Models of maternity care: a caseload midwifery perspective
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Abstract

Maternity services within Australia are undergoing major change and under the guidance of the 2010 National Maternity Services Plan will move towards a more women-centred approach to care. This will see maternity services move back under a midwifery led focus of care as opposed to the current medical model of care. This assignment compares four different models of maternity care and argues that the midwifery-led caseload model of care has the most beneficial outcomes for the women during pregnancy, birth and in the postnatal period. Moreover, it discusses the benefits of midwife led care in relation to primary health care.

Over the last century the changing expectations of women and society has immensely impacted on the delivery of maternity services throughout the world, and in particular Australia. These ‘now expected’ standards of maternity care have shown a rise in medical interventions during birth, resulting in more health dollars being spent and a greater number of women reporting ‘dissatisfaction’ with their birthing experience (Hartz, Foureur & Tracy 2012; Williams et al. 2010; Sandall et al. 2009). In 2002, a National Maternity Action Plan (NMAP) was prepared by an all-encompassing number of midwifery representatives and organisations throughout Australia with the aim to save health dollars and bring Australia into line with international best practice, while in addition meeting public demands for a range of readily available and appropriate maternity amenities (Maternity Coalition 2002). NMAP calls on both Federal and State/Territory governments to facilitate such change by making available to all women, in both urban and rural settings, the opportunity to access midwifery led care. The World Health Organisation (WHO) explains that midwives are ‘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 (WHO) 1999). In 2010, the Australian Government responded to the growing need for improved maternity care and cost effective maternity services with the release of the National Maternity Services Plan (NMSP) (Australian Health Ministers Conference (AHMC) 2010).
This assignment will look at four different models of maternity care provided to women from both midwifery led care and medical led care perspectives. It will compare and contrast the midwifery caseload model of care with know your midwife/team (KYM), private obstetrician, and GP share care models by evaluating the underpinning philosophies and values of the identified models, including how each fits within a primary health care framework. It will further outline each models strengths and challenges, discussing how women’s expectations have impacted on the delivery of maternity services in Australia.

It is evident through literature that maternity care in Australia is among the safest in the world (AHMC 2010; Department of Health and Ageing 2008; Maternity Coalition 2002). However, it is also argued that birthing choices are somewhat restricted despite the vast range of maternity care models offered to women in Australian society (AHMC 2010; McIntyre, Francis & Chapman 2011). In 2010, the NMSP was developed to help portray the importance of maternity services within the health system by providing a national framework to help guide policy and program development in maternity care throughout Australia over the next five years (AHMC 2010). Priorities for the plan encompass four areas: access, service delivery, workforce and infrastructure. This plan is the next step following NMAP to ensure women in Australia have access to best-practice maternity care. The NMSP focuses on primary maternity services during pregnancy, birth and up to six week postnatal for women and babies. The five year vision imparted in the plan includes four main points:

- Maternity care will be woman-centred, reflecting the needs of each woman within a safe environment; all Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live; provision of such maternity care will contribute to closing the gap between the health outcomes of Aboriginal and Torres Strait Islander people and non-Indigenous Australians; and appropriately trained and qualified maternity health professionals will be available to provide continuous maternity care to all women (AHMC 2010, p. 9).

The NMSP explains that the underpinning philosophy of primary maternity services is that birth is ‘a normal but significant physiological event, and that different women have different needs in relation to pregnancy and childbirth’ (AHMC 2010, p. 13). Furthermore, NMSP was developed with the broader aim of improving primary health care for women in Australia (AHMC 2010).
Talbot and Verrinder (2010, p. 3) define primary health care as ‘essential health care based on practical, scientifically sound and socially acceptable methods and technology’. In 1978, the WHO argued that primary health care should be universally available to all families and individuals at a cost that society and the country could afford to maintain. The underpinning philosophy of primary health care stemmed from the Declaration of Alma-Ata which gave rise to the slogan ‘Health for all by the year 2000’ (WHO 1978). Primary health care embraces the holistic view that health goes well beyond the narrow medical model. As a result of the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion was developed defining health promotion as ‘the process of enabling people to increase control over, and to improve, their health’ (WHO 1986). In the 2008 World Health Report it was noted that a vast proportion of resources are spent on curative services, with prevention and health promotion (that could cut 70% of the global disease burden) neglected (WHO 2008). Talbot and Verrinder (2010, pp. 4-8) examine the enormous task of implementing such philosophies and promotions proposed by the Alma-Ata and Ottawa Charter, concluding that major changes in health systems are still required, with political will and support greatly needed. With the development of NMSP an improvement in primary health care and health promotion for women seeking maternity care is now foreseeable.

The caseload model is a prime example of high quality midwifery led care with a women-centred care focus. Midwifery led care involves a woman receiving personalised care from the midwife or midwives with whom she has developed a relationship with. Hartz, Foureur and Tracy (2012, p. 39) explain that caseload midwifery is characterised by a primary midwife undertaking responsibility to ensure the continuity of care throughout pregnancy, birth and up to six weeks postpartum. Postnatally, caseload women are usually discharged within twenty four hours with the assurance that the primary midwife will make home visits for the first ten days and then up to six weeks postpartum as required. Caseload midwifery usually consists of a primary midwife with one or two support midwives, working with a select group of women to provide a full range of care (Bates 2004, p. 134). These midwives may be based in a hospital setting or in the community with a caseload of up to 30 to 40 women per year for each full time worker (Bates 2004, p. 135).

The underpinning philosophy of caseload midwifery is the professional partnership entered into by both midwife and expectant mother that values birth as a natural and normal progression. This partnership ensures that the values of empowerment, women-centred care, equality, informed
choices, shared responsibility, continuity of care and carer, and partnership satisfaction are upheld by both the midwife and woman (Sandall et al. 2009, p. 9). Johnson et al. (2005) explain that the primary midwife meets with the woman six to eight times antenatally, referring the woman to an obstetrician or GP at weeks twelve, thirty six and post forty weeks. Caseload midwives are expected to be available for their women when required and are known to work long hours. According to Bates (2004, p. 134-5) job satisfaction for caseload midwives is very high but similar to KYM midwives, burnout rates are elevated and not all midwives are able to commit to this style of care.

The KYM model of maternity care usually consists of a group of midwives sharing the care of up to 250 women per year (Bates 2004, p. 134). Bates (2004, p. 134) explains that the aim of KYM is for women to meet anywhere from four to six midwives with a guarantee that one will be present at the birth. The underpinning philosophy of the KYM model is similar to caseload in that continuity of care throughout pregnancy, birth and postpartum is essential and contributes to maternal satisfaction (Freeman 2006). The NMSP explains that if a midwife wants to provide continuity of care throughout the pregnancy, birth and postpartum, a flexible and collaborative approach is required and must be supported by the integration of effective consultation and referral pathways, effective clinical networks, collaborative interdisciplinary professional relationships, and sound information sharing and communication (AHMC 2010, p. 14). This is further supported by the National Midwifery Guidelines for Consultation and Referral and the ANMC Competency Standards for the Midwife (Australian College of Midwives 2008; Australian Nursing and Midwifery Council 2006).

According to Hodnett (2008), continuity of care and carer by midwives is associated with high levels of maternal satisfaction. The AHMC (2010, p. 14) states that ‘continuity of care enables women to develop a relationship with the same caregiver(s) throughout pregnancy, birth and the postnatal period’. NMSP outlines the increasing demand and importance for midwifery continuity of care models (AHMC 2010). Literature argues that both caseload and KYM models ensure maternal satisfaction through continuity of care in association with women-centred care (Johnson & Stewart 2003; Bates 2004; Sandall et al. 2009; Williams et al. 2010). This satisfaction is more prevalent in caseload care due to smaller teams of midwives. An Australian study by Johnson and Stewart (2003) reports that there are considerable benefits for women and their families attributed to the midwife being known to the women within a caseload model of maternity care. Although small in size, the study shows that 94% of women receiving caseload care had met the midwife
prior to labour. 98% further reported that they felt confident their midwife would be present at all antenatal appointments highlighting the ability of this model to deliver continuity of care.

The Royal Hobart Hospital (2010) patient handout on KYM explains that its purpose is to give women a confident approach to pregnancy with the underpinning philosophy supporting pregnancy and birth as a natural and normal process. Similar to the caseload model this ensures that values such as informed choice, empowerment and women-centred care are upheld and delivered to all women receiving this model of midwifery led care. Sandall et al. (2009) states that midwife led models of care are ‘based on the premise that pregnancy and birth are normal physiological life events, and is women centred’. Johnson and Stewart (2003) explain that women-centred care refers to a women making informed choices and being involved in and having control over their care, and their relationship with their primary caregiver. This theory aligns with the concepts underpinning primary health care in that the women and midwife have equal power in regard to decision making and choices surrounding the pregnancy and birth. The 2008 World Health Report declares that the core primary health care principles include universal coverage, people centred services, healthy public policies, and leadership (WHO 2008). The midwifery led models of care discussed in this assignment fit within a primary health care framework as midwives practicing as primary health practitioners provide not only specialised care to women and their families during pregnancy, birth and postpartum, they also advocate and support the ‘normal’ process of childbirth. Furthermore, midwives facilitate women to make the best decisions for themselves and their families through self-determination and empowerment. Primary health care supports the move away from traditional medical models of care and embraces wellness models that include health promotion and individual health care control which midwife led models of care advocate.

Unsurprisingly, there are many challenges that present in midwife led models of care. In the hospital based KYM model there is often an expectation for midwives to rotate through all shifts and around all areas of clinical practice (Bates 2004, p. 134). Although this ensures the maintenance of maternity skills, Ball, Curtis and Kirkham (2002) report that KYM midwives dislike the lack of stability this provides as it prevents them from gaining specialised expertise in the areas of their choice. Bates (2004, p. 134) reports a further challenge claiming that larger teams of KYM midwives have been shown to deliver more fragmented care in line with standard hospital maternity care; the very reason KYM was developed. The NMSP explains that fragmented maternity care
results in lack of continuity of carer as women transition from pregnancy to birth and into parenthood (AHMC 2010, p. 14). This fragmentation can adversely affect the maternity experience and outcomes for women and their families. Fragmentation is least likely to present in the caseload model of maternity care as only one midwife is responsible for the women’s journey through pregnancy and the postpartum period.

Women accepted into both caseload and KYM models of care must fit within a ‘low risk’ category (Bates 2004; Sandall et al. 2009). If a woman is considered ‘high risk’ or if any medical issues arise then it is understood that women participating in the midwifery led models will be referred to an obstetrician and/or transferred to a tertiary hospital where they can be reviewed. As Armstrong (2005, p. 12) points out, this can prove quite challenging in that it is not unusual for the obstetrician to assume full responsibility of the woman once this occurs.

According to the NMSP there are many women who choose to access continuity of care from GP’s and specialist obstetricians. The plan recognises that these choices should be respected and supported by improved access for those who choose to use them (AHMC 2010). Reibel (2004, p. 329) explains that western countries are more likely to place trust in medical led care in comparison to midwife led care. Reibel (2004, p. 329) further explains that midwives operate under a wellness model while obstetricians operate under an illness model. Literature shows that obstetricians view birth as a potential high risk requiring medical intervention and technological support, whereas midwives view pregnancy and birth as a low risk, natural event requiring guidance, support and empowerment with the use for medical intervention on a needs base only (WHO 1999; Sandall et al. 2009; Soltani & Sandall 2012). There are many differences between midwife led care and medical models of care. These include variations in philosophy, values, focus, and relationships between the health care provider and woman (Sandall et al. 2009, p. 8). The use of interventions during labour, and the goals and objectives of care vary also.

A private obstetrician model of care sees private patients of an obstetrician attend private rooms for care throughout pregnancy (Department of Health and Ageing 2009). A private obstetrician is closely involved in the women’s care during labour, although they may not be present for its duration. They will plan to be at the birth and will continue to provide care during the postnatal period. The underlying philosophy of the private obstetrician model is to provide continuity of care
under a medical framework with back up from technological support. This philosophy of care ensures the values of continuity of carer during the antenatal period and patient safety with medical intervention at hand if and when required. In comparison with the caseload model, values such as women centred care, informed choices, and equal partnerships are of less importance, with medical dominance deemed a higher priority (Soltani & Sandall 2012).

Private obstetrician care is a popular model of maternity care used by women in Australia with private health care. The National Association of Specialist Obstetricians and Gynaecologists 2008, as cited in McIntyre, Francis and Chapman (2011, p. 2) report that ‘30% of women give birth privately under the care of a doctor, mainly in private hospitals. They are highly satisfied with the care they receive but unfortunately not all women have access to private obstetric services’. A survey undertaken in Victoria examining the views of care provided to women during pregnancy found highest levels of satisfaction (84.4 per cent) among women who were private patients of specialist obstetricians or GP obstetricians (Department of Health and Ageing 2009, p. 18). These results may be considered unsurprising, given that there is an element of status having a private obstetrician within Australian society and private patients are more likely to have chosen the obstetrician as their healthcare provider. The results further indicate a preference for continuity of carer from a known source which is similar to caseload. With limited research available on why women choose private obstetrician care, it would be interesting to ask these women if they would choose obstetrician led care if private health care wasn’t an option.

Literature shows that maternal outcomes are not improved by choosing a private obstetrician when normal pregnancy and birth is expected in comparison to involving obstetricians when complications arise. A likely cause of this is that obstetricians follow the medical model of birth, which anticipates problems, rather than managing birth as a natural process (Sandall et al. 2009; Soltani & Sandall 2012). Statistics confirm this showing ‘a steady growth in the number of births by caesarean section in both private hospitals (increasing from 22 per cent of all births in 1991 to 41 per cent in 2006) and public hospitals (rising from 16 per cent in 1991 to 28 per cent to 2006)’ with caesarean sections in private hospitals significantly higher than public (Department of Health and Ageing 2009, p. 10). The NMSP confirms reports that Australia has high rates of birth by caesarean section (30.9% of births in 2007) compared with an overseas average of 25.7%. The plan further
reiterates the increasing rate in both the public and private sectors, with medical intervention substantially higher in the private sector (AHMC 2010, p. 10).

Maternal outcomes of caseload care compared with private obstetrician care are significant. A study by Sandall (2009) shows that women in caseload models are less likely to experience antenatal hospitalisation, have fewer inductions, less episiotomies, and a reduced need for medical intervention including instrumental birth and caesarean section. These findings were further supported in a review by Soltani and Sandall (2012) which examines the results of eleven trials involving 12,276 women documented in a Cochrane Systematic Review of midwife led care versus other models of care. Tracy et al. (2005, p. 336) explain that epidurals, inductions, episiotomies and other medical interventions are not first line options in the caseload model of maternity care. If medical interventions such as these are deemed necessary, the caseload midwife collaboratively discharges the women into the care of an obstetrician. It is essential that midwives working within the caseload model work collaboratively with obstetricians, GP’s, child health nurses, social workers and all other health professionals to ensure optimal maternity led care. This dedication to team work is a definitive example of primary health care in the fight to improve maternal satisfaction in Australia.

Options for midwifery led care are limited within the private sector. Frequently highlighted in the 2009 Maternity Services Review, ‘was the value of collaborative models of maternity care that drew on the knowledge and skills of different health professionals’ and promoted continuity of care (Department of Health and Ageing 2009, p. 20). As part of the NMSP issues such as this will be addressed. The Plan is underpinned by 10 principles for maternity care that build on such principles. The plan states that ‘maternity care will be provided for all women and their babies within a wellness paradigm, utilising primary health care principles while recognising the need to respond to emerging complications in an appropriate manner’ (AHMC 2010, p. 26). This wellness paradigm for pregnancy, birth and postpartum acknowledges that pregnant women are mostly well because pregnancy and birth are normal physiological life events. The plan reiterates that clinical decisions about medical intervention should be informed by this understanding (AHMC 2010, p. 25).

In contrast to the current system governing maternity practice today, literature suggests that obstetricians, GP’s, rural doctors and midwives work as professional equals with different and
complementary skills and knowledge (Department of Health and Ageing 2008; Department of Health and Ageing 2009; McIntyre, Francis & Chapman 2011). Although there is limited documentation available on GP share care, it is evident this model encompasses such proposal.

Sandall (2009, p. 9) explains that GP shared care is often shared between the GP and other healthcare providers such as midwives and obstetricians. She further (2009, p. 9) states that ‘at various points during pregnancy, childbirth and the postnatal period, responsibility for care can shift to a different provider or group of providers’. This type of model varies quite significantly throughout the world however, the Department of Health and Ageing (2009) in Australia report that shared care is a formal arrangement between a public hospital and local practitioner with the majority of pregnancy care provided by the local practitioner. Visits to the hospital at the beginning and latter part of pregnancy are necessary with a public hospital providing the intrapartum and immediate postnatal care.

The underpinning philosophy of GP shared care is working collaboratively with maternity healthcare providers to ensure optimal patient care. This ensures that the values of continuity of care, informed choice, greater accessibility for woman (especially in rural and remote areas) and shared responsibility are upheld (GP Antenatal Shared Care Protocol 2008). It also ensures that GP share care fits within a primary health care framework (working collaboratively with health care teams for a better outcome and providing accessible health care for all).

Benefits of GP share care include continuity of carer which was previously discussed. However, continuity of care may be more enhanced in this model in that woman may have known their GP’s for significant periods of time, even years, and the GP will be familiar with the woman’s health history. The NMSP reports that continuity of care in shared care models ‘relies on the ability of practitioners to work together and on the capacity of services to link together as the woman moves through pregnancy to childbirth’(AHMC 2010, p. 25). For GP’s working in rural and remote areas this proves more challenging. Although accessibility to GP share care may be heightened (AHMC 2010), the NMSP outlines the difficulties rural and remote women face. Many of these difficulties result from, or are exacerbated by, lack of access to health care. Even in low risk pregnancy where a woman in a rural or remote area may have access to her GP, she may still have to travel considerable distances for birth and aspects of antenatal care (AHMC 2010, p. 22). An issue raised
for rural women was the fragmented nature of their maternity care. The NMSP outlines that the ‘transition between primary care sector and acute care sector whether in the postnatal, antenatal or birthing period requires excellent communication systems, referral processes and clinical guidelines’ (AHMC 2010, p. 23). It also states that ‘collaborative care models developed for rural communities must reflect local circumstances, including the availability of appropriately skilled workforce’ and that ‘the role of outreach services is an important component of the service mix’ (AHMC 2010, p. 23).

Similar to caseload midwifery, GP share care has come under siege by specialist obstetricians who claim to support the increasing role of midwives and GP’s within the current ‘medical’ model with the obstetrician still taking overall responsibility for the care of women during birth and labour (Royal Australian New Zealand College of Obstetrics Gynaecology 2008, cited in McIntyre, Francis & Chapman 2009, p. 5). This view is somewhat challenged in rural and remote areas where obstetrician care is minimal and can only be sought through long distance travel.

It is without a doubt that medical led models of care, in particular the private obstetrician model, are less cost effective than midwife led care. With increased medical intervention and large out of pocket expenses it is questionable how informed women with private health care are about their choice of model. Cairnes (2008) explains that since the introduction of the Medicare Safety Net in 2004, obstetrician fees have increased by 269% which indicates the phenomenal cost of specialist care. With increased health promotion for midwife led care, health costs could be significantly reduced, with decreased rates of medical intervention prevalent in these models, in particular caseload. In contrast to caseload and KYM models which fit nicely within the primary health care framework, the medical models are more disjointed due to high intervention rates, inappropriate use of technology, fragmented care and the lack of encouragement for women to take control of their own health care.

Women in Australia have many choices surrounding maternity care however, lack of health promotion and information surrounding the existing models of care has led to an increase in medical intervention, increased health dollars spent and more women reporting dissatisfaction with their birthing experience. Literature reports that more women choose medical led care over midwifery led care despite the benefits of the latter. Throughout this assignment it is evident that
maternity care should be evidence-based and woman-centred, acknowledging pregnancy, labour, birth and parenting as significant life events for women. Continuity of care and carer, using primary health care principles and a wellness paradigm have also been identified as important features of maternity care for all women. From the literature presented it is evident these values are all heightened within a caseload model of maternity care. While each model of care has its own strengths and challenges, midwife led care certainly surpasses medical led care with its strengths, in particular less medical interventions, meaning less health care costs and increased maternal satisfaction. Although health care is restricted in some parts of Australia the NMSP aims to improve the services available in these areas with the introduction of more midwife led models of care. With the current maternity care system in Australia not satisfying its consumers or health care providers, the NMSP aims to improve access, service delivery, workforce and infrastructure of maternity care over the next five years. The plan fits within a primary health care framework in that its aims are similar to the core primary health care principles of universal coverage, people centred services, healthy public policies, and leadership. The caseload model of care is promising and shows potential to help bring Australia into line with international best practice.
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