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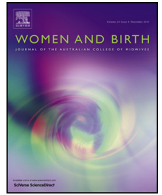

Original Research - Qualitative

The development of a caseload midwifery service in rural Australia

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ABSTRACT

Problem: The past two decades have seen progressive decline in the number of rural birthing services across Australia.
Background: Despite health system pressures on small birthing units to close there have been examples of resistance and survival.
Aim: This descriptive study explored the evolution of a rural birthing service in a small town to offer insight into the process of transition which may be helpful to other small healthcare services in rural Australia.
Methods: Quantitative data derived from birth registers on number and types of birth from 1993–2011 were analysed. Interviews were conducted between January and August 2012 with nine participants (GP obstetricians, midwives, a health service manager and a consumer representative).
Findings: This rural maternity service developed gradually from a GP obstetrician-led service to a collaborative care team approach with midwifery leadership. This development was in response to a changing rural medical workforce, midwifery capacity and the needs and wants of women in the local community. Four major themes were developed from interview data: (1) development of the service (2) drivers of change (3) outcomes and (4) collaborative care and inter-professional practice.
Discussion: The success of this transition was reported to rest on strategic planning and implementation and respectful inter-professional practice and alignment of birth philosophy across the team. This team created a unified, progressive community-focused birthing service.
Conclusion: The development of collaborative care models that embrace and build on established inter-professional relationships can maximise existing rural workforce potential and create a sustainable rural service into the future.

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Statement of significance

Problem

A progressive decline in the number of rural birthing services across Australia has meant many rural women have to travel for birth. This has resulted in an increase in unplanned out of hospital births and has put greater financial, emotional, social and cultural strain on rural families.

What is already known

The development of caseload midwifery services is a response to the need for rural maternity care to transition to collaborative arrangements between GP obstetricians, midwives and birthing women in a community. Birthing services can be retained rather than closed if health services offer midwifery-led models that encourage continuity of care for women. Other examples of rural collaborative maternity care models in small towns exist, which have developed to suit specific local circumstances.

What this paper adds

The development of collaborative care models that embrace and build on established inter-professional relationships can maximise existing rural workforce potential and create a sustainable rural service into the future.

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1. Introduction

Small rural communities face many challenges in maintaining publicly-funded locally based health care such as birthing services. Challenges include cost containment and workforce recruitment and retention. These challenges can result in closure of services with resultant access difficulties and lack of choice for women.[1] In recent years, there has been a progressive decline in the number of rural birthing services across Australia, with more than 50% (130) of rural maternity units closing between 1995 and 2005.[2,3] This has been associated with an increase in unplanned out of hospital births[4] reflecting difficulties for women in accessing regionalised services in larger hospitals.[5] Normal birth rates are lower in larger hospitals, even correcting for complexity of care provided in these settings.[6] It is also difficult to provide continuity of care with the benefits associated with this[7] when birth is relocated.[8] Closures have left many rural and remote communities without a maternity or birthing service which has put greater financial, emotional, social and cultural strain on rural families.[3,9]

Despite health system pressures on small birthing units to close,[10] there have been examples of resistance and survival,[11,12] in some instances partly due to activism of the local community members ensuring their needs and wants are known.[13] The birthing service on which this study is based is an example of a birthing service vociferously supported by its community. This community influence has helped maintain and shape a service which has developed over the last 20 years from a physician-led service to a low risk (defined as all of Category A and some of Category B (e.g. gestational diabetes) of the Australian College of Midwives Consultation and Referral Guidelines[14]) midwifery-led service. The model centres on midwifery caseload with general practitioner (GP) support and specialist obstetrician back up at a regional hospital if the woman requires transfer. It offers a service that has expanded to offer water birth and a publicly-funded homebirth service.

At present, the research literature contains only two studies that we identified describing the evolution and survival of Australian rural birthing services[11,12] (both about the same service). Our aim in this paper is to address this gap by providing a description of the development and current function of the service and to offer some insight into the process of transition which may be helpful to other small healthcare services in rural Australia.

1.1. Background

The birthing service was located in a small country town in New South Wales (NSW). It had a population of approximately 3000, of which 2% identified as Aboriginal and/or Torres Strait Islander, a smaller proportion than for NSW. Compared to NSW a greater proportion of the population spoke only English at home (90% compared to 72% in NSW).[15] Since the 1970s the town and its hinterland have been a venue for a counter culture, embracing 'alternative' alongside more mainstream lifestyles. The population are more likely to have no religion (37% compared to 18% in NSW), and are much more likely to do voluntary work through an organisation or group (27% compared to 17% in NSW).[15] The town has close community ties and includes a group of women who have strong natural drug free, low intervention birthing philosophies.

The birthing service is a publicly-funded service based in a 'home like' three room maternity unit. Much of the refurbishment of this unit was funded from a bequest from a member of the community. It provides care for less than 200 women per year in rural NSW. The centre offers three types of maternity care programs for care before, during and after birth: the midwives caseload program where women are cared for by midwives, the shared care program where women are able to access both a doctor and midwifery care and the doctor only program in which a woman will be cared for mainly by a GP obstetrician. The vast majority of women access the caseload program, around one in five access the shared care option and less than one percent access the doctor only program.

2. Methods

We undertook a small descriptive investigation combining quantitative data from birth registers and qualitative data from semi structured interviews. The study, including the interview schedule, was guided by the research question "What do participants perceive to be the characteristics of the birthing service that facilitated the successful transition from physician-led to midwifery-led collaborative care?" Our approach to data collection and analysis was underpinned by a subtle realism epistemology[16] that accepts that the social world exists independently of individual understanding but that we as researchers can only access that social world through our participants' interpretations of it.

The research was undertaken by a female postgraduate medical student (first author) with training and support from a team of three experts in rural health research with content expertise in midwifery and social sciences training. The disparate disciplinary frames of reference within the team created a rich environment for understanding the data collected.

2.1. Participants

During 2012, we purposively sampled participants to include a range of key stakeholders relevant to the service to obtain a breadth of views, and to ensure the historical perspective was captured. Participation in the study was high, due in large part to the ongoing commitment of local providers to the sustainability of local birthing services. We contacted 11 potential participants and nine agreed to participate. The two who declined stated that whilst interested in the study, they were too busy to participate. Participants were three GP obstetricians, four midwives (currently or previously working at the birthing service), a health service manager and a consumer representative who was a local community member. Participants had experience ranging from one to 25 years of working with the birthing service.

2.2. Data collection

We initially identified participants through the leadership networks of the birthing service and recruited via email by the first author followed by telephone contact. Some participants were subsequently recruited via snowballing (identification from existing study participants[17]). Participants gave written consent and interviews were audio recorded with permission. The interviews were one to one and semi-structured to allow flexibility in the interview, and focused on questions around the participant's role, the development of the service over time, and the strengths and areas for development of the service.

All interviews were conducted by the first author. Interviews were most often held in participants' workplaces in a suitable quiet space, and took between 30 min and two hours, the average interview lasting 47 min.

In addition to interviews, retrospective data from hand-written birth registers for 1993–2011 were rendered non-identifiable by health service staff and provided to the research team. The birth register included transfer data for women who were transferred postpartum, but not in the antenatal or intrapartum period. This

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