

National Maternity Action Plan For The Introduction Of Community Midwifery Services In Urban And Regional Australia

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NATIONAL MATERNITY ACTION PLAN

FOR THE INTRODUCTION OF COMMUNITY MIDWIFERY SERVICES IN URBAN & REGIONAL AUSTRALIA

Prepared by

Maternity Coalition

AIMS (Australia)

Australian Society of Independent Midwives

Community Midwifery WA Inc

SEPTEMBER 2002

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ABBREVIATIONS

Association for Improvements to Maternity Services	(AIMS)
Australian College of Midwives	(ACMI)
Australian Competition and Consumer Commission	(ACCC)
Australian Institute of Health and Welfare	(AIHW)
Australian Medical Workforce Advisory Committee	(AMWAC)
Australian Midwifery Action Project	(AMAP)
Australian Midwifery Act Lobby Group	(AMALG)
Australian and New Zealand Journal of Psychology	(ANZJP)
Australian Refined Diagnosis Related Group	(AR – DRG)
British Medical Journal	(BMJ)
British Journal of Obstetrics and Gynaecology	(BJOG)
Community Midwifery Program	(CMP)
Community Midwifery WA Inc	(CMWA)
Lead Maternity Carer	(LMC)
Medical Journal of Australia	(MJA)
National Health and Medical Research Council	(NHMRC)
National Maternity Action Plan	(NMAP)
New Zealand College of Midwives	(NZCOM)
World Health Organisation	(WHO)

GLOSSARY

Continuity of care	Care that is focused on the individual woman and her needs
Continuity of carer	The provision of care by a named professional or small group of professionals, throughout a woman's childbearing experience.
Midwifery-led care	Where the midwife is responsible for the delivery of care to particular women and their families and when midwives lead the development of guidelines for practice
Named midwife	A named qualified midwife who is responsible for providing midwifery care to a particular woman.
Peer review	An assessment of competence and skills by individuals, in groups of like minded equals, with the aim of improving performance.
Shared care	Antenatal care shared between the hospital and the woman's GP

NATIONAL MATERNITY ACTION PLAN FOR THE INTRODUCTION OF COMMUNITY MIDWIFERY SERVICES IN URBAN & REGIONAL AUSTRALIA

EXECUTIVE SUMMARY

The National Maternity Action Plan (**NMAP**) has been prepared by a broad coalition of consumer and midwifery representatives and organisations from across Australia. The **NMAP** outlines the rationale behind the need for major reform of maternity services, and, proposes a strategy for Federal and State/Territory governments to enable comprehensive implementation of community midwifery services in both urban and regional/rural Australia within the public health system.

The **NMAP** calls on both Federal and State/Territory governments to facilitate substantial change to the way in which maternity services are provided, by making available to all women the choice of having a community midwife provide continuous maternity care through the publicly funded health system.

Community midwifery services in the main provide continuity of midwifery led care to healthy women throughout the childbearing continuum, in collaboration with other practitioners such as general practitioners and specialist obstetricians, where indicated. Midwives are able to follow individual women across the interface between community and acute health services and to provide care to each woman from early in her pregnancy until the baby is 4-6 weeks of age.

Universal access to continuity of midwifery care will ensure savings in health dollars and bring Australia into line with international best practice in addition to meeting community demands for a range of readily accessible and appropriate maternity services.

Community midwifery is informed by international best practice standards that acknowledge midwives as “the most appropriate and cost effective type of health care provider to be assigned to the care of women in normal pregnancy and birth, including the risk assessment and the recognition of complications” (World Health Organisation, 1999, Care in Normal Birth).). In other western countries, particularly in the United Kingdom, New Zealand and Canada, midwifery is promoted and funded both as a public health and a primary health strategy, since community based care from midwives can be responsive to local needs, particularly with regard to health inequalities and social exclusion.

Continuity of midwifery care has been proven to result in fewer women needing expensive obstetric interventions, such as caesarean surgery and operative deliveries. Research also shows that such care contributes to long-term breastfeeding, improved adjustment to parenting, and may lower the incidence of post-natal depression.

Widespread access for pregnant women and their families to continuous care provided by community midwives would:

- Provide women with care that is as safe as current routine care
- Provide women with the choice of a midwife as their lead maternity carer in line with international best practice

- Improve maternal and infant outcomes
- Reduce the need for costly obstetric interventions in childbirth for the majority of pregnant women
- Be at least as, if not more cost effective than conventional models of maternity care.

The appropriate role for obstetric specialists lies in the care and treatment of women who develop medical complications during pregnancy or childbirth. Qualified and experienced community midwives should be providing primary care to pregnant women analogous to the role played by GPs in general health care: identifying and referring women to obstetric specialists as needed while providing care to healthy women for the duration of the finite episode of pregnancy and birth. This model involves close and effective collaboration between midwives and obstetricians in the care of women who develop complications. Once the baby is around 4 weeks old, women return to their GP for ongoing primary health care for themselves and their baby

It is the vision of the consumer and midwifery organisations involved in the development of this National Maternity Action Plan that within the next 5 years there will be equitable access to community midwifery programs providing continuity of care by a known midwife for all women who choose this model of care in all States and Territories.

This paper addresses the following:

- Reasons why reform of maternity services is urgently required
- What community midwifery care provides for women and babies
- Details of a successful best practice community midwifery program in Australia and how similar programs can be readily set up in other States and locations
- Recommendations to governments regarding implementation of community midwifery programs.

RECOMMENDATIONS

To ensure that Australian maternity services are able to meet the diversity and needs of individuals and the broader community in the twenty first century, the national consumer and midwifery organisations involved in preparation of this plan strongly recommend the following:

1. That Federal and State/Territory governments commit to urgent reform of maternity services with a view to ensuring all pregnant women have the option of accessing primary care from a qualified and registered community midwife throughout the childbearing continuum and within the public health system.
2. That the Federal Government introduce a Policy on Maternity Service Provision and an Implementation Framework that addresses structural reforms such as funding, legislation, standards of care and indemnification to enable planned and sustainable implementation of community midwifery programs in both urban and regional areas as a matter of priority.
3. That Federal and State/Territory governments ensure that there is effective consumer representation and participation at both policy and hospital/clinical levels to ensure that consumers of maternity services are included in the decision making processes that directly affect them.

4. That Federal and State/Territory governments further commit to ongoing expansion of community midwifery services in response to growth in consumer demand for these services.
5. That the Western Australian Community Midwifery Program, with its emphasis on community management and its provision of one-to-one continuity of midwifery care, be used as a proven and successful template for community midwifery programs to be established in all other States and Territories. Such Programs would ideally offer this type of care to women choosing to give birth in hospital delivery suites, birth centres or in the community.
6. That Federal and State/Territory governments work cooperatively to identify and eliminate policy and legislative barriers that currently limit or preclude midwives providing evidence-based and cost-effective primary health services to healthy pregnant women and their babies within the public health system.
7. That the Federal government reviews the Medicare Schedule to include midwives as legitimate experts in the provision of maternity care, and to enable women their right to choose either midwifery or medically led care. Alternatively the Federal Government should implement funding reforms in maternity provision similar to the Lead Maternity Carer arrangements that have been adopted by New Zealand.
8. That Federal and State/Territory governments implement the necessary legislative changes to enable midwives to order tests and prescribe drug therapy already commonly used in pregnancy, labour and birth.

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1. INTRODUCTION

The National Maternity Action Plan for the Implementation of Community Midwifery in Urban and Regional Australia (NMAP) has been developed through a national committee comprising representatives from peak consumer and midwifery advocacy groups. These include: The Maternity Coalition, Community Midwifery WA Inc (CMWA), the Association for Improvements to Maternity Services (AIMS), the Australian Society of Independent Midwives (ASIM).

The strategy paper was circulated widely for comment from a range of experts in maternity services across Australia. Midwifery and consumer groups were also encouraged to comment on the strategic direction outlined in the strategy.

There was strong overall consensus on the key elements of the Plan, in particular:

- That midwifery led care is the most appropriate care for the majority of pregnant women,
- That maternity services should be reformed to provide universal access to continuous care by community midwives through the public health system,
- That governments should establish community midwifery programs throughout urban and regional Australia as a matter of priority.

This paper therefore presents the rationale to support these claims and a proposed strategy for Federal and State governments to comprehensively implement community midwifery services in urban and regional/rural areas. It outlines the key elements of community midwifery, summarises the research evidence that supports this model of care as world-best practice for pregnant and birthing women, and, introduces successful examples within Australia of the use of community midwifery. It also considers the main administrative issues that would need to be addressed in establishing community midwifery programs in each State and Territory.

2. THE CASE FOR REFORM OF MATERNITY SERVICES

2.1 Australia's comparatively high intervention rates

There are about 250,000 births in Australia each year. At present the vast majority of women give birth in tertiary hospitals, mainly in 'delivery suites', which generally provide a high technology, medicalised model of maternity care.

Obstetric interventions in the labours and births of Australian women are now commonplace. An average of one in every five babies is currently born by caesarean surgery (around 50,000 per annum or 20%). Some private hospitals have rates of more than 40%¹. The World Health Organisation (WHO) recommends that caesarean sections should not be necessary for greater than 10% of women, with 15% being an upper limit for surgical intervention.² Those in favour of current rates of caesarean sections often argue that comparatively high rates reflect the higher age profile of women giving birth in Australia, especially those women who use private health insurance to access private hospitals. However recent research has shown that even low risk healthy women receive significantly greater numbers of caesarean sections

¹ This is shown in maternal and perinatal statistics published in each State and Territory.

² WHO. Care in Normal Birth: a practical guide. 1999. WHO/FRH/MSM/96.24
<http://www.who.int/rht/documents/MSM96-24/msm9624.htm>

than is recommended by WHO as best practice³. Further, it has been noted that a traumatic birth experience (often associated with unanticipated caesarean surgery) may have a significant impact on decisions regarding future reproduction⁴.

Other forms of intervention are also being widely used during the labours and births of healthy, low risk women. A study of 171,000 births in NSW found that of low risk first time mothers, labour is induced or augmented with oxytocin for one in three public patients and half of all private patients. Between a quarter (public) and a half (private) use epidural anaesthesia. Forceps procedures or vacuum extraction are used to deliver one in every five babies born in a public hospital and one in every three born in a private hospital. One in three public women and half of all private women receive episiotomy^{5 6}. Overall, less than one quarter of public first time mothers and one fifth of private patients give birth without obstetric intervention of any sort. These interventions are not always clinically indicated or in accordance with evidence based best practice.

Contrary to the current literature and statistical evidence, popular opinion in Australia still assumes that obstetric care is the safest way to manage birth for all women. The argument is commonly put that obstetric technologies and techniques have contributed to declining maternal and infant mortality in Australia as in other western countries over recent decades. Proponents of this view often overlook two important facts.

Firstly, there is strong evidence to show that improved maternal and infant outcomes have correlated with improvements in public health⁷. The ability of women to give birth to their babies without complications has been significantly improved over the past 50 years by better nutrition, housing, sanitation, hygiene and overall health. A reduction in the number of babies born to each childbearing woman, and fewer pregnancies to very young and older women has also improved both maternal and infant mortality rates.

Secondly, if high rates of obstetric intervention in childbirth deliver the best outcomes, then it follows that those countries with the highest rates of intervention would have the lowest rates of maternal and infant mortality (deaths) and morbidity (illness and injury related to childbirth). However, this is not the case. Indeed, the western countries with the lowest perinatal and maternal morbidity and mortality rates have been found to be those with comparatively low rates of obstetric intervention in childbirth, and where there is widespread use of midwives as the primary caregivers of pregnant and birthing women.^{8 9}

2.2 Failure to match international best practice

Australian rates of intervention do not currently meet international best practice, as exemplified in countries such as the Netherlands¹⁰ and New Zealand.¹¹ These countries have well established models of midwifery care with the majority (up to 80%) of pregnant women

³ Roberts, C.L, Tracy, S., Peat, B 2000 "Rates for obstetric intervention among private and public patients in Australia: population based descriptive study", *BMJ* 2000; 321:137-141 <http://bmj.com/cgi/content/abstract/321/7254/137>

⁴ Gottvall K, Waldenström U "Does a traumatic birth experience have an impact on future reproduction?" *BJOG* 2002; 109: 254-60

⁵ Roberts et al *ibid*.

⁶ Nassar N, Sullivan EA, Lancaster P, Day P. *Australia's mothers and babies 1998*. Australian Institute of Health and Welfare National Perinatal Statistics Unit, 2000 AIHW cat.no.PER15 http://www.aihw.gov.au/npsu/report_f.htm

⁷ Wagner, M 1996 *Pursuing the birth Machine, the Search for appropriate technology*. Sydney, ACE Graphics

⁸ Enkin M, Keirse JNC, Neilson J, Crowther C, Duley L, Hodnett E, Hofmeyr J. 2000 *A Guide to effective care in pregnancy and childbirth*. 3rd Ed. Oxford. Oxford University Press <http://maternitywise.org/guide/about.html>

⁹ Tew M. "Do obstetric intranatal interventions make birth safer?" *BJOG*. 1986; 93: 659-674

¹⁰ Wieggers TA, Keirse MJNC et al. "Outcome of planned home and planned hospital births in low risk pregnancies in the Netherlands". *BMJ* 1996;313:1309-13

¹¹ Ministry of Health NZ 2000, Health Funding Authority, Maternity Services: A Reference Document. November 2000 <http://www.moh.govt.nz/moh.nsf/>

receiving primary care from midwives with referral to specialist obstetric care only when necessary.

The American Public Health Association (APHA) takes a position in support of the expansion of midwifery as a key strategy to improving access to care for childbearing families for the purpose of increasing their health care options and thereby to the subsequent improvement of birth outcomes¹².

The first key recommendation of the recently published report from an Expert Advisory Group on Caesarean Section in Scotland states “all women should have the benefit of one-to-one midwifery care in labour. Such support reduces the rate of obstetric interventions including Caesarean section”¹³.

Although there are comparatively high rates of obstetric intervention in Australia the most recent maternal mortality report shows increased numbers of maternal deaths. A recent report produced by the National Health and Medical Research Council (NHMRC) finds that the rate of maternal deaths directly related to pregnancy and birth rose from 32% in the triennium 1991-1993 to 46% in the period between 1994 and 1996¹⁴. The maternal mortality rate for Australia now stands at 13 per 100,000 confinements in 1994-96 compared to 10.9 per 100,000 confinements in 1991-93. This increase reverses the trend of declining direct maternal deaths seen over the previous 15 years. There was an increase in the proportion of direct maternal deaths in which avoidable factors were considered to be possibly or certainly present from 7 (26%) of 27 deaths in 1991-1993 to 22 (48%) of 46 deaths in 1994-1996¹⁵. While further reports are needed to determine whether the 1994-1996 triennium was an aberration or indicative of a new trend, the report serves as a timely reminder that health policy for maternity services needs to emphasise and facilitate normal birth wherever possible.

There is strong evidence now that rising rates of maternal mortality in the USA and Brazil are related to their rising rates of caesarean section.¹⁶ As Wagner notes “maternal mortality even for elective (non-emergency) caesarean section is 2.84 fold or nearly three times higher than for vaginal birth.

*The normalising of the (caesarean) operation throughout society has lulled women into a false sense of security. It's only a matter of time before we have a sharp increase in maternal mortality because of Caesarean sections. We are beginning to see it happen already.*¹⁷

There is growing evidence that surgical intervention in birth also contributes to higher rates of maternal morbidity (illness and injury) eg postnatal depression.¹⁸ Research suggests the increasing use of caesarean surgery as a method of delivering babies is a major contributing factor in making women more vulnerable to postnatal depression.¹⁹ Studies have shown that

¹² American Public Health Association, Inc. 2001 Supporting Access to Midwifery Services in the United States (Position Paper) American Journal of Public Health 2001;91(3):482-485

¹³ Expert Advisory Group on Caesarean Section in Scotland. Experts Report and Recommendations to the Chief Medical Officer, Scottish Programme for Clinical Effectiveness in Reproductive Health. Expert Advisory Group on Caesarean Section in Scotland, Edinburgh . 2001. <http://www.show.scot.nhs.uk/crag>

¹⁴ NHMRC 2001 Report on Maternal Deaths in Australia 1994-96. NHMRC Cat. No. 0145246 AIHW Cat. No. PER 13 Commonwealth of Australia 2001, p.1 <http://www.nhmrc.gov.au/publications/pdf/wh32.pdf>

¹⁵ Walters W Ford J Sullivan E King J Maternal deaths in Australia. MJA 2002;176:413-414

¹⁶ Wagner M 2001 Fish can't see water: the Need to Humanize Birth. Int J Gynecol Obstets 75s25-37

¹⁷ “Caesareans linked to risk of infertility” Guardian Unlimited 21 April 2002 <http://www.guardian.unlimited.observer.uknews/caesareans-linked-to-risk-of-infertility>

¹⁸ Fisher J, Astbury J, Smith A. “Adverse Psychological impact of operative obstetric interventions: a prospective longitudinal study”. ANZJ Psych 1997;31:728-38

¹⁹ Boyce PM, Todd AI. “Increased risk of postnatal depression after emergency caesarean section.” MJA 1992; 157:172-4

women who had spontaneous vaginal birth “were most likely to experience a marked improvement in mood and an elevation in self-esteem across the late pregnancy to early postpartum interval. In contrast, women who had caesarean deliveries were significantly more likely to experience a deterioration in mood and a diminution in self-esteem.”²⁰

2.3 *One-to-one continuous midwifery care lowers intervention rates*

Normal birth is more likely to be achieved when a woman has access to ‘continuity of carer’ or ‘continuity of care’ from a midwife who is responsible for her care throughout pregnancy, labour and birth, and the postnatal period. “The systematic review comparing continuity of midwifery care with standard maternity services including data from all Australian trials shows that continuity of midwifery care is associated with lower intervention rates than standard maternity care, and that midwifery models of care are as safe as the existing standard services”²¹. The continuity of carer model of care has been proven to reduce the use of obstetric interventions in labour and birth, including the need for pharmacological pain relief, inductions, augmentations, instrumental deliveries, episiotomies and caesarean sections.^{22 23 24}

This conclusion is strongly reinforced by the authors of *Effective Care in Pregnancy and Childbirth*. These researchers included not only an international search of all trials that met their strict criteria but all relevant medical journals from the 1950s onwards, writing to over 40,000 obstetricians in 18 countries to identify unpublished studies. Their research has been incorporated into the Cochrane database. After critical evaluation of studies comparing one-to-one continuous midwifery care with medical models of care they conclude:

*Evidence from controlled trials shows that women who had continuity of caregivers were less likely to use pharmacological analgesia or anaesthesia during labour and birth, to have labour augmented with oxytocin, to have a labour length of more than 6 hours, or to have a baby with a 5 minute Apgar score below 8. They were also more likely to feel well prepared for labour, perceive the labour staff as caring, feel in control during labour and feel well prepared for childcare*²⁵.

Chalmers et al identify continuity of care from a qualified midwife as best practice for the healthy majority of women:

*as technical advances became more complex, care has come to be increasingly controlled by, if not carried out by, specialist obstetricians. The benefits of this trend can be seriously challenged. Direct comparisons of care given by a qualified midwife with medical back-up with medical or shared care show that midwifery care was associated with a reduction in a range of adverse psychosocial outcomes in pregnancy, and with reductions in the use of acceleration of labour, regional analgesia/anaesthesia, operative vaginal delivery and episiotomy, fewer babies weighing less than 2500 grams, needing resuscitation or needing admission to special care units*²⁶.

²⁰ Fisher J, Astbury J, Smith A. “Adverse Psychological impact of operative obstetric interventions: a prospective longitudinal study.” *ANZJ Psych* 1997; 31:728-38

²¹ Waldenström U, Turnbull D “A systematic review comparing continuity of midwifery care with standard maternity services” *BJOG* 1998;105(11):1160-70

²² Hodnett ED. Caregiver support for women during childbirth (Cochrane Review). In: *The Cochrane Library*, Issue 3, 1999. Oxford: Update Software.

²³ Homer CSE, Davis GK, Brodie P, Sheehan A, Barclay LM, Wills J, Chapman G. “Collaboration in maternity care: a randomised controlled trial comparing community-based continuity of care with standard hospital care.” *BJOG* 2001;108:16-22

²⁴ Rowley, M, Hensley, M, Brinsmead, M, & Włodarczyk, J. “Continuity of care by a midwife team versus routine care during pregnancy and birth: a randomised trial.” *MJA* 1995;163 (9): 289-293.

²⁵ Chalmers I, Enkin M, Kierse M 1996 eds *Effective Care in Pregnancy and Childbirth*, Oxford University Press, Oxford p.15-16

²⁶ *Ibid*, p.15

The effectiveness of midwifery continuity of care largely stems from the relationship of mutual trust built up between a midwife and a woman during the antenatal period. The establishment of this relationship, typically developed through extensive contact in the antenatal period, enables the midwife to provide care in a way that meets the individual woman's emotional, psychological, cultural and physical needs, as well as her medical needs.

This model of care has also been found to produce better outcomes for both mothers and babies, and to assist in mother/baby attachment or bonding^{27, 28}. Further, it has been shown that one-to-one midwifery care is beneficial beyond the birth episode, assisting in the establishment of long-term breastfeeding and reducing postnatal depression rates.^{29, 30, 31} Community based midwives are also more likely to identify the need to implement early intervention strategies in relation to a range of issues that may affect a family's ongoing wellbeing, as they have access to the familial environment.

Indeed, such are the demonstrated benefits of one-to-one continuous midwifery care to birthing women and their babies that Chalmers et al conclude that *"it is inherently unwise, and perhaps unsafe, for women with normal pregnancies to be cared for by obstetric specialists, even if the required personnel are available"*³².

2.4 Benefits for Indigenous women

Access for Australian Aboriginal women to one-to-one continuous midwifery care in Australia is currently very limited. Yet international evidence on the benefits of one-to-one midwifery care for Indigenous women in other countries, particularly where it is provided to women within their own communities, suggests that community midwifery care of pregnant women has the potential to significantly improve maternal and infant outcomes for Australian Aboriginal women and their babies. One-to-one continuity of care from a known midwife has the potential to provide care for Indigenous women that is more specific to their cultural needs and expectations than conventional hospital based care, particularly when an Aboriginal health worker is also involved in the care or when Indigenous midwives are able to attend other Indigenous women.

While the cultural needs of Australian Aboriginal women are distinct from those of Indigenous people in other countries, international experience indicates one-to-one continuous midwifery care is likely to be an effective model of care for improving women's experience of childbirth as well as the maternal and infant mortality and morbidity outcomes.

For example, in New Zealand, where publicly funded continuity of midwifery care has been available for the past ten years, the perinatal mortality rates for Maori women are as low as those for European/other.³³ More Maori women choose midwife only care, with more than 73% of all Maori women choosing this option in 1999.³⁴ Both the maternal mortality rates and perinatal mortality rates are lower in New Zealand than Australia, in the Indigenous populations.

²⁷ Expert Advisory Group on Caesarean Section in Scotland. Experts Report and Recommendations to the Chief Medical Officer, Scottish Programme for Clinical Effectiveness in Reproductive Health. Expert Advisory Group on Caesarean Section in Scotland, Edinburgh . 2001. <http://www.show.scot.nhs.uk/crag>

²⁸ McCourt C, Page L. *Report on the evaluation of one-to-one midwifery*. Thames Valley University, London 1996.

²⁹ Hildingsson I, Haggstrom, T. 'Midwives lived experiences of being supportive to prospective mothers/parents during pregnancy' *Midwifery* 15:82-91, 1999

³⁰ Littlewood J, McHugh N. *Maternal distress and postnatal depression: The myth of Madonna* Houndmills:MacMillan Press, 1997

³¹ Fisher J, et al op cit

³² Chalmers I, et al op cit

³³ NZ Ministry of Health. *Report on Maternity 1999*. Wellington, New Zealand. <http://www.moh.govt.nz>

³⁴ ibid

Similar initiatives have been instituted for Canadian Indigenous women. Models of midwifery care have been established which are community based, offering one-to-one continual midwifery care to Indigenous women within their own communities.³⁵ This is in response to Indigenous demands for self-determination of health - and has resulted in the development of a traditional training program and a birth centre on the land at Six Nations (on the Ontario/U.S. border) which trains First Nations women, based in their community, to care for other First Nations women there. Government education initiatives in Ontario have prioritised the integration of Indigenous midwifery students to provide community-based, continuity of care midwifery in urban and rural environments. This is in recognition of the value placed on provision of this model of care delivery³⁶ and in response to a stated desire by Indigenous communities for access to community midwifery.

Community midwifery projects have also been developed with considerable success in the remote Arctic areas of Canada, initiated in response to the devastating social effects of "evacuated childbirth" policies.³⁷ A pilot project on the east coast of Hudson's Bay has expanded to include 7 Inuit communities. Women from the Povungnituk community decided that the building of a maternity centre in 1986 needed to incorporate the training of Inuit women, selected by their community, to become community-based midwives who would care for birthing women at home, in their own community instead of evacuating all birthing women to tertiary centres in the south. White midwives were originally recruited from the south to train and work alongside the Inuit trainees. While high-risk women continue to be flown out, the vast majority (>90%) of births take place in the community. These projects have not only demonstrated good clinical outcomes for Inuit women but have also reintegrated birth and birth care back into Inuit communities.³⁸

2.5 Benefits for socio-economically disadvantaged women

The ability of one-to-one continuous midwifery care to improve outcomes for both mothers and babies is also noteworthy for socio-economically disadvantaged women, including teenage mothers, single mothers and mothers experiencing drug or alcohol problems. Results from the Albany Practice in London support this model of care.^{39 40}

In the Albany Practice in London, a group of six self employed midwives plus a practice manager/administrator work in partnership, self managing a contract with Kings College Hospital (since 1997) to provide care for 216 women per annum. Kings provides indemnity insurance for the midwives. Women are referred by local GPs in Peckham, an area of high socioeconomic inner city deprivation with the poorest quality housing (highest deprivation score of all practices at Kings). Women of all ethnicities are represented including Caucasian; African/Caribbean; and Indo Chinese women. The practice is based in the community, and the program provides midwifery cover 24 hours a day. Each midwife has an individual caseload for which she is the primary midwife.

³⁵ Coochie, C, Nabigon H, 1997 "A path towards reclaiming Nishnawbe Birth Culture: Can the Midwifery Exemption Clause for Aboriginal midwives make a difference?" in Shroff, F ed. *The New Midwifery: Reflections on Renaissance and Regulation*, Women's Press, Toronto.

³⁶ Ibid.

³⁷ Kaufert, Patricia & O'Neil, John 1988 "The Politics of Obstetric Care: The Inuit Experience." Unpublished paper, Department of Community Health Services, University of Manitoba: Winnipeg.

³⁸ Van Wager, Vicki. (2002) Personal communication regarding the Innulitsivik Maternity, Povungnituk, Quebec.

³⁹ Sandall J; Davies J; Warwick C (2001) Evaluation of the Albany Midwifery Practice: Final Report. March 2001. Florence Nightingale School of Nursing and Midwifery. London

⁴⁰ Select Committee on Health of the House of Commons. Second Report Public Health 2001. Vol. 1

<http://www.publications.parliament.uk/pa/cm20001/cmselect/cmhealth/30/3011.htm#n93>

An independent evaluation of the program⁴¹ compared outcomes with other midwifery group practices at Kings College Hospital, and found that in 1999, 89% of the women were attended by their primary midwife and that there was a lower induction rate, lower elective and emergency c/s rate, less use of pethidine and epidural anaesthesia and lower episiotomy rate. There was also a comparatively higher vaginal birth rate, more use of birthing pool, higher intact perineum rate, and higher rates of breastfeeding in the short and medium term. The women recorded very high satisfaction rates, and the majority of staff at Kings was very positive about the practice. It has become a model practice in the UK, cited in the House of Commons as an example of a public health strategy.⁴²

In Australia, improved outcomes for women 'at risk' of poor outcomes has been achieved through one-to-one continuous midwifery care provided to woman in the northern suburbs of Adelaide. Although the Northern Women's Community Midwifery Programme can only assist a small number of women each year, the outcomes for adolescent mothers have been excellent compared to similar women who receive conventional care.^{43 44}

2.6 Benefits for women in regional and rural areas

There is currently a national shortage of appropriately skilled midwives⁴⁵, as well as general practitioner and specialist obstetricians⁴⁶ in Australia. This issue has had a major impact on regional and rural centres. In rural Australia in particular, women are being forced to leave their families and communities in increasing numbers in order to access hospital based birthing services in other locations.

This situation imposes unreasonable expense and inconvenience on pregnant women and their families, especially those with responsibility for caring for older children⁴⁷. It also means that women are often without familial support during an important family event. Furthermore, the great distances that women are being required to travel in rural areas to access maternity services may be used to justify induction of labour for practical convenience rather than for medical reasons. This practice may precipitate a cascade of interventions, leading to unnecessary medicalisation of the birthing process, with its inherent risks. The WHO Safe Motherhood program asserts that "The district is the basic unit for planning and implementing [maternity care]"⁴⁸.

The withdrawal of regional maternity services can be at least partly addressed, with acknowledgment from the Federal and State/Territory governments that midwives are experts in maternal and neonatal care, and are able to care for healthy pregnant women and their babies. The widespread availability of community midwifery programs would enable the healthy majority of regional and rural women to receive primary care for pregnancy and birth in their home locality, with midwives able to identify and refer women with medical or obstetric complications to specialist care in the nearest facility. Although the provision of one-to-one continuous midwifery care within the public health system would not solve the

⁴¹ Sandall et al 2001 op cit

⁴² Select Committee on Health of the House of Commons. Second Report Public Health 2001. Vol. 1
<http://www.publications.parliament.uk/pa/cm200001/cmselect/cmhealth/30/3011.htm#n93>

⁴³ Homer C; Brodie P; Leap N(2001) Establishing Models of Continuity of Midwifery Care I Australia. A resource for midwives and managers. Centre for Family Health and Midwifery, UTS, Sydney. Page 53

⁴⁴ Church A, Nixon A (2002) An evaluation of the Northern Women's Community Midwifery Program, Adelaide IN PROGRESS

⁴⁵ Tracy S et al 2000 "Contemporary issues in the workforce and education of Australian midwives" *Australian Health Review*;23(4):78-88.

⁴⁶ AMWAC 1998 *The obstetrics and gynaecology workforce in Australia: supply and requirements 1997-2008*. Australian Medical Workforce Advisory Committee 1998.6.Sydney

⁴⁷ Kildea S 1999 *And the women said.....reporting on birthing services for Aboriginal women from remote Top End Communities*. Women's Health Strategy Unit, Territory health Services, Govt Print NT

⁴⁸ WHO 1994. Mother-Baby Package: Implementing Safe Motherhood in Countries. WHO/FHE/MSM/94.11

problem of a shortage of specialists working in regional areas, it would help to lessen the stress and inconvenience to women by providing alternative birthing services where adequate arrangements can be made for transfer to obstetric care facilities in the minority of cases where this is required.

2.7 *Limited access to one-to-one continuous midwifery care*

Despite the proven benefits, backed by reputable research, of one-to-one continuous midwifery care for all women, access of women in Australia to birthing services provided by midwives as the lead professionals (such as at birth centres and for home births) remains very limited. Since the introduction 12 years ago of reform to maternity services in New Zealand to provide access to one-to-one continuous midwifery care through the public health system, New Zealand women have been voting with their feet in ever increasing numbers, with over 70% of women now choosing to give birth with a midwife as their lead maternity carer⁴⁹. One-to-one continuous midwifery care is also a widely available option to women in the United Kingdom, Canada, the Netherlands and other European countries. In Australia, fewer than 1% of women can currently access one-to-one continuity of care from a midwife in the public health system and only in specific locations in WA, SA and the ACT.

Outside the public health system, women can only choose a midwife as their primary carer if they have the financial capacity to meet the cost of this service themselves. This option, too, is now severely diminished since the loss in 2001 of accessible and/or affordable professional indemnity insurance for privately practicing midwives. In the absence of accessible services offering one-to-one continuous midwifery care in the public health system, the demise of private midwifery services is leaving women little or no choice regarding their preferred carer or place of birth.

There have been numerous government inquiries into maternity services at both State and Federal levels over the past 15 years (see Appendix A). Despite these reports, which in the majority recommend the implementation of 'one-to-one' or 'continuity of midwifery care', the medical model of care, with the general practitioner or specialist obstetrician as the lead professional, remains the dominant maternity service model across the nation.

This situation is not in the best interest of women and babies as recipients of maternity services, and does not comply with internationally recognised best practice. It represents an overuse of precious specialist obstetric resources and the exclusion of more appropriate midwifery care.

2.8 *Benefits to consumers from enhanced choice in maternity services*

Limited access to community midwifery services is not consistent with the principles of national competition policy, which is based on the premise that consumer choice, rather than the collective judgement of suppliers (in this case doctors) should determine the range of (maternity) services that are available.⁵⁰

Current barriers to midwives being able to provide women with alternatives to medicalised care include:

⁴⁹ NZ Ministry of Health. *Report on Maternity 1999*. Wellington, New Zealand. <http://www.moh.govt.nz>

⁵⁰ Chairman, Professor Allan Fels, *The Trade Practices Act and the Health Sector*, speech to the Australian College of Health Service Executives, 7 February, 1998

- A Medicare schedule that does not acknowledge midwives as expert carers or provide a schedule for their services;
- A lack of professional indemnity insurance for community midwifery practitioners;
- Maternity services policies that are not informed by evidenced based research, or, by the recommendations of peak bodies such as the World Health Organisation⁵¹ and the National Health & Medical Research Council of Australia^{52,53}
- The long standing refusal by health departments and/or hospitals to grant access agreements to appropriately accredited midwives so that they can provide a 'seamless' service between the home and public hospitals, and attend their clients in public hospitals as professionals⁵⁴
- Lack of collaboration among many medical professionals in the maternity services and their failure to recognise and respect midwives as autonomous professionals, capable of safely and effectively being responsible for the care of healthy pregnant women.

2.9 *Community midwifery care is cost-effective*

A further imperative for the reform of maternity services is that widespread implementation of community midwifery has the potential to produce savings in health budgets in the medium term.⁵⁵ The 'maternal episode' accounts for a significant proportion of the nation's health budget, as childbirth "is the single most important reason for hospitalisation and accounts for the highest number of occupied bed days".⁵⁶

Rising rates of caesarean surgery and other medical interventions over the past few decades have also contributed to rising costs in the provision of maternity services per birthing woman.⁵⁷

So too, information regarding the long terms risks associated with caesarean surgery such as a higher risk of ruptured uterus in subsequent pregnancies and placental problems that can lead to infertility, as well as increased respiratory problems in babies are rarely presented to women.⁵⁸

Because primary midwifery care of healthy women has been shown to result in significantly fewer interventions, women accessing one-to-one continuous midwifery care are likely to complete the pregnancy episode at a much lower unit cost than women who are unable to access midwife led care.

Appendix B provides a comparison of the costs of standard hospital based maternity care that currently dominates Australian maternity services, with models of community midwifery care. Limits to publicly available estimates of hospital costs make comparison difficult. However, the analysis contained in appendix B is fully referenced and, if anything, a significant underestimate of the costs of medicalised childbirth services.

⁵¹ WHO (1999) Care in Normal Birth: a practical guide. WHO/FRH/MSM/96.24 <http://www.who.int/rht/documents/MSM96-24/msm9624.htm>

⁵² NHMRC 1996, National Health & Medical Research Council *Options for Effective Care in Childbirth* Australian Government Printing Service, Canberra

⁵³ NHMRC 1998 National Health & Medical Research Council *Review of Services Offered by Midwives* Australian Government Printing Service, Canberra

⁵⁴ Department of Health NSW. 1989. *Maternity Services in New South Wales. Final Report of the Ministerial Taskforce on Obstetric Services in New South Wales*. Sydney: Department of Health Publication No: (HSU) 89-007.

⁵⁵ Homer, C. S. E., Matha, D., Jordan, L. G., Wills, J., Davis, G. K. 2001. Community-based continuity of midwifery care versus standard hospital care: a cost analysis. *Australian Health Review*. 24 (1): 85-93.

⁵⁶ Senate Community Affairs Reference Committee. *Rocking the Cradle: a report of childbirth procedures*. Canberra. Commonwealth of Australia 1999. Available at http://www.aph.gov.au/senate/committee/clac_ctte/index.htm

⁵⁷ see Maternal and Perinatal statistics published by each State and Territory.

⁵⁸ Wagner M "Choosing Caesarean Section" *The Lancet* 2000:Nov;Vol356:1677-80

The estimates are based on assessments of the direct costs to acute services of standard hospital labour and birth, and do not include a range of additional related costs such as neonatal intensive care unit costs, readmission to hospital, post-natal support services, and antenatal screening services.

The actual savings from significant numbers of women birthing in the care of a known community midwife would probably be significantly greater than Appendix B suggests, primarily because of the reduced need for costly interventions that women birthing with a known midwife have been shown to have (see Section 2.4). At the very least, the analysis in Appendix B shows community midwifery models of care to be highly cost effective and to be a competitive alternative approach to maternity care for the majority of women.

Community midwifery services are also cost effective because they can be established without the need for capital expenditure. Community midwifery programs can be established in urban, regional or rural areas by utilising existing infrastructure, through developing appropriate administrative, policy and financial arrangements to support the community midwifery services.

2.10 *Community midwifery as a medium term solution to the indemnity crisis*

A final advantage to the adoption of midwifery models of care as a mainstream maternity service is that this model of care has the potential to play a major role in the medium term in addressing the problems surrounding professional indemnity insurance for maternity carers. The reasons for the current crisis in professional indemnity for obstetricians are complex.

One of the points on which there is broad agreement is that the rising frequency of obstetric litigation, together with a landmark pay out of millions of dollars to a claimant in 2001, have significantly contributed to rising premiums to unaffordable levels for both general practitioner and specialist obstetricians. Wagner has discussed in detail the issues associated with caesarean section and its overuse by medical doctors as a defence to avoid litigation and states “Defensive obstetrics violates a fundamental principle of medical practice: whatever the physician does must be first and foremost for the benefit of the patient”⁵⁹.

This circumstance has also impacted on independent midwives, who are currently unable to access any affordable professional indemnity insurance. Although litigation against midwives is rare, access to professional indemnity has virtually disappeared. The major reason for this situation is that the numbers of independently practicing midwives has been comparatively small. For example, before the withdrawal by Guild Insurance of professional indemnity insurance in 2001, there were about 80 midwifery practitioners registered with the Australian College of Midwives. Guild Insurance stated that it was not a viable number to maintain the cover.

The proven capacity of midwifery models of care to reduce the use of obstetric intervention in labour and birth while providing excellent outcomes for mothers and babies means that the widespread use of midwifery expertise in one-to-one care of pregnant women is likely to significantly reduce the overall risks to insurers involved in maternity services. Since virtually every obstetric intervention carries some degree of risk as well as benefits, lower rates of intervention are likely to lower the risks of litigation through an adverse outcome.

⁵⁹ Wagner M *ibid*

There is also strong anecdotal evidence to suggest that women who receive one-to-one care from an expert midwife they get to know well are less likely to turn to litigation in the event of an adverse outcome for themselves or their babies. This stems from the sense of responsibility which women are encouraged to take for their care, through fully informed decision-making about their options, alternatives and risks associated with their care and any treatment for complications or abnormalities. The midwife-woman relationship also typically provides women with strong support to address the emotional trauma related to an adverse outcome. While litigation remains an important right for consumers who believe there has been negligence in their care by either a midwife or a doctor, this is less likely to be the first option of a woman who has received continuity of care from a known midwife. Women in these circumstances tend to be more realistic that bad outcomes sometimes happen through no fault of their carers.

In summary, it is evident that strategies designed to reduce costs and at the same time increase the effectiveness of maternity care for women are urgently required. The anticipated benefits of widespread implementation of community midwifery models of care are:

- Cost effective, safe and highly satisfactory maternity health services for women regardless of place of residence and regardless of socio-economic or ethnic background
- Significant reductions in costly obstetric interventions where primary midwifery care (that is continuity of care *and carer*) is provided throughout the childbearing continuum)
- Reduction in the risk of maternity care through lower levels of obstetric intervention to achieve good outcomes for the majority of women and babies, thereby reducing litigation
- Early intervention to assist establishment of long term breastfeeding; reduction in rates of post natal depression requiring medical attention and/or drug therapy; and greater assistance to mothers and fathers to adjust to the demands of a new baby.

Changes to current maternity service provision are required at both State/Territory and national levels to embrace one-to-one continuous midwifery care as a viable, safe, evidence-based and cost effective service that is responsive to what women want and need.

3. THE PRINCIPLES & PRACTICE OF COMMUNITY MIDWIFERY

3.1 Principles of community midwifery care

The midwife is internationally recognised as “the most appropriate and cost effective type of health care provider to be assigned to the care of women in normal pregnancy and birth, including the risk assessment and the recognition of complications”.⁶⁰

Best practice midwifery aims to ensure that a woman and her midwife work in a special partnership, which is established throughout the pregnancy, and that the woman is then attended in labour and postnatally by her own midwife whom she knows well. This partnership is special because it is based on reciprocity and trust and a respect for the expertise of both the woman and the midwife⁶¹. Each woman's personal knowledge of her gynaecological and obstetric history and her personal understanding of self are bodies of knowledge considered to be as important within the woman/midwife partnership as that of the clinician. This continuum of care forms the basis of midwifery models of care and, as discussed in part 2.4, is widely acknowledged as ensuring that obstetric interventions are minimised, and that women have higher rates of satisfaction with their birth experience.^{62,63,64,65}

Community midwifery is informed by the following guiding principles:

- Pregnancy and childbirth are normal and significant life events
- The woman is the focus of maternity care. She should be able to feel she is in control of what is happening to her and able to make informed decisions about her care, based on her needs, having discussed matters fully with the professionals involved⁶⁶
- Midwifery care follows the woman across the interface between institutions and the community, through all phases of pregnancy, birth and the postnatal period. It therefore involves collaboration with other health professionals where necessary.⁶⁷

Community midwifery care can be provided in a woman's home, hospital or birth centre settings.

Primary midwifery care in community settings, that is community midwifery, differs in many significant ways from most current hospital based midwifery practice based on rostered shiftwork.

Firstly, the most obvious difference is the ability of the community midwife to act as the primary carer and offer each woman one-to-one care throughout the childbearing continuum. This model of care is often referred to as caseload or community midwifery. Through such continuity of carer, the midwife and the woman have the opportunity to form a relationship of mutual trust and respect throughout the pregnancy. When labour begins, the woman is confident that someone who knows and understands her needs will attend her and will remain

⁶⁰ WHO. Care in Normal Birth: a practical guide. 1999. WHO/FRH/MSM/96.24 www.who.int/rht/documents/MSM96-24/msm9624.htm

⁶¹ Guilliland K, Pairman S (1995) *The Midwifery Partnership: A Model for Practice*. Department of Nursing and Midwifery Monograph Series 95/1. Victoria University of Wellington, NZ 1995

⁶² Hodnett ED. Caregiver support for women during childbirth (Cochrane Review). In: *The Cochrane Library 2000*

⁶³ Rowley, M, Hensley, M, Brinsmead, M, & Wlodarczyk, J. Continuity of care by a midwife team versus routine care during pregnancy and birth: a randomised trial. *Medical Journal of Australia* 1995;163 (9): 289-293.

⁶⁴ Enkin M, Keirse JNC et al. 2000 A Guide to effective care in pregnancy and childbirth. OUP <http://maternitywise.org/guide/about.html>

⁶⁵ Parratt J. *Trusting enough to be out of control: The Impact Of Childbirth Experiences On Women's Sense Of Self*. Masters Thesis, University of Southern Queensland, 2000.

⁶⁶ Page LA 2000 *The New Midwifery: Science and Sensitivity in Practice*. London. Harcourt

⁶⁷ Homer C, Brodie P, Leap N. 2001 *Establishing Models of Continuity of Midwifery Care in Australia: a resource for midwives and managers*. Sydney. Centre for Family health and Midwifery, UTS Sydney.

with her throughout the labour and birth. This is of great comfort to women, especially if a complication arises and they are unable to have the birth of their choice.

Secondly, midwives providing one-to-one continuous care are able to treat pregnancy and birth as a normal event that only requires intervention if a deviation from the normal occurs. This principle ensures that each woman is individually assessed in relation to her own health, social and cultural requirements. As midwives are comprehensively educated to recognise abnormalities in pregnancy and birth, they are able to refer a woman to specialist care where appropriate⁶⁸.

A midwife providing primary care on a caseload basis also works in collaboration with secondary, or specialist, levels of care to ensure the best outcome for each woman and her baby. One-to-one continuous midwifery care is most effective when good working relationships exist between midwives, medical practitioners and other hospital staff.

3.2. Community Midwifery Programs

The primary principle of community midwifery is that it is women centred and community managed, thus ensuring that the service meets the requirements of the community in which it is situated.

The emphasis of community midwifery programs is on a 'wellness' rather than a sickness model of maternal care. A wellness model of maternity care assumes, that:

- pregnancy and childbirth is, in the majority of cases, a normal life event that will proceed to an uncomplicated outcome
- women make informed choices when factual, unbiased information is readily available
- women take responsibility for their health and antenatal education
- women have ease of access to their choice of preferred carer and birth place
- birth is viewed as normal, with complications able to be readily identified and planned for, or responded to, effectively
- midwives are educated and experienced in providing primary care and diagnosing complications that require consultation with, or referral to, specialist care
- specialist obstetric care is a readily accessible secondary, rather than primary, level of care
- specialist hospital care is maintained for those women who most need it.⁶⁹

Importantly, for community midwifery programs to succeed they need to be managed by people in the community who regard pregnancy and childbirth as a normal life event and recognize the potential of a woman's birth experiences to affect not only her own life, but that of her child, her immediate family, and also the broader community.

Community management is preferable to the alternative of birthing programs being managed as part of acute health services in hospitals. The dominant paradigm within hospital services is illness, and pregnancy and birth are usually viewed as a medical (and inherently dangerous) episode.

Initiatives to establish community midwifery programs need to:

⁶⁸ Wagner M 1998 Midwifery in an Industrialised World. *J of the Canadian Society of Obstetrics and Gynecology* 20;13:1225-34

⁶⁹ Standards of Care and Protocols for Preceptorship, (2001) 2002 Community Midwifery WA Inc, Fremantle, WA

- be undertaken by a substantive community group, able to act as a management body (ie as an incorporated association);
- be focussed on the primary aims and principles of community based health services, such as preventative health; and,
- comprise consumers, midwives, medical practitioners and other community members committed to the provision of effective choices in pregnancy and childbirth care to ensure that the service reflects community needs.

There are currently two publicly funded community midwifery programs offering the option of home birth in Australia, and several other models offering some level of midwife-led care. A brief appraisal of these Programs is provided in Appendix C.

3.3 *The WA CMP: A successful model of one-to-one continuous midwifery care*

In terms of a national strategy, the Community Midwifery Program (CMP) in Western Australia provides a proven template of excellence in maternity care, and is a readily adaptable model for duplication in both urban and regional/rural locations. The CMP WA was specifically established to provide a publicly funded homebirth service. However it is not this element of the Program that makes it a best practise model for other States and localities. Rather it is the provision of one-to-one continuity of midwifery care from experienced midwives within the public health system that makes it an excellent example that is worthy of emulation in other States. It is the model of care rather than the location of birth that is of paramount importance to achieving excellent outcomes such as those delivered by the CMP.

The Community Midwifery Program (*CMP*) has been providing one-to-one continuous care from community midwives since 1996, primarily for women who meet the criteria for home birthing. The *CMP* has been independently evaluated on two occasions and shown to be both a successful model of care with good outcomes, and, highly valued by the women who utilise the service^{70, 71}.

The *CMP*'s guiding philosophy is that childbirth is, in the majority of cases, a normal life event, which, left to nature, will proceed to an uncomplicated outcome. This is underpinned by providing expert midwifery care that respects the individual needs of women and their families by supporting their emotional, social and cultural needs.

The *CMP* is fully government funded and offers primary community midwifery care to women in the Perth metropolitan area. The service provides women with the option of continuity of care and carer throughout their pregnancy, labour/birth and postnatal phases. Currently funding allows for the service to be offered to 150 women per annum, demand for 'places', however, exceeds this number.

Comprehensive standards of professional care, that meet the WA Department of Health's Homebirth Policy and Guidelines for Management of Risk Factors, have been developed to ensure that the *CMP* provides an optimal service.

⁷⁰ Thiele B and Thorogood C 1998 *Evaluation of the Community Based Midwifery Program*, 1998, Community Midwifery WA Inc, Fremantle WA

⁷¹ Thiele B and Thorogood C 2001 *Evaluation of the Community Midwifery Program, 2001, Preliminary Report* to Community Midwifery WA Inc

The service also includes a comprehensive prenatal education program offering both Preparation for Childbirth classes and half day Active Birth Workshops. The *CMP* also maintains four Information and Resource centres, staffed by midwives.

The *CMP* is managed by Community Midwifery WA Inc, a not-for-profit community organisation that aims to improve the availability of choices in childbirth. A description of the organisation and management structure is attached (Appendix D). The success of the *CMP* is assisted by the close working relationship between the Program's management and the Department of Health. For example, in response to the withdrawal of professional indemnity insurance, the Department of Health took over employment of the midwives to ensure their access to indemnity cover.

Continuity of care and carer has been shown in a number of studies to provide women with a positive and beneficial experience. A good birth experience contributes to an overall sense of wellbeing and a good start on the parenthood journey. Independent research undertaken utilising Program participants supports this view.⁷²

The fact that the Program is based in the community, ie, is community managed, has contributed to its flexibility, appropriateness, ongoing success, and growth.

4. MATERNITY SERVICES POLICY REFORM

The optimal outcome for Australian women would be the inclusion of community midwifery programs as readily accessible options within the national and State/Territory public health systems. At present, only a small percentage of women (<1%) have access to 'one-to-one' continuous midwifery care through the public health system, and mostly only in major metropolitan centres.

While some hospitals offer team based midwifery care which improves the chances that a woman will be attended by a midwife known to her, it is the caseload model of midwifery care (which in itself enables the mutual relationship to fully develop between a woman and her midwife) that research has shown to be most effective in producing the best outcomes. Less than 1 per cent of the 250,000 women giving birth each year in Australia currently have access each year to one-to-one continuity of midwifery care. The only programs offering this care through the public health system are in select localities in Western Australia, South Australia and the Australian Capital Territory.

Australian women are entitled to access best practice midwifery services. While community midwifery may not be the model of choice for every woman, all women should have the opportunity to choose a midwife as their primary or lead maternity carer. Further, the opportunity to make this choice should be available regardless of whether women reside in metropolitan, regional, or rural Australia. Both consumers (including women and their babies) and government funding agencies are disadvantaged by the current lack of choice in maternity services.

Despite the numerous State and Federal government reports over the past two decades⁷³ (as shown in Appendix A), in addition to the excellent outcomes of the Federal Alternative

⁷² Dodd, J and Reibel, T *Birth Transforms Her: A report on birth choices, adjustment to parenting, breastfeeding and postnatal depression* Community Midwifery WA Inc 2000

⁷³ See appendix A

Birthing Services Program initiative⁷⁴, virtually no progress has been made towards achieving changes to the way in which maternity services are provided. Progress across Australia towards implementation of midwifery models of care has been very limited. The current trend toward centralising maternity services in large metropolitan centres is further guarantee that increased numbers of women will receive unnecessary and costly interventions in childbirth, resulting in higher levels of morbidity for women, their babies and families. This is despite an increasing body of knowledge that shows that one-to-one continuous midwifery care is the most appropriate and sustainable model of care for the vast majority of women^{75 76 77}.

Health policy reviews at both State/Territory and Federal government levels are also required to ensure women and their families have equitable access to a complete range of midwifery and medical maternity services across Australia. In particular, governments should identify and remove anti-competitive policies that limit the capacity of midwives to provide a service comparable to medical professionals in the provision of services to healthy pregnant women.

Currently medical models of care dominate maternity services in all States and Territories. A primary reason for this situation rests with government health policy at both Federal and State level, including funding discrimination that recognises only specialist obstetricians and general practitioners as providers of primary maternity care. A review of the Medicare schedule by the Federal government is required, to include the services of midwives as expert providers of primary maternity care.

Alternatively the Federal government should implement funding reforms in maternity provision, similar to that which have been introduced in New Zealand, whereby the Lead Maternity Carer (LMC) is paid a set fee by the State regardless of whether they are an obstetrician, general practitioner or midwife. The Section 88 Maternity Notice of the New Zealand Public Health & Disability Act 2000 encompasses the arrangements relating to payments for all maternity services. With the implementation of Section 88 the NZ Ministry of Health has introduced standardised maternity contracts that enable a primary maternity provider to offer specified Lead Maternity Care and other primary maternity services, thus ensuring both price equity amongst providers (LMCs), and equity of access for all women. Since the introduction of LMCs in the early 1990s, midwives are now the Lead Maternity Carers for over 70% of women during pregnancy, birth and the postnatal phase.

The implementation of comparable maternity funding reform in Australia would also require national standards for access agreements to public hospital facilities, specialist services, diagnostic testing, and prescribing for all LMCs, including midwives. These recommendations have already been made in the 1998 National Health & Medical Research Council publication, *'A Review of Services Offered by Midwives'*.

Additionally, the need for national consistency and a coordinated national approach to address regulatory reform in midwifery is also urgently required to ensure that midwifery education and practice in Australia meets international standards. Currently in all States and Territories, midwifery is regulated under the guise of 'specialist nursing practice' within Nurses Acts that are, in themselves, inconsistent.

⁷⁴ NSW Health Department (1998) New South Wales Alternative Birthing Services Program – Evaluation Of Phase 2 – Aboriginal Strategies. 1998b. Sydney.

⁷⁵ Spitzer M. (1995) Birth Centres: Economy, Safety and Empowerment *Journal of Nurse-Midwifery* Vol. 40, No. 4 July/August pp371-375

⁷⁶ Hueston WJ, Rudy M (1993) A comparison of labour and delivery management between nurse midwives and family physicians. *The J of Family Practice* 37 (5) :449-453

⁷⁷ MacDorman M & Singh G (1998) Midwifery care, social and medical risk factors and birth outcomes in the USA *Journal of Epidemiology & Community Health*, 52(5):310-317.

Recent analysis of the various acts and regulations, “raise concerns about the capacity of the current statutes to protect the public adequately and ensure that minimum professional standards are met”⁷⁸. According to the Australian Midwifery Act Lobby Group (AMALG) adoption of national standards in education and practice should be legislated consistently in all States and Territories, as should midwifery title protection⁷⁹. In New Zealand the issue of professional self-regulation is currently being addressed via the Health Competency Standards Assurance Bill and the establishment of a Midwifery Council.

Further, the lack of available, affordable professional indemnity insurance for maternity service providers and students currently undertaking education in this field is an issue that requires urgent national policy reform and action by government. Shortages of providers in rural and regional areas is especially a cause for concern in the maintenance of maternity services outside major metropolitan centres. The cultural appropriateness of currently available services for Indigenous women also requires review, especially in light of the dramatic improvements in maternal and infant outcomes achieved through community midwifery care in New Zealand and Canada.

To summarise, the primary issues for consideration of maternity services policy review, at both levels of government, include:

- addressing the barriers that currently preclude midwives from providing women with an accessible and evidence based alternative to medical care during their pregnancies and births in the public health system,
- ensuring the availability of indemnity cover for midwives,
- ensuring hospital visiting/practicing rights/access for midwives,
- legislative reform to current funding arrangements for maternity services, including a review of acute services budgets, to ensure implementation of cost-effective community midwifery programs in both urban and rural Australia,
- legislative reform to enable nationally consistent midwifery regulation,
- addressing the urgent need to maintain maternity services in regional and rural areas of Australia,
- implementing early intervention and preventative health strategies that will benefit all women during their childbearing years.

In order to meet the needs of diverse communities the challenge for government is to recognise the changing trends in maternity service provision, with ‘consumers’ demanding more choices within the public health system. Therefore, maternity services policy reform should include:

- Establishment of community midwifery programs in all metropolitan and major regional centres in all States and Territories.
- Establishment of hospital and community based primary midwifery care programs in small rural centres.
- Establishment of additional midwife-led, and managed, birth centres or suites within existing services in both metropolitan and regional areas in all States and Territories, where the population can sustain such centres/suites.

⁷⁸ Brodie P & Barclay L 2001 Contemporary Issues in Australian Midwifery Regulation *Australian Health Review*, Vol 24, Issue 4:103-118

⁷⁹ For further details and information refer to the AMALG website at www.amalg.asn.au

- Education programs aimed at informing consumers, general practitioners, and other health care providers, of the benefits of ‘one-to-one’ continuous care from a known community midwife.

Further, health policy at both levels of government needs to provide specific directives regarding maternity services, and, funding for such programs should be quarantined to ensure that the programs remain viable and protected from less cost effective services.

With particular reference to the professional indemnity crisis currently facing the Australian health system, we would urge governments, both Federal and State/Territory, to consider reforms that address issues of system safety, open disclosure and other effective case management strategies for those involved in adverse events, rather than merely corrective justice.

We also urge the government to consider adequate funding of long-term care costs and compensation for all persons who incur injury related to childbirth. Reform with a national focus is required in the professional indemnity arena with equitable contributions from all practitioners in the maternity system.

5. IMPLEMENTING COMMUNITY MIDWIFERY PROGRAMS

It is the vision of the consumer and midwifery organisations involved in the development of the National Maternity Action Plan that within the next 5 years there will be equitable access to community midwifery programs in all States and Territories for all women who choose this model of care.

In order to ensure that services are effective and meet the needs of local communities, the development and management of community midwifery programs, should be implemented with significant input from consumers and from midwives with experience in midwifery-led care and/or community midwifery.

Essential components of each community midwifery program include:

- Adequate funding levels capable of responding to increasing demand
- Suitably qualified midwives able to demonstrate knowledge of one-to-one continuous midwifery care
- Access to appropriate educational programs to support the transition from hospital to community based midwifery practice
- Community based management with balanced representation from committed health professionals and community members
- A project community liaison officer
- Adequate administrative support
- Quality assurance mechanisms, including the capacity for analysis, continual monitoring and improvement of programs
- Facility for independent evaluation of each programs’ outcomes over a minimum period of two years for inclusion in a governmental review
- Inclusion of comprehensive antenatal education for both program participants and the wider community
- Continuing capacity for preceptorships for both registered and student midwives to ensure the ongoing availability of a highly skilled midwifery workforce.

5.1. Funding

Currently the majority of publicly funded maternity care available to women in Australia is funded through the acute hospital services budget. This takes no account of antenatal, birth and postnatal care that could be offered to women as a community based service through alternative funding sources such as public or community health. Therefore, a reasonable portion of the acute hospital services budget currently directed to hospital maternity services could be redirected to the provision of community midwifery programs within public or community health budgets.

Initially, ‘seed funding’ will be required to establish community midwifery programs in a number of locations, with recurrent funding being guaranteed. Funding is required at realistic levels to establish and maintain effective community based services and the funding source should be protected from other more costly medical services. Once established, community midwifery programs have proven to be cost effective as well as resulting in improved health outcomes.

An indication of funding needed for programs of around 100 births (or any multiple thereof) is provided in Appendix B. Funding levels would, however, be variable, dependent upon location; population of the community, and estimated demand.

There would also need to be provision for an increase in funding over time, as the programs become known and demand for one-to-one continuity of care from a community midwife increases.

The New Zealand experience where the percentage of women choosing a midwife as their lead maternity carer rose from single digits to over 70% in 12 years suggests that demand can be expected to grow significantly once women become familiar with this care option.

Importantly, any input of funding for community midwifery programs will potentially be offset by reductions in funding required for current medical based services which would otherwise service the same women. Indeed, as discussed in Part 2.8 savings to the public health budget are likely to be obtained from widespread use of community midwifery services.

Savings are, of course, unlikely to be realized for very small numbers of births, since acute care backup services for the minority of women who need them must still be provided. However, given the New Zealand experience where demand for one-to-one community midwifery care has grown to more than 70% of births and the maternity budget is now showing a trend downwards⁸⁰, savings will be achieved once significant numbers of women are able to access community midwifery services.

5.2. Workforce Issues

There is currently a national shortage of midwives willing to work in hospital based maternity services throughout Australia⁸¹. Many hospitals are not even advertising

⁸⁰ New Zealand Health Funding Authority 2000 *Improving our Health: marking our progress*. November 2000

⁸¹ Tracy S et al 2000 “Contemporary Issues in the Workforce and Education of Australian Midwives” *Australian Health Review*;23(4):78-88.

midwifery vacancies for lack of applicants. The widespread establishment of community midwifery programs has the potential to address this problem in a number of ways.

Firstly, community midwifery programs have the potential to attract experienced midwives who have chosen to work independently from acute care settings, as self-employed midwives. Until the professional indemnity insurance crisis arose in mid 2001, these midwives typically sold their services to women privately, with women paying the full cost of their services themselves. The loss of affordable PI insurance has resulted in many independent midwives ceasing practice, with an associated loss to the community of very experienced and capable midwives.

Community midwifery programs have the potential to bring an existing workforce of highly experienced and skilled community midwives into the public maternity services system.⁸² These midwives provide a valuable resource not only in caring for women, but in assisting other midwives to develop the necessary skills and confidence to provide similar services in the future.

Secondly, anecdotal evidence strongly suggests that many midwives would be encouraged to return to their profession with the advent of widespread community midwifery. Through providing a working environment that is more consistent with the education and experience of midwives in the 'wellness' model of care, it is likely that community midwifery programs would attract midwives who have become disaffected with working in acute services models of care and who have withdrawn from midwifery or moved into other professional areas of work.

Thirdly, community midwifery programs provide a valuable workplace for the education and development of midwives. They would facilitate student midwives, new graduates and qualified midwives who wish to update their skills, to obtain suitable on-the-job education from experienced community midwives. By providing wider access to mentors (or preceptors) for student and recently qualified midwives, community midwifery programs will assist with overcoming the current shortage of midwives in the medium term.

Additionally, midwives employed to provide a community based service must be appropriately supported and respected for their role as health professionals and primary carers. Therefore, their pay and conditions must reflect the circumstances of providing continuity of care and carer and being on call, and reflect the level of responsibility involved.

It is also essential that appropriate accreditation and clinical privileges to local and tertiary maternity units/hospitals are made available to community midwives. This is necessary to ensure women in their care have ready access to one-to-one continuous care from a known midwife for either hospital, birth centre, or home births and to secondary, or specialist care, as required.

Payment of midwives providing caseload care through a community midwifery program can be organized in a number of ways depending on local circumstances. An effective model is where funding is provided to a community non-profit incorporated body (for example, as in the case of Community Midwifery WA Inc, the host body for the Community Midwifery Program), with responsibility for implementation of community midwifery programs and provision of prenatal education programs and information services. As the organisation is community based there is a strong community focus. Payment of community midwives can

⁸² The Australian Midwifery Action Project Report. 2002 .In Press

then be managed through local hospital payrolls, while management of the service is maintained in the community.

The widespread establishment of community midwifery programs also has the potential to address workforce issues among medical professionals. As noted earlier, there is currently a shortage of general practitioner and specialist obstetricians in Australia⁸³. Community midwifery programs have the potential to relieve some of the pressure on obstetric and general practitioner maternity providers by caring for healthy pregnant women who do not develop complications. This would also facilitate increased work satisfaction for specialist obstetricians, through giving them the flexibility to give greater time and attention to women most in need of their care. For general practitioner providers in rural areas, the provision of expert midwifery care for healthy pregnant women would relieve the burden on these practitioners to provide maternity care alongside all their other responsibilities.

5.3. *Extended Education*

Working in the community requires a high degree of motivation and a commitment to the model of care being provided. To this end, extended education must account for the holistic role of the community midwife. The skills base of the community midwife, therefore, extends to a number of areas outside the usual clinical role of midwives working within medical models of care.

Preceptorships, where a qualified midwife works in tandem with an already experienced community midwife for a designated period, allow for a period of skills acquisition in a practical environment and under the mentorship of an experienced colleague. Such preceptorships are essential in maintaining high standards of maternal and infant care. Preceptorship schemes can be built in to community midwifery programs with relative ease. Such schemes would assist in addressing the current national shortage of suitably qualified and experienced midwives able to undertake primary midwifery care.

5.4. *Professional Standards*

All midwives who participate in community midwifery models of care should meet a clearly defined set of relevant criteria designed to measure their professional practice, and, be required to regularly submit evidence of adherence to those standards through a peer reviewed accreditation process. These standards should be based on best practice standards for midwife-led care.

The process of quality assurance for professional standards would be best achieved through the use of a credentialing body that would assess applications for accreditation for midwives as lead professionals following nationally agreed principles and guidelines.

The Australian College of Midwives Inc (ACMI) already offers accreditation of independently practicing midwives, and has recently developed national standards for the accreditation of midwifery educational programs in Australia. The College is also committed to reviewing and refining competency standards for practice with the view to establishing national guidelines for practice. Professional development and current best practice would be reviewed in relation to each local community midwifery program. At the same time, it is

⁸³ AMWAC 1998 *The obstetrics and gynaecology workforce in Australia: supply and requirements 1997-2008*. Australian Medical Workforce Advisory Committee 1998.6.Sydney

imperative that best practice midwifery and professional standards relate to a combination of practice and theory, with a greater emphasis on practice.

5.5 *Timeframe*

The introduction of community midwifery programs should not be on a trial basis. The one-to-one continuity of care utilised by community midwifery programs has been well tested and proven. Therefore, governments are urged to establish recurrently funded community midwifery programs as a matter of priority, in the interests of all women and their babies.

It may be appropriate for governments to identify targets for the introduction of these services, such as 20% of women utilizing midwifery-led care by 2004. The New Zealand experience suggests that, as women become familiar with what community midwifery care entails, the demand for this care can be expected to grow steadily but dramatically.

6. CONCLUSION

The National Maternity Action Plan for the introduction of community midwifery services in urban and regional Australia is intended to provoke rigorous debate and reform of maternity services nationally.

Children are the future of Australia, and with their mothers, deserve the best start possible to life.

The authors, and all of the individuals and organisations who have endorsed the NMAP, urge the elected members of State, Territory and Federal parliaments and those in charge of health policy and implementation to read this document with a view to ensuring that changes are undertaken in the short, medium and long term.

These changes should aim to provide universal access for Australian women to evidence-based, one-to-one continuous midwifery care as a mainstream and free option within the public health system. Such care is supported by research evidence, is cost effective, is lower risk than conventional medicalised care and produces the same if not better outcomes for women and babies. It is what women want.

7. APPENDICES

APPENDIX A

Commonwealth, and State/Territory Government Reports and Policy Documents directly relating to maternity service provision & commissioned evaluations of existing maternity services

- 1985** Aboriginal Women of Central Australia, Congress Alukura by Grandmother's Law, 1985, Model of Healthy Public Policy.
- 1989** Department of Health NSW. (1989). *Maternity Services in New South Wales. Final Report of the Ministerial Taskforce on Obstetric Services in New South Wales.* Sydney: (Shearman Report) Department of Health Publication No: (HSU) 89-007.
- 1990** Health Department of Victoria. (1990). *Having a baby in Victoria. Final Report of the Ministerial Review of Birthing Services in Victoria.* Melbourne: Health Department of Victoria.
- Health Department of Western Australia (HDWA) (1990). *Report of the Ministerial Taskforce to Review Obstetric, Neonatal and Gynaecological Services in Western Australia.* Vol. 1- 111, Dept of Health, Perth WA, 1990.
- 1991** NHMRC (1991). *Homebirth Guidelines* NHMRC, Canberra.
- 1993** ACT Department of Health, *ACT Maternity Services Review*, 1993.
- 1994** ACT Health (1994) *ACT Maternity Services Review*. Canberra. Commonwealth Department of Health and Family Services
- NSW Health Department. (1994) *Review of Aboriginal Perinatal and Maternal Morbidity and Mortality in New South Wales 1986-1991.* New South Wales Public Health Bulletin Supplement. S3
- Birthing Services Working Group, Report of The South Australian Birthing Services Working Group, South Australian Health Commission (SAHC), 1994.
- SAHC Working Party, *Models of Maternity Care Working Party Report*, SAHC Adelaide 1994
- 1995** *Selection Committee on Intervention in Childbirth Report* 1995 Western Australian Legislative Assembly
- 1996** NHMRC (1996) National Health & Medical Research Council *Options for Effective Care in Childbirth* Australian Government Printing Service, Canberra
- Evaluation of the Alternative Birthing Services Program Phase Two* for the Commonwealth and Health Department of WA, Carol Thorogood, Bev Thiele, Jan Lewis, Centre for Research for Women 1996
- 1997** Department of Human Services Victoria (DHS, Vic) (1997) *Birthing Services Program in Victoria.* Melbourne. DHS
- Dale Street Women's Health Centre (DSWHC), *Community Midwifery Project: Final Report*, South Australia, and March 1997

- Community Midwives Pilot Project Evaluation: Alternative Birthing Services Program in the ACT, Marian Hambly, March 1997
- Community Based Midwifery Program Evaluation: Alternative Birthing Services Program in Western Australia*, Bev Thiele and Carol Thorogood, Centre for Research for Women, December, 1997
- 1998** NHMRC (1998) National Health & Medical Research Council *Review of Services Offered by Midwives* Australian Government Printing Service, Canberra
- NSW Health Department. (1998b) *New South Wales Alternative Birthing Services Program – Evaluation Of Phase 2 – Aboriginal Strategies*. Sydney.
- Queensland Health 1998 *Midwifery Workforce Planning for Queensland, August 1998*, Health Workforce Planning & Analysis Unit, Queensland Health.
- 1999** Department of Human Services Victoria (DHS, Vic) (1999) *Maternity Services Enhancement Strategy*. Melbourne. DHS. Quality Branch Acute Health Division
- Kildea S. (1999) *And the women said.....Reporting on birthing services for Aboriginal women from remote Top End Communities*, Women's Health Strategy Unit, Territory Health Services, Govt. Printer of the Northern Territory.
- NSW Health Department (1999) Maternity Services Advisory Committee *The NSW Framework for Maternity Services*.
- Rocking the Cradle: A Report into Childbirth Procedures* Senate Community Affairs Reference Committee, December 1999
- 2000** NSW Health (2000a). *A Framework for Managing the Quality of Health Services in NSW*, State Health Publication No: (HPA) 990024 edn, NSW Health Department, Sydney.
- NSW Health (2000b). *Homebirth Policy Statement. Circular 2000/53* NSW Health Department, Sydney.
- Evaluation Report for Northern Women's Community Midwifery Program in SA, SAHC
- 2001** NHMRC (2001). *Homebirth guidelines for parents*. Last modified 26 June 2001 edn, NHMRC, Canberra.
- NSW Health (2001). *Report of the Greater Metropolitan Services Implementation Group* NSW Health Department, Sydney
- Department of Health, Western Australia, *Homebirth Guidelines and Management of Risk Factors Policy*, 2001

APPENDIX B

The Cost Effectiveness of Community Midwifery Care.

This appendix provides an overview of available evidence on the costs of medicalised maternity services offered in maternity hospitals compared with services offering community midwifery care (ie. one-to-one continuity of care from a known midwife from 12 weeks prenatal to 6 weeks postnatal). Cost effectiveness is clearly important if community midwifery programs are to be embraced as a part of mainstream maternity services across Australia.

B.1 Methodology

It must be noted that comparison of costs is a difficult task, as there is limited published data on the relative costings of current hospital based maternity services. Hospital administrators from a number of institutions have confirmed that precise costings for hospital maternity services are difficult to estimate. Where data is available, there are often variations in the levels of estimated costs depending on the source used.

This appendix therefore offers an indication of relative costings, based on a transparent methodology that clearly identifies the sources of estimates provided. The estimates used of the costs of standard public hospital acute care are conservative, as there is a lack of available data on the costs of many interventions commonly used in labour and birth, such as epidural, induction, augmentation, instrumental delivery and episiotomy. All sources of information and support for assumptions made are referenced in footnotes to the relevant tables.

It should be noted that there has been no attempt to assess the costs to governments (particularly the Commonwealth government through Medicare rebates) of private hospital maternity care services). The immediate focus is on the cost effectiveness of government funded maternity services provided by traditional obstetric models of care vis-a-vis publicly-funded midwifery-led care of the majority of healthy pregnant women.

B.2 Estimate of costs of standard hospital care for labour and birth

Funding of hospital care is a complex area. The Commonwealth government provides resources mainly in the form of Medicare rebates that vary for each birth depending on the interventions used for individual women. The Commonwealth also indirectly funds maternity services through State grants and through incentives to individuals to hold private health insurance.

State and Territory governments fund the majority of the service provided for women accessing public hospital maternity units, and some of the costs of care given to private patients in public hospitals. Levels of funding provided vary between States and between hospitals, depending on their location and the local demand for maternity services.

Table 1 provides estimates of costs to funding agencies of standard public maternity services. The estimates have been compiled from a range of published data sources. Data published by the Australian Institute of Health and Welfare (AIHW) has been used to estimate the average cost for a vaginal birth without complications. The AIHW compiles this data from State Health department data collections, published as the Australian Hospital Statistics. They represent the national Australian figure for normal birth in hospital, including an average length of postnatal stay for 3.1 – 3.5 days. The estimates of the costs of normal vaginal birth do NOT include the antenatal episode of care, or the costs of admissions to neonatal intensive care units.

Due to the lack of nationally consistent published data on the percentages of women who receive specific interventions in their labour and births, it is not possible to provide detailed estimates of costings beyond the categories used in the first column of Table 1 (antenatal visits, spontaneous vaginal birth, vaginal birth with at least one intervention, caesarean birth and postnatal visits).

While the estimates provided are the best available, they significantly underestimate the true costs to funding agencies of the majority of healthy pregnant women receiving the medical model of care. In addition to underestimating the significant financial costs of rising levels of obstetric intervention in childbirth, the estimates do not include admission to special care nurseries of babies adversely affected by their birth. Nor are the costs included of postnatal support services that assist women long after the birth, such as those women who now suffer from postnatal depression.

Table 1 Estimated costs of standard public hospital maternity care*, Australia, 2000

	Percentage of women likely to receive this service	Estimated cost of service per woman	Cost per 100 women
Antenatal consults — 6x30 mins checks	100%	\$150	\$15,000
Labour & birth — spontaneous vaginal birth	40% ¹	\$2,470 ²	\$98,800
— vaginal birth with at least one intervention	40% ³	\$2,870 ⁴	\$114,800
— caesarean section	20% ⁵	\$4,670 ⁶	\$93,400
Postnatal consults — 3x30mins checks	100%	\$75	\$7,500
Total service (excluding neonatal intensive care)	—	—	\$329,500

*Standard hospital maternity care is taken here to refer to labour wards and delivery suites in which care is provided by midwives, nurses, obstetricians, anaesthetists, and other specialists on a roster/shiftwork basis. It does not include the examples of midwife-led care summarised in Appendix C.

¹ This figure is derived from the study of 170,000 births in NSW in the late 1990s by Roberts, Tracy & Peat (BMJ 321: 137-141, 15 July 2000) which showed that 39% of first time low risk mothers and 67% of multiparas gave birth in public hospitals as public patients without any obstetric intervention (including induction, augmentation, rupture of membranes, epidural, instrumental delivery & episiotomy). See <http://www.bmj.com/cgi/content/full/321/7254/137#T2>. However, these percentages relate only to low risk women, the focus of that study. The Victorian Perinatal Statistics of approximately 65,000 confinements in that State gives a similar picture. For example, onset of labour was spontaneous in only 40.4% of cases, the remainder being either induced or augmented or both, or there being no labour due to Caesarean section prior to labour commencing. (See Riley, M & Halliday, J. 'Births in Victoria 1999-2000, Perinatal Data Collection Unit, Victorian Department of Human Services, Melbourne 2001 <http://www.dhs.vic.gov.au/phb/topics.htm#perinatal>).

² This figure is provided by the Australian Institute of Health and Welfare. It represents the average cost for a vaginal birth without complications compiled from state health department data collections to be published as the Australian Hospital Statistics. They represent the national Australian figure for normal birth in hospital, including an average length of postnatal stay for 3.1 – 3.5 days. This does NOT include the antenatal episode of care or admission to Special Care Nursery. Based on cost by volume/ public patient separations cost statistics for all AR-DRGs version 4.1, public hospitals Australia, 1999-00; AIHW Australian Hospital Statistics 1999-00. AIHW Cat. No. HSE-14. Table. S10.1 www.aihw.gov.au/publications/hse/ahs99-00

³ The estimate that 40% of women in public hospitals receive at least one obstetric intervention in labour and/or birth is based on a number of sources. The Victorian Perinatal Data for 1999-200 shows that of the approximately 65,000 births in Victoria each year, only 40.4% of women experienced spontaneous onset of labour, while 46.4% were induced and/or augmented and the remaining 13.2% had no labour (due to elective caesarean sections). Of public patients who laboured, 23.8% had epidurals, and 16.0% had other forms of pharmacological pain relief, of all public patients, 11.1% had either forceps or vacuum extraction of their babies, and 20.6% had caesarean sections. (See Riley, M & Halliday, J. 'Births in Victoria 1999-2000, Perinatal Data Collection Unit, Victorian Department of Human Services, Melbourne 2001 <http://www.dhs.vic.gov.au/phb/topics.htm#perinatal>).

⁴ This estimate is based on the AIHW estimate of a vaginal birth without intervention, plus the AMA suggested fees for the insertion of epidural anaesthesia of \$405.00 (see AMA suggested fee: List of medical services and fees, November 2001, AMA publishing, Sydney <http://www.ama.com.au/>). Approximately one third of women who receive care in public hospitals as public patients use epidurals (34.5% of public patients in the study of 171,000 NSW births by Roberts, Tracy & Peat, BMJ 321:137-141, 15 July 2000) It therefore seems appropriate to use the fees for epidural as a preliminary indication of the additional costs involved in the care of women who receive interventions in labour and birth. However, this is undoubtedly a significant underestimate. As the Roberts, Tracy & Peat article shows, once one intervention is used, such as epidural or induction, there is a cascade effect where there is a high likelihood that other interventions will become necessary. A lack of published statistics on costs of various interventions and their frequency precludes more detailed estimates of these costs here.

⁵ The latest AIHW Mothers and babies 1999 Report records the national caesarean section rate as 21.9% with variation between states: South Australia (24.9%) had the highest caesarean rate in 1999 and the Australian Capital Territory (19.6%) the lowest. Caesarean rates were higher among older mothers, those having their first baby, and those who were private patients. AIHW National Perinatal Statistics Unit report; *Australia's mothers and babies 1999*. Canberra 2001 <http://www.npsu.unsw.edu.au/ps11high.htm>

⁶ Based on cost by volume/ public patient separations cost statistics for all AR-DRGs version 4.1, public hospitals Australia, 1999-00; AIHW Australian Hospital Statistics 1999-00. AIHW Cat. No. HSE-14. Table. S10.1 www.aihw.gov.au/publications/hse/ahs99-00

B.3 Estimate of costs of midwifery-led care for labour and birth

There are a variety of midwifery led models of care currently offered in Australia, as outlined in Appendix C. Many of these are based on teams of midwives providing care on a rostered shift-work basis. The estimates provided below do not cover these services. Rather they refer to the practice of care where midwives provide primary care to women from 12 weeks of pregnancy through birth to around 6 weeks postpartum on a caseload basis— providing continuity of care on a one-to-one basis and working on call 24 hours a day, 7 days a weeks, for around 46 weeks a year. This model of care is here termed ‘community midwifery’.

Community midwifery care has consistently been found to involve similar or lower cost on a per birth basis compared to standard medicalised maternity care There are several reasons for this. Research shows that compared with women who access standard medicalised maternity services, women who receive continuous care from a known community midwife:

- 3 use fewer interventions to give birth to a healthy baby,
- 4 are less likely to request pharmacological pain relief
- 5 occupy hospital beds for fewer days
- 6 give birth to fewer underweight babies and their babies are less likely to require neonatal intensive care
- 7 have less need of postnatal support services, such as counselling for post-natal depression

Estimating the costs of community midwifery care is necessarily affected by the fact that historically there has been considerable variation in the remuneration received by community midwives. The fees charged have depended on the location in which community midwives work, whether they work in private practice or a government-sponsored program, and the demand in their local area for their services. The failure of most private health insurance companies, until quite recently, to provide consumers with rebates for private midwifery services has also contributed to pressure to keep midwifery fees low.

One comparative study of midwifery and obstetric care found a range between \$1,400-\$1,600 per birth for community midwifery (see Homer et al 2001). Midwives working for the WA Community Midwifery Program receive around \$1,800 per birth (see CMP WA Community Midwifery Program, Western Australia based on 1999-2000 cost analyses). The Australian Society of Independent Midwives advises that its members have received between \$1,500 and \$3,500 per birth for their service, depending in particular on whether the midwife works in an urban or regional location.

The World Health Organisation recognises midwives as the most appropriate and cost effective caregivers for the majority of pregnant women. At the same time, community midwifery by definition, requires midwives to provide a service on call 24 hours a day, 7 days a week, 46 weeks a year. Estimating the cost of community midwifery programs must take these issues into account, as well as the fact that the skills and experience of midwives have historically tended to be undervalued in the employment marketplace, alongside other female-dominated professions, such as nursing. Given the nature of the care provided, remuneration of around \$2,500 to \$3,000 per birth is now widely considered to be appropriate.

Table 2 assumes a rate of \$3,000 per birth for community midwives. Importantly, even at this level of remuneration, the cost effectiveness of the midwifery-led model is retained in comparison to routine obstetric care services, notwithstanding the fact that the estimates of standard medical care contained in Table 1 are undoubtedly lower than the real cost per birth.

Table 2 Estimated costs of community midwifery maternity care*, Australia, 2002

	Percentage of women likely to receive this service	Estimated cost of service per woman	Cost per 100 women
Antenatal consults 8 7-10x60mins, monthly from 12-28 wks, fortnightly to 36 wks, weekly 36 wks to birth	100%	included	—
Labour & birth 9 spontaneous vaginal birth	80% ¹	included	—
10 vaginal birth with at least one intervention	10%	provided by existing acute care services	—
11 caesarean section	10% ²	provided by existing acute care services	—
Postnatal consults 12 4-6x60mins in early newborn period to 6 weeks	100%	included	—
Total service (excluding neonatal intensive care)	—	\$3,000 ³	\$300,000

* Community midwifery maternity care is taken here to mean care provided by midwives in a one-to-one, caseload relationship with women, where the same midwife provides care on call 24 hours/day, 7 days/weeks to pregnant women, and provides all antenatal education, attendance and professional supervision at the birth, and postnatal support to 6 weeks postpartum.

¹. It is internationally accepted that 80-85% of women will experience healthy pregnancies and have the ability to give birth to their babies without complication Enkin M, Keirse JNC, Neilson J, Crowther C, Duley L, Hodnett E, Hofmeyr J. 2000 A Guide to effective care in pregnancy and childbirth. 3rd Ed. Oxford. OUP Research cited in the body of this document indicates that midwifery continuity of care provided to women on a one-to-one basis reduces the use of obstetric interventions.

². The World Health Organization recommended that the caesarean section rate should not exceed 10% in any OECD country, with a very upper limit of 15% See: WHO. World Health Organisation, Care in Normal Birth: a practical guide. 1999. WHO/FRH/MSM/96.24 www.who.int/rht/documents/MSM96-24/msm9624.htm See also Wagner 1996, *Pursuing the birth Machine: The Search for Appropriate Technology*. Countries with national caesarean section rates at 10% or lower have strong models of midwifery-led care available to the majority of women as the primary model of care. A 10% caesarean section rate has also been confirmed in the experience of IPMs in Australia.

³. The per birth remuneration for independently practising midwives in Australia has varied between midwives and between States and Territories from around \$1,400 to \$3,500 (see Homer Caroline S Matha Deborah V, Jordan Lesley G, Wills Jo, Davis Gregory K . Community -based continuity of midwifery care versus standard hospital care: a cost analysis. *Australian Health Review* 2001; 24(1):85-93). The Community Midwives Program in WA has remunerated midwives at the rate of \$1,800 per birth in the past and is seeking a revision of this rate to \$2,500. Given the on call 24 hours a day, seven days a week, 10-11 months per year nature of the care provided, remuneration of around \$2,500 to \$3.00 per birth seems appropriate. Even at the higher end of this scale, the cost effectiveness of the midwifery-led model is retained in comparison to routine obstetric care services..

B5 Conclusion

There is real potential for significant improvements in maternity services—as measured by consumer satisfaction and the health and well being of women and babies immediately following birth and in the first year afterwards—without the need for increased outlays in maternity services. Governments should be called upon to support access to one-to-one continuity of care from a community midwife as a mainstream and cost-effective option in maternity services.

APPENDIX C

Examples of existing publicly funded programs offering some level of midwifery-led care

The following are examples of existing publicly funded programs that offer variable levels of midwifery-led care.

The first two examples, the Community Midwifery Programs in Western and South Australia, are the only publicly funded models currently available anywhere in Australia that offer autonomous primary midwifery care in a community based setting with the option of either a home or hospital birth. Both these Programs are also community managed.

All other examples are hospital based and managed, with some community based ante and postnatal care incorporated into the model. Generally, only those programs offering caseload care of women by individual midwives are able to provide the one-to-one care throughout the entire maternal episode (pregnancy, birth and postnatal), that research has demonstrated to be most effective in reducing rates of intervention and increasing maternal satisfaction with the birth experience and outcomes.

Community Midwifery Program, Western Australia

Births per annum (WA): 25,000 Program Capacity: 150 per annum

Operating since 1996. Offers one-to-one community based care for pregnancy, birth and postnatal continuum, mainly for homebirths. Primary midwifery care, with medical backup and hospital booking. Care continues in all circumstances. Midwives are employed by Department of Health for insurance reasons, but management is undertaken by Community Midwifery WA (not-for-profit, community based organisation). Program covers the whole of the metropolitan area.

Northern Women's Community Midwifery Programme, South Australia

Births per annum (SA): 18,000 Program Capacity: 120 per annum

Operating since 1998. Offers one-to-one community based care for pregnancy, birth and postnatal continuum, for either hospital, birth centre or home births. The Programme targets young women, Aboriginal women and socio-economically deprived women in the northern suburbs. Primary midwifery care, with medical backup and hospital booking. Care continues regardless of risk factors. Midwives are employed by the Department of Human Services at the Northern Women's Community Health Centre, and manage the Programme in consultation with the Centre's Team Leader.

Canberra Community Midwifery Program, ACT

Births per annum (ACT): 4,700

Program Capacity: 540 per annum

Operating since 1997. Offers diverse models of care for birth centre and hospital births. The Program cares for 540 women per year (on a first come basis), with all women being allocated to North or South midwifery teams. Northside midwives operate on a one-to-one caseload basis: southside midwives operate as a team providing care on a roster/shift basis. Antenatal care provided mainly in the birthcentre or community centres. Early labour care at home; labour and birth and immediate postnatal care in birth centre or delivery suite; overnight stay in birth centre if mother and baby well and space available; postnatal care at home up to day 10-13, longer if needed. The Program has recently been given government approval to provide a limited number of homebirths each year.

The St. George Outreach Maternity Program (STOMP), New South Wales

Births per annum (NSW): 88,000

Program Capacity: 720 per annum

Offers team midwifery for community based antenatal clinic care, hospital intrapartum care and combined hospital and home based postnatal care. The model is able to cater for women who develop risk factors during their pregnancy, thereby retaining care within the team in collaboration with obstetricians. STOMP midwives cover 12 hour periods on call to respond to the needs of STOMP Program women in labour or requiring telephone advice during their pregnancy.

The Mackay Midwifery Model, Queensland

Births per annum (in region):

Model Capacity: 1,000 per annum

Diverse model offering birth centre and hospital births. The birth centre caters to 192 women per year (on a first come basis), with all other women being allocated to North or South midwifery teams. Midwives operate on a caseload basis. A hospital-based team operates on roster/shift basis to maintain other normal services and support. Both high and low risk women are included, with some shared care with GPs. Midwives work in all areas, covering antenatal clinic, classes, delivery suite, ante and postnatal ward and home visiting.

Community Midwife Program, Wangaratta, Victoria

Births per annum (in region): 63,000

Program Capacity: 120 per annum

Operating since 1997, offers midwife only care, shared care or obstetric care with midwife support, all for hospital births. Antenatal care undertaken in a Community House located on the hospital grounds, with early discharge and home based postnatal care available. Midwives carry a caseload of women for ante- and postnatal care and share a rotating on call system for labour.

Source: Establishing Models of Continuity of Midwifery Care in Australia: A resource for midwives and managers Homer, C., Brodie, P., Leap, N. 2001

APPENDIX D

Organisation and management structure of the Community Midwifery Program, WA

The Community Midwifery Program commenced in 1996 as a pilot program funded by the Federal Alternative Birthing Services Program, and administered by the Western Australian Department of Health. The program was funded to assist 70 women per annum for either a home or hospital (domino) birth in the South Metropolitan region of Perth in addition to providing antenatal education.

In 1997, the management of the Community Midwifery Program was taken over by Community Midwifery WA Inc (formerly Fremantle Community Midwives), a not-for-profit community organisation formed to promote greater choices in childbirth. The organisation implemented a board of management from the membership, which accepted financial and overall management responsibility for the Program. The board of management operated as a two layer structure, but this has since been modified to reflect a more efficient management strategy.

In 1998, a business case was approved by the Department of Health for an increased and expanded service. The Program changed to a midwifery caseload model, offering sub-contracts to midwives who were accredited as Independently Practicing Midwives with the Australian College of Midwives (ACMI). The majority of these midwives had their accreditation facilitated through the preceptorship component of the program. In all other respects the midwifery led model of care originally implemented remains the same, although the midwives are now employed by the Department of health, through the metropolitan Health Service to meet professional indemnity requirements.

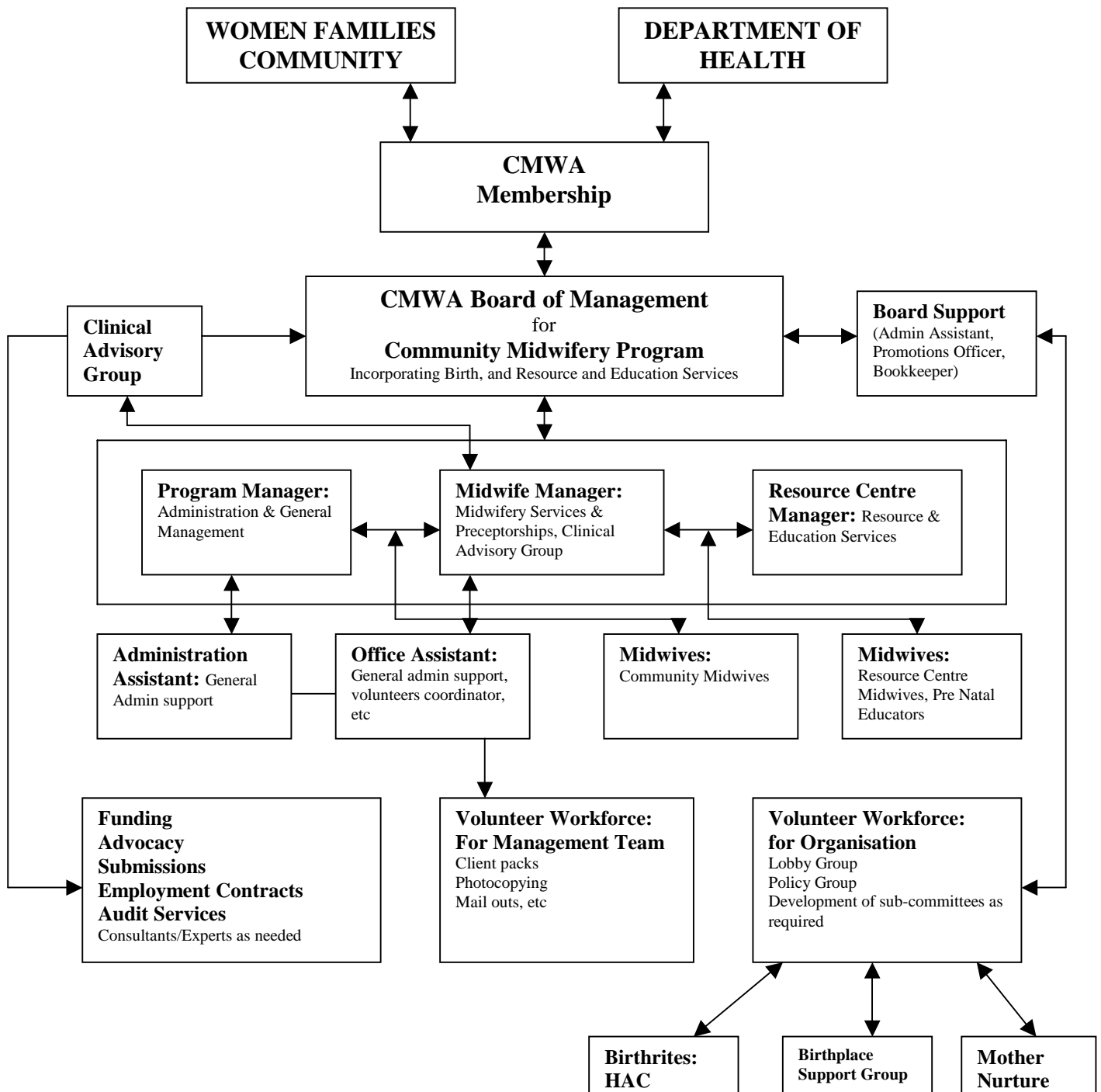
The Program's midwifery service is now available to 150 women within the boundaries of the greater Perth metropolitan area and has been recurrently funded since 1999. The Program also has an extended Prenatal Education Program and four metropolitan Resource Centres providing information and lending libraries , available to the whole community.

The board of management consists of a range of professionals, consumer representatives, and other interested parties all of whom have a common will to maintain a safe and cost effective model of community based midwifery led care.

There is also a Clinical Advisory Group consisting of an obstetrician, general practitioner, independent midwife, the Program midwife manager and a Program midwife. This Group meets regularly and provides advice on policy and clinical review of some cases where requested by either a client or a midwife, or considered necessary by the midwife manager.

Community Midwifery WA provides strong networking advocacy for a range of birth and parenting related consumer groups and opportunity for professional development for all midwives in the community. The organisation also works in collaboration with these groups in a range of promotional and educational activities. This provides the impetus to create good community networks where people are motivated to assist each other. At the same time , the broader community is able to have an input into the Program's services through representation on the board of management and through community consultation processes.

Despite the sudden withdrawal of professional indemnity insurance for independently practicing midwives in July, 2001, CMWA successfully negotiated a resolution with the WA Department of Health to ensure that the service could continue. AS ,mentioned above, the Department of Health now directly employs the midwives with indemnity being provided through the State’s own insurer (RiskCover) to minimize risk for Program clients in the event of an adverse outcome. The payroll is managed at one of the hospital services. All other aspects of the program remain within the control of the CMWA and Community Midwifery Program with regular reporting to the Department of Health.



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