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Australian private midwives with hospital visiting rights in Queensland: Structures and processes impacting clinical outcomes

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ABSTRACT

Background: Reporting the outcomes for women and newborns accessing private midwives with visiting rights in Australia is important, especially since this data cannot currently be disaggregated from routinely collected perinatal data.
Aim: 1) Evaluate the outcomes of women and newborns cared for by midwives with visiting access at one Queensland facility and 2) explore private midwives views about the structures and processes contributing to clinical outcomes.
Methods: Mixed methods. An audit of the 'all risk' 529 women receiving private midwifery care. Data were compared with national core maternity variables using Chi square statistics. Telephone interviews were conducted with six private midwives and data analysed using thematic analysis.
Findings: Compared to national data, women with a private midwife were significantly more likely to be having a first baby (49.5% vs 43.6% p = 0.007), to commence labour spontaneously (84.7% vs 52.7%, $p < 0.001$), experience a spontaneous vaginal birth (79% vs 54%, $p < 0.001$) and not require pharmacological pain relief (52.9% vs 23.1%, $p < 0.001$). The caesarean section rate was significantly lower than the national rate (13% vs 32.8%, $p < 0.001$). In addition fewer babies required admission to the Newborn Care Unit (5.1% vs 16%, $p < 0.001$). Midwives were proud of their achievements. Continuity of care was considered fundamental to achieving quality outcomes. Midwives valued the governance processes embedded around the model.
Conclusions: Private midwives with access to the public system is safe. Ensuring national data collection accurately captures outcomes relative to model of care in both the public and private sector should be prioritised.

Statement of significance

Issue

Little is known about the outcomes for women accessing maternity care from private midwives with visiting rights in Australia, and there are no studies to date analysing factors impacting on clinical outcomes.

What is already known

Compared with other models of care, public sector midwifery caseload care is safe for women and babies. Women report higher maternal levels of satisfaction in continuity of midwifery care models, and it is cost-effective.

What this paper adds

This study contributes to knowledge about the outcomes for 'all risk' women using private practice midwives with visiting rights and extends understanding of the context of care affecting clinical outcomes.

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1. Introduction

The 2016 updated Cochrane systematic review of midwife-led continuity models (caseload) versus other models of care for childbearing women and their infants found midwife-led care leads to better outcomes.[1] Women who received caseload midwifery care were more likely to have a spontaneous vaginal birth and less likely to experience a pre-term birth. Women also experienced less overall fetal/neonatal death and required fewer interventions during labour and birth than women whose care was provided by different obstetricians, General Practitioners (GPs) and midwives.[1] All studies included in the Cochrane review were of services provided in the public health service with no 'point of service' hospital costs to women.

However, despite improved outcomes for women and newborns and national maternity policy prioritising improved access to caseload midwifery most of Australia's maternity care is still delivered in tertiary, rather than primary care settings.[2,3] In addition, even though caseload midwifery provides significantly improved outcomes, national, state and territory perinatal data collection systems do not yet routinely collect and record the model of maternity care and therefore outcomes cannot be evaluated relative to this important variable.[4] The proportion of women receiving caseload midwifery in Australia is unknown, however a recent survey of 149 health services identified that only 8% of women were provided with continuity of midwifery care.[5]

To enhance women's access to continuity of midwifery care the Federal government legislated for midwives to have access to Medicare in 2010.[6] Medicare is Australia's national health insurance system. It is intended to provide universal access to health care. Predominantly Medicare provides a specified rebate for health care services provided by medical practitioners. However since 2010, women cared for by a midwife with access to Medicare have been able to obtain a rebate for the cost of the midwife's services. Under the reforms, Medicare eligible private practicing midwives (referred to in this paper as private practice midwives [PPM]) with visiting access to a hospital may admit and care for their clients during labour and birth as private patients in public hospitals. Gaining hospital visiting access or 'visiting rights', as it is commonly referred to, is essential for private practice midwives as this is the only mechanism by which women using their services can be assured continuity of care regardless of place of birth.

In the private midwifery caseload model a pregnant woman engages her own midwife who provides care throughout pregnancy, birth and early parenting. The midwife uses the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral to guide decision making and clinical care.[7] Models such as these provide childbearing women with the unique and personalised experience they have been demanding for many years.[6,8–12]

One state in Australia, Queensland, utilised the national reforms earlier and more fully than other Australian states and territories. To date, approximately 12 of the 42 public maternity facilities in the state provide visiting access to Medicare eligible private practice midwives whereas most other states and territories have not, or have only very recently, implemented visiting access agreements. One of the first maternity units to facilitate access for private practicing midwives was located in South East Queensland. At this hospital a Steering Committee was established with representatives of stakeholders including consumers, to oversee the development and implementation of visiting access arrangements. The maternity unit developed an Access Licence Agreement (ALA), a Clinical Guideline, and a number of work instructions to support the ALA for private practice midwives.

In October 2012 the first four midwives were credentialed using processes that aligned with clinical privileges for medical practitioners and signed the ALA. In June 2013 another seven midwives obtained visiting access bringing the total to 11. In 2014/5 four more midwives gained access. Subsequently five midwives have decided not to seek reaccreditation for a range of reasons (such as relocation, gaining access elsewhere and deciding to cease private practice). Women booked with private midwives are cared for in either the Birth Centre or Birth Suite depending on the complexity of the woman and/or her baby. If medical care is required, the midwife consults with and/or refers to the obstetric team employed by the health service. The private midwife continues to provide midwifery care regardless of the involvement of other members of the health care team.

The governance processes embedded around the model include a fortnightly case review and reflection session that also includes an opportunity for obstetric consultation and referral, monthly, six-monthly and annual outcome reporting (written), inclusion of private practice midwives in professional development both as participants and facilitators, and annual assessment of evidence of competency across the full scope of midwifery practice. The private practice midwives have access to all the educational opportunities afforded to the staff within the service. The Clinical Midwifery Consultant responsible for managing the public caseload practice provides clinical leadership to the private midwives and is their initial point of contact within the service.

Reporting the outcomes for women and newborns accessing private midwives in Australia is important, especially since this data is not able to be disaggregated from routinely collected perinatal data at state and national levels. At the time this paper was written there was only one other article reporting maternal and newborn outcomes of private midwives, with hospital access, since the introduction of the 2010 reforms.[13] In addition, understanding the structures and processes contributing to clinical outcomes may enhance our ability to develop sustainable quality services. As previously highlighted realigning maternity services with the evidence has been slow. Existing structures and processes are likely to impact on this progress. However little is known about how midwives and maternity organisations transition towards caseload care or the sustainability of caseload services.[14] There is significant evidence that despite excellent outcomes, caseload services in Australia and in other OECD countries not only struggle to expand but are also frequently threatened with closure, downsized, degraded or closed either permanently or temporarily.[14,15] Understanding the organisational factors surrounding the provision of caseload midwifery care, both public and private, may be key to reforming maternity service delivery.[16–20]

Therefore the aims of this study were to evaluate the outcomes of the women and newborns cared for by private midwives with visiting access to a large tertiary referral centre in South East Queensland and to explore the midwives views about the structures and processes contributing to these clinical outcomes.

2. Method

This was a two-phase mixed methods study using clinical audit and a descriptive qualitative approach.[21]

2.1. Phase 1: maternal and neonatal outcomes

A retrospective audit of the clinical outcomes of all women and newborns cared for by private midwives with visiting access was undertaken at one South East Queensland maternity unit between 1 October, 2012 to 31 May, 2016 ($N = 529$). De-identified outcomes were retrieved from an Excel database that is updated every fortnight and forms part of the routine governance process around

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