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Reforming maternity services in Australia: Outcomes of a private practice midwifery service

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ABSTRACT

Background and aims: recent legislative changes in Australia have enabled eligible midwives to provide private primary maternity care with fee rebates through Medicare. This paper (1) discusses these changes affecting midwifery practice; (2) describes Australia's first private midwifery service with visiting rights to hospital for labour and birth care since Medicare funding for midwives was introduced in 2010; and (3) compares outcomes with National Core Maternity Indicators.

Methods: an audit of all client records ($n=323$) for the survey period from September 2012 to February 2014 was undertaken. Data were extracted and compared with the 10 perinatal indicators using Chi square statistics.

Findings: this convenience sample of all-risk women was similar to the national birthing population for age and parity. Compared to national indicators, women were significantly more likely to have spontaneous commencement of labour (79.6% versus 54.8%) ($\chi^2=79.88$, $p<.001$), lower rates of induction (10.2% versus 26%) ($\chi^2=79.88$, $p<.001$), and not require pharmacological pain relief (54.8% versus 23.9%) ($\chi^2=152.2$, $p<.001$). The majority of women had a normal vaginal birth (70.3% versus 55.1%) ($\chi^2=28.13$, $p<.001$). The caesarean section rate (22% versus 32.3%) was significantly lower ($\chi^2=15.64$, $p<.001$) than the national rate. Average gestation of neonates was 39.3 weeks; average birth weight was 3525gms, and fewer required transfer to the special care nursery (8.4% versus 15.3%) ($\chi^2=11.89$, $p<.001$).

Discussion: this is the first report of maternal and neonatal outcomes for a private midwifery service in Australia since the introduction of access to Medicare for midwives. Maternal and newborn outcomes were statistically better than national rates. Routinely reporting and publishing clinical outcomes needs to become the norm for private maternity care.

Conclusions: this private midwifery caseload model has been instrumental in the ground-breaking change to primary maternity services that extends women's access to safe midwifery care in Australia. The potential impact of private practicing midwives to align maternity care with the best available evidence is significant.

Introduction

Clear evidence of the benefits of caseload midwifery care has been generated from countries such as the United Kingdom, New Zealand, Canada and Australia. A recent systematic review found maternity care by a caseload midwife leads to better outcomes for women and babies (Sandall et al., 2013). Women who received continuity of care throughout pregnancy and birth from a small group of midwives were less likely to experience a pre-term birth, and require fewer interventions during labour and birth than women whose care was shared between different obstetricians, General Practitioners (GPs) and midwives (Sandall et al., 2013). Similarly, in New Zealand Dixon et al. (2012) found positive maternal and neonatal outcomes for low risk women planning to birth in free standing midwife-led units compared to women admitted to obstetric units. In Australia, a large randomised controlled trial by Tracy et al. (2013) comparing caseload

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midwifery care versus standard maternity care found that for women of any risk, caseload midwifery was safe and cost-effective. Despite this evidence and over three decades of government reviews and reports (e.g. Shearman, 1989; Hirst, 2005) recommending reform of maternity services to address the medicalisation of childbearing, the caesarean section rate in Australia is at an all-time high (33%) (Li et al., 2013). This paper (1) discusses recent legislative and regulatory changes affecting midwifery practice, (2) describes Australia's first private midwifery practice with visiting rights to hospital for labour and birth care; and (3) presents maternal and neonatal outcomes of this service.

Changes to maternity care in Australia

Maternity care in Australia is provided by midwives, obstetricians, and general practitioners (GP) with or without an obstetric qualification. In 2011 of the 299,588 live births, 96.9% occurred in hospitals, a small proportion occur in birth centres (2.2%) and planned home births were rare (0.8%) (Li et al., 2013). In public and private hospitals, obstetricians and midwives employed by the hospital assist women during labour and birth. The proportion of births in private hospitals was 29% (Li et al., 2013). In rural areas, GP obstetricians and midwives provide the majority of care. While birth centres and midwife-led services employ midwives to provide care for women throughout pregnancy, labour and birth, and post partum; access to these services is limited (Brown and Dietsch, 2013). Access to publically funded home birth services is rare, as are private midwifery home birth services.

Over the last decade increased lobbying by midwives, women and their families for change to the maternity care system to enhance women's access to continuity of midwifery care lead to political commitment for reform. The Review of Maternity Services in Australia (Department of Health & Aging, 2009) was significant and resulted in subsequent legislative and regulatory changes including Medicare funding for midwives introduced in the 2009/2010 Budget (Commonwealth of Australia, 2010a, 2010b, 2010c Health Legislation Amendment); Commonwealth supported access to professional indemnity insurance (PII) for midwives (Commonwealth of Australia, 2010a, 2010b, 2010c PII); and a National Maternity Plan promoting continuity of care for women (Department of Health, 2011). Medicare is the national base health insurance model intended to provide universal access to health care. It is not means tested and is available to most people. It provides a specific rebate for health care services provided by medical practitioners. Eligible midwives received a Medicare provider number in 2010 meaning that women could obtain a rebate for the cost of services provided by midwives.

These changes resulted in women being able to obtain rebates under the Medicare Benefits Scheme (MBS) for care provided by midwives notated (or endorsed) by the regulator and referred to as 'eligible midwives'. This new structure provided primary maternity care in a community setting from a private practice midwife, and gave birthing women a greater degree of choice in selecting safe, quality maternity services. Under the reforms, privately practicing midwives (with visiting access) may admit and care for their clients during labour and birth in a public or private hospital. Hospital visiting rights for private practice midwives are essential for achieving continuity of care for pregnant women wishing to birth in hospital. At this stage, privately practicing midwives have only been able to secure visiting rights to hospitals to provide care for their clients in labour in one Australian state; Queensland.

A private midwifery practice model for continuity of midwifery care

My Midwives, a private midwifery service, was established in December 2010 to offer continuity of midwifery care (My Midwives, 2014). My Midwives commenced with two midwives and has grown to now include around seven midwives and at least four student midwives in Toowoomba, Queensland. In addition to My Midwives Toowoomba, there are now seven other licensed practices in Australia and they are leading the way nationally in innovative primary midwifery care. My Midwives also aims to redefine midwifery practice options in Australia facilitating midwives to work in woman-centred ways, where they are accountable to the woman rather than to an employing organisation. There are other private midwifery group practices established in Australia, which are predominantly structured as discrete practices.

Women are able to self-refer to My Midwives and other private midwifery practices. The midwives working within My Midwives are self-employed or work in a model where most midwives are self-employed. These midwives are notated by Australian Health Professional Regulatory Authority as 'eligible' midwives and/or are 'endorsed' for scheduled medicines to enable them to prescribe medications. The requirements for notation by the Australian Health Practitioner Regulation Authority are: registration as a midwife with no restrictions on practice; three years experience across the full scope of midwifery; currently competent across the full scope of midwifery; 20 additional hours of continuing professional development; completion of a professional practice review process; and completion of an accredited prescribing course or undertaking to complete same within 18 months (Nursing & Midwifery Board of Australia, 2010).

These additional regulatory requirements enable midwives to obtain a Medicare provider number, access subsidised professional indemnity insurance, order Medicare rebated screening and diagnostic tests and prescribe scheduled medicines. Women therefore have access to Medicare rebated consultations for antenatal and postnatal care wherever the consultations occur (home, clinic or hospital) and Medicare rebates for in-hospital labour and birth care where the midwife has visiting rights. This paper describes the My Midwives Toowoomba team who were the first midwives to have hospital visiting access in Australia since the 2010 legislative reforms.

The My Midwives Toowoomba practice provides care to women regardless of risk. Past and current clients include teenage mothers, women from diverse cultures, and those experiencing intimate partner violence, mental illness and disabilities. Women with any level of pregnancy and labour risk receive care in conjunction with medical staff where required, including women with multiple pregnancies, pre-existing medical conditions, and other complex pregnancy and birth related issues as defined by professional guidelines.

Continuity of care (antenatal, intrapartum, post partum) provided by the same midwife is the norm, but mixed models of care are offered as well. The service supports education and research and contributes to the education of Bachelor of Midwifery students who work in a preceptor model of clinical learning. There is also a team midwifery service involving four midwives. This care is fully covered by public funding through combining options of Medicare funding and state-based sources.

Most women anticipating a vaginal birth commence labour at home and then travel to the hospital maternity unit (birth suite or birth centre) for birth with their midwife as the primary carer. Women can birth in the hospital setting with their midwife providing all care and are usually discharged within hours of birth. They receive immediate and ongoing postpartum care at home until six weeks after birth. If necessary, the midwives can phone the on call medical staff of the hospital and can refer directly to the on call consultant obstetrician. When significant risk or health issues present, the midwife can access medical staff through the hospital or refer the woman/baby to a GP. Women

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