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DISCUSSION

Australian caseload midwifery: The exception or the rule

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Summary The aim of this paper is to review the clinical outcomes of descriptive and comparative cohort studies of the Australian caseload midwifery models of care that emerged during the late 1990s and early 2000s. These models report uniformly a decrease in caesarean section operation rates when compared to local, state and national rates, irrespective of the obstetric risk of the women cared for. These outcomes are in contrast to the findings of the randomised controlled trials and comparative cohort studies of caseload midwifery conducted, predominantly in the United Kingdom, in the mid to late 1990s. The Australian studies show that caseload midwifery is a model of care that is associated with lowered rates of caesarean section operations, and other obstetric intervention rates. The absence of definitive evidence of the effect of caseload midwifery, derived from published descriptive and comparative cohort studies, underlines the need for a sufficiently powered randomised controlled trial of caseload midwifery. The randomised controlled trial of caseload midwifery being undertaken in two major teaching hospitals in Australia will provide definitive answers relating to the effect of the caseload midwifery model of care for women of all risk in the Australian context.

Background

The caseload model of midwifery is characterised by a midwife undertaking responsibility for the continuum of care through pregnancy, birth and postpartum for a small caseload of women. There have been attempts to define the term 'caseload midwifery'[1] however it remains poorly understood in Australia and is very often confused with the term 'team midwifery'. Although caseload midwifery is structured around the concepts described above, depending on context,

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the term 'caseload midwifery' appears to be synonymous with midwifery-managed care,[2] one to one midwifery care[3,4] and independent midwifery care.[5] In countries such as Germany, Denmark, Sweden, the Netherlands and the United Kingdom, midwifery care based on caseload and continuity of care has either been historically an integral part of the maternity health care system or has been introduced by statute, as is the case in New Zealand in 1990.[6]

In countries like Australia and the United Kingdom where the term 'caseload midwifery' is most commonly utilised, caseload midwifery is an integrated model of care within established public maternity services. Caseload midwifery is differentiated from the usual or standard model of maternity care by several key concepts such as the 'named midwife', 'continuity of care by known carer/s' and 'autonomous and flexible midwifery work patterns' that are dependent on the midwife being able to manage her working day around the requirements of the women who form her caseload.[3,7] While caseload midwifery is similar to other midwifery-led models of care in its focus on women centred and collaborative care,[8–12] it is different from the concept of 'team midwifery' as described by Biro et al.[8] Routine or standard maternity care on the other hand remains predominantly fragmented, organisation and/or practitioner-centric.

Australian caseload models began to emerge in the late 1990s[13–15] and have flourished.[13,16–23] The maternity setting for these models is varied, major referral metropolitan services, free-standing birth centres and regional and rural centres and community based homebirth services with varying complexity in risk status of the women, dependent on the context. The evaluation of these models has been limited to quasi-experimental comparative cohort studies both published[15,17] and unpublished[13,16,18–20,24] and unpublished descriptive audits[14,25] (Table 2).

The caseload midwife emerged within a context of a midwifery group practice. This means the caseload midwife is usually supported by a small number of other caseload midwives within a midwifery group practice.[22] The evolution of the caseload midwife within a midwifery group practice grew from sustainability of private midwife practices in the United Kingdom in the 1990s,[30,44] to ultimately support workplace industrial laws governing the practice of public sector midwives in all states and territories in Australia. The industrial agreements require caseload midwives to take a break after 12 h of continuous service and this requirement has meant that midwives must work in close relationships with their backup colleagues in a group practice. Typically annual caseloads for midwives working full time are 35–40 women throughout the pregnancy, birth and early postnatal period. As well as being the primary midwife for such a caseload of women each year, each midwife may also be a second or 'back up' midwife for women who have another midwife as their primary caregiver. In this way the caseload midwives provide cover for each other off duty or on leave.[22] In the Australian public health sector, midwives providing caseload care in sustainable models are employed on an annualised salary.[7] The caseload midwives are usually employed within area health services under industrial agreements ratified by the state industrial bodies.[7,22] These agreements provide for an annualised salary that allows for a self-management of their workload, deciding their own working patterns and negotiating their own leave cover. In this way, the caseload midwife is unimpeded in her attention to the needs of the women in her caseload. In New South Wales, the New South Wales Nurses Association and the New South Wales Department of Health within the industrial agreement, Model Pilot Agreement for Midwifery Caseload Practice Annualised Salary Agreement, have ratified this definition. NSW caseload midwives receive a base salary either for year of service, or for an individually awarded classification such as clinical midwife specialist or consultant, with a 29% loading that replaces shift loadings and on-call allowances.[26] The caseload midwives usually work closely with a nominated obstetric specialist to ensure collaboration and consultation. The choice of a particular obstetric colleague for midwives to consult ensures fluent and efficient communication.

The aim of this paper is to review the clinical outcomes of descriptive and comparative cohort studies of the Australian caseload midwifery models of care that emerged during the late 1990s and early 2000s. These models report uniformly a decrease in caesarean section operation rates when compared to local, state[27–29] and national rates, irrespective of the obstetric risk of the women cared for. These outcomes are in contrast to the findings of the randomised controlled trials and comparative cohort studies of caseload midwifery conducted, predominantly in the United Kingdom, in the mid to late 1990s (Table 1). The Australian studies infer that caseload midwifery is a model of care that is associated with lowered rates of caesarean section operations as well as other obstetric intervention rates. The absence of definitive evidence of the effect of caseload midwifery derived from published descriptive and comparative cohort studies, underlines the need for a sufficiently powered randomised controlled trial of caseload midwifery. The randomised controlled trial of caseload midwifery being undertaken in two major teaching hospitals in Australia will provide definitive answers relating to the effect of the caseload midwifery model of care for women of all risk, in the Australian context.

Method

A search of the literature was undertaken utilising the search engine OVID to access the computer databases Medline (1950 to present), Cumulative Index of Nursing and Allied Health Literature (CINAHL), Maternity and Infant Care and the Cochrane Database of Systematic Reviews. Terms searched for included midwifery, midwifery care, caseload midwifery, continuity of care, midwifery-managed care, midwifery-led care and nurse-midwifery. Combining randomised controlled trials, randomised, comparative studies and descriptive studies further limited the results. Searches were then reviewed for relevance and saved. Some literature was sourced from reference lists of relevant articles obtained as a result of the search. Some of the Australian literature was sourced due to the author's previous work in this area and personal and professional knowledge of contemporary midwifery practice in Australia and internationally.

Findings

The rapid increase in the rates of caesarean section operation is a global phenomenon. With this increase is a corresponding