clinical competencies and to rotate through all areas of midwifery practice. In the primary units 1 midwife is on duty 24/7; however this is usually a midwife with many years experience in primary care, emergency management and transfer.

Samantha Burke, Midwifery Director at CWH, reported that the supply of LMCs in Christchurch now almost meets the demand for LMCs, but up until recently this has not always been the case with hospital midwives required to make up the shortfall. However, Sam raised concerns that the LMCs were taking on higher caseload numbers of 60+ both to meet demand and also to ensure an income comparable to the non LMC hospital midwives. Sam identified that the research supporting the LMC model was based on caseloads of approximately 40:1; therefore this change in the caseload model is highly likely to impact upon the quality of clinical and social outcomes and may be a threat to maintaining the model.

Sam, and Sonia Mathews (Birth Suite Manager) said they have observed that as caseloads rise many LMC midwives tend to modify their practice including leaving early labour care to the hospital midwives, leaving women in the care of the postnatal ward midwives more often and for longer and contracting out community postnatal care. Sam also explained that many LMC midwives were choosing to bring low risk women to the tertiary service to birth often bypassing closer primary birthing units; anecdotally the explanation would seem to be about easier access to hospital support midwives such as for second midwife at the birth and in the postnatal ward. Sonia identified concerns that she had seen an increasing trend in LMCs handing over care of complex women probably because they took up too much time, and because some LMCs were losing their skills in care of complex pregnancy and birth. Sam reported that some LMCs were handing over care for relatively routine procedures such as induction of labour and epidural.

Antenatal:
Women usually book with an LMC before they are 12 weeks pregnant, most LMCs provide all the antenatal care, however if the woman has complex medical/obstetric issues care will be shared with the obstetricians at the hospital antenatal clinic. A referral guideline and criteria for birthing in the primary unit have been developed and are available on the NZ Ministry of Health web site.

Intrapartum:
For the majority of women an LMC provides intrapartum care, this may be in a hospital, birth center or at home and may be in collaboration with an obstetrician if the woman has obstetric complications and the obstetrician is not already the LMC. For those women without an LMC or where an obstetrician is the LMC hospital midwives provide care. Bronwyn Torrance midwife at Lincoln primary unit said that the core midwives at Lincoln generally assisted the LMCs as second midwife at the birth and provided some early post natal support while the woman was in the unit and coordinated transfer if required. Transfer in labour rates to higher level care from home (19.2%) or primary birthing units (15.6%) are relatively stable, but for some units, for example Blenheim or Queenstown transfer to a complex care facility can be a lengthy process sometimes involving a plane ride to the North Island.

Postnatal:
Women birthing in a primary birth centre usually go home within a few hours of the birth, whereas women birthing in a hospital usually go home within 2 days or are transferred to a primary unit with postnatal care facilities. LMC midwives provide community based postnatal care (in home or in clinic/group) for up to six weeks
postnatal before handing over care to community child health nurses.

4.3.3: Relevance for Australian Maternity Services:
The NZ Government has published a maternity care quality and safety comparison study (2013) available at [www.health.govt.nz](http://www.health.govt.nz) using six similar countries as comparators in studying morbidity, mortality and consumer satisfaction. While acknowledging the difficulties comparing data often collected in different ways and with different definitions the NZ system measures similar to or more favorably on most performance indicators than Australia with less medical intervention.

The NZ Government acknowledges that any significant ongoing improvements in maternity quality and safety are more closely linked to improvements in public health rather than advances in obstetric care. Maternal risk factors such as obesity, age related, poverty related, mental health and substance abuse need more than a system that only focuses on managing the increased risk factors created by these public health issues.

The NZ system of **primary relationship based caseload maternity care** provides a vehicle for **targeted public health initiatives** particularly for **vulnerable women** and their families.

The NZ maternity care system provides access to a **wider range of women centered choice** than the Australian system both for **place of birth** and access to evidence based **models of care**.

NZ has a **robust framework to escalate care needs** for women and babies who need complex care. The framework has been developed by all stakeholder groups related to maternity care including consumers and is mandatory.

Like Canada **regulation of midwives** in NZ is **separate from nursing** and much **more robust** than in Australia. In NZ midwives are required to provide actual evidence that they have met and continue to meet a minimum standard.

Australia has no mechanism/framework for providing support to all newly qualified midwives, but expects that an employer will provide support and supervision with no support for self-employed midwives. Canada and NZ recognize that a newly qualified midwife needs support in their **first year of practice** and provide a mechanism to enable all new midwives employed and self-employed to access **transition support**. However, in Canada the supervision of newly qualified midwives is more robust than in NZ.

Australia has a misalignment of maternity care practitioners with **shortages in many rural/remote areas**. There are some rural/remote incentives for medical practitioners, but very few for midwives, and none for private practice midwives. Both NZ and Canadian Governments **provide incentives for midwives** to move to areas of shortage and assistance to set up in practice.

5: Conclusion and Recommendations:
Health planners and health authorities are tasked with the responsibility for making population based decisions on health infrastructure. These decisions are based on elements such as social, political, financial and wide applicability which are often in conflict with the needs of individual communities, the people who live there and the health professionals.

However, the health of the next generation depends heavily upon the health of mothers and their parenting skills. The relationships children form early in life can be protective or destructive and will impact on their development into adulthood with wide ranging societal consequences.

Australia has a lot to learn from similar countries both in terms of what it working well and what to avoid. From my brief look at other systems it is clear that there are some fundamental take home messages for Government, Educators, Regulators, Professional Associations and individual midwives to consider. The key tenants for change are **improved access, choice, consumer control and safety within an economically sustainable system**.
Practice:
The English, Canadian and New Zealand maternity systems are based upon **primary community based care** provided as locally as possible and in conjunction with other primary care providers or community based agencies. This is a logical way of providing services and recognizes that maternity care is not isolated from family/community, but is part of community building/maintenance. This is an important lesson for Australian maternity care which is often centered on health professionals needs, very fragmented and divorced from the psychosocial aspects of family life. Providing geographically based primary maternity care co-located with other women and children/family services improves access to care and ongoing access to support.

**Relationship based care as a public health initiative** where midwives and women are supported to develop positive partnerships has demonstrated increased safe normal birth, increased consumer satisfaction, reduced midwife burn out and reduced cost. Researchers are currently studying some of the finer nuances of relationship based care and discovering links to reduced still birth, preterm birth and reduced admissions to neonatal intensive care for babies of mothers who received continuity of midwifery care for pregnancy, birth and post birth.

The available research evidence highlights that the best **place of birth** for women without complex physical problems is not in acute care hospital settings, but in low key birth centers or at home. This may seem simplistic (the best ideas often are simple) and undoubtedly will challenge the preconceived prejudices that surround maternity care in Australia.

Birthing on country is an important **cultural safety issue for Indigenous Australians**. First Nations women in very remote areas in Canada and rural areas in New Zealand are safely giving **birth on their homelands** in low key birth centers or at home.

**Development of a national mandatory framework to escalate care needs** for women and babies who need complex care.

**Practitioners:**
In order to provide a primary community based maternity system with midwives working in partnership with women and other health professionals in relationship based caseload models there is a need to invest in:

- Educating new midwives and developing existing midwives to work across their full scope of practice.
- Removal of professional barriers which prevent full scope of practice and expanded scope.
- Development of a support and supervision framework for new practitioners in both public and private settings.
- Development of a more robust and separate regulation system for midwives which include access to professional mentors.
- Ensuring that affordable practice insurance is available for all midwives in all practice settings.
- Ensuring that midwives in private practice and public maternity systems are remunerated to provide relationship based care.
- Providing incentives for midwives in both public and private practice to move to areas of workforce shortage.

Dissemination of findings will be at local, state, national and international levels.

1. Through local work on improving models of maternity care at Gold Coast Health and through midwifery student preparation through Griffith University.
2. Through state, national and international conference presentations, and articles for professional journals.
3. Through state and national influencing of Department of Health and political influencers by work undertaken by the Midwifery and Maternity Provider Organization of Australia.