

# WHAT LESSONS CAN AUSTRALIA DRAW FROM THE: New Zealand Maternity Care Experience

**In July 1996, New Zealand radically changed the legislation for maternity care provision under the banner of ‘More choices for women’, making midwives equal to general practitioner (GP) obstetricians as Lead Maternity Care (LMC) providers irrespective of medical background or experience. There was no evidence produced by the New Zealand Government to prove that that was what New Zealand women had wanted.**

Until 1996, more than 50 per cent of all deliveries in New Zealand were managed by GP obstetricians and women could choose the model of care they preferred. Under the new system, a woman could choose her own LMC who would be responsible for her care throughout her pregnancy and postpartum period, including the management of the labour and birth. The LMC could be a midwife, a specialist obstetrician or a GP obstetrician.

While the LMC system potentially offers women more freedom of choice about the continuity of her caregiver, the funding model of the LMC system—the Maternity Payments Schedule—has proven unsustainable for many doctors, including GP obstetricians. The doctors were required to spend more than half of their LMC budget purchasing midwifery services, while midwives could retain their entire budget, paying only if the services of a GP obstetrician were required. A midwife could refer patients directly to a specialist obstetrician, who was paid for an opinion out of separate funds, excluding the GP obstetrician from shared care. Midwives could claim up to \$NZ3000 per delivery compared to the average GP obstetrician’s claim of \$NZ780.

GP obstetricians effectively withdrew from maternity care as it became economically unviable for them to continue. It also became unlawful for GPs to charge a service fee for care if a pregnant patient were to present to the practice in an emergency situation. As a result of this legislation, general practitioners were displaced by midwives and now there are few GPs still delivering babies in New Zealand. The previous teamwork and partnerships between midwives and doctors has been lost. In country areas, GPs still delivering babies are a rarity and this is undoubtedly an incredible waste of expertise.



PIETER MOURIK  
FRANZCOOG

WODONGA, VICTORIA

The changes have gradually led to the complete removal of all maternity care, and postnatal care up to six weeks, from the rest of family health and primary care, encasing maternity care in a non-medical model. There is no longer funding for a formal six week consultation with a GP; only the baby check is funded.

No national database was ever established to analyse the effect of the change in maternity care because it was considered too politically sensitive or unnecessary to collect this information. Midwives have no legal obligation to report adverse outcomes to a national database. Limited quality outcome data only became available five to six years after the transition.

A strong argument for the midwife model of care is that it ‘decreases interventions’. However since 1996, interventions (including caesarean section rates and postpartum complications) have increased to a level that has even alarmed some midwives. There are also indications that some midwives are now dropping out of maternity care due to stress and long working hours. Recent research by midwives in Britain has failed to show any clear benefits from midwife continuity of care.<sup>1</sup>

Now it seems there is little choice for New Zealand women. Once a GP or a specialist obstetrician leaves obstetrics they rarely return, creating a shortage of trained doctors willing or able to see pregnant women.

The essential obstetric training course for GPs, the Diploma of Obstetrics, which had 150 applicants a year, has virtually closed down, with fewer than 20 applicants completing the course. Even then, few intend to practise obstetrics while in the past, many Diploma of Obstetric graduates in New Zealand went on to a career in obstetrics. Many of these obstetric workforce shortages could be avoided by proactive care and more experienced supervision of the patient by an obstetrician in partnership with a midwife.

The situation in New Zealand seems most critical in rural areas. Instead of more choice, women have

## A DECADE IN REVIEW:

# Midwives & the New Zealand maternity system

**C**hild bearing for the vast majority of the world's women is a normal, physiological process influenced by social culture and family traditions. It is a family event that requires a health-oriented approach even in the presence of co-morbidities. In New Zealand, as in many other countries, midwifery is now the primary health workforce whose specific role is to facilitate this transition to parenthood for women and their family, regardless of their choices around other service providers or place of birth.

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less as their family practitioner has been excluded from their pregnancy and confinement. For the first time, complications (including mortality and morbidity) have increased after years of progressive improvement.<sup>2</sup>

Now that the continuity of care that was provided by GPs has been lost, there is evidence of a reduction in immunisation and delayed diagnoses for congenital hip dysplasia and eye and ear infections in babies.<sup>3</sup> In addition, there have been an increased number of missed cases of postnatal depression which delayed the patient's treatment. These examples have all been documented by the New Zealand Government Health authorities.

It is crucial that Australia learns from this experience and does not blindly follow the same pathway that certain sections of health administration and various governments seem to favour.

It is incorrect to presume that this New Zealand model of care will give 'more choices for women' and result in fewer interventions in pregnancy and labour. Australia must learn from the New Zealand experience and promote GP involvement in maternity care, not displace them.

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Prior to 1990, women's first contact with the maternity service was via the GP. There was no one model of care as general practitioners worked in a multitude of ways and with a range of providers. Equity of access and service for parents was poor, especially for Maori and the lower socio-economic population (Coopers and Lybrand, 1993).

General practitioners, many of whom did not have specific obstetric qualifications, were the predominate community provider of antenatal care until 28 weeks. Most women were then referred to hospital clinics or colleagues with the Diploma of Obstetrics. Other women self referred directly to the hospital. Even at the height of GP obstetrics, only 20 per cent of GPs provided a full maternity service (New Zealand Medical Association, Evidence at Maternity Benefit Tribunal Hearing, 1993).

The vast majority of women relied on midwives unknown to them to attend them in antenatal clinics, labour and birth and to provide their postnatal in care in hospital. Although the mix of intrapartum providers varied from region to region throughout the Eighties, on average some 66 per cent of women had a midwife conducting the delivery on her own responsibility, regardless of which doctor a woman was booked with (Hospital Labour Ward Log books, 1989). Midwives and obstetricians were the intrapartum workforce for the majority of women. For example, in a study by the Canterbury Area Health Board (CAHB) in 1990, the average number of deliveries conducted by GPs was ten per annum and none did forceps deliveries (CAHB minutes, 1990).

While individual GPs had a range of working styles and services, in the main the GP who did obstetrics saw the woman once or twice postnatally, following discharge from hospital; otherwise the majority of women returned to the hospital clinics at six weeks. The baby received oversight from the Plunket nurse. Only women who could afford care from a private obstetrician were (and still are) able to receive



KAREN  
GUILLILAND

CHIEF EXECUTIVE OFFICER  
NEW ZEALAND COLLEGE  
OF MIDWIVES

CHRISTCHURCH, NZ

continuity from an obstetrician that they knew. The changes in 1990 and 1996 occurred as one of the responses to this fragmented scenario of care.

New Zealand midwives have been able to offer women antenatal, labour, birth and postpartum care on their own responsibility for 15 years. Initially midwives endeavoured to share care with the GPs as this was who they had worked with in the past. It became rapidly obvious that this led to over-servicing, was costly and with no apparent gains to

Outside the funding issue there are still some tensions in the maternity service but these largely relate to the interface between primary and secondary/tertiary services. The New Zealand model of care promotes the rights of parents to maternity services that are based on partnership, information and choice. While birth is a life-changing event and as such has an element of risk, the majority of women still experience it as physiologically normal and family centered. Most women will usually start pregnancy assuming normality and will engage an LMC to facilitate their experience but some will go on to require secondary, tertiary or emergency intervention. This does not necessarily mean she or her LMC have 'failed' to achieve a normal birth or that obstetricians 'rescue' midwives. The ability of a woman to access any or all of these services, when she needs them and on a 24-hour basis, is a measure of a well-integrated effective health system.

However it is the transition from normal life expectations and parental control to the need for interventionist care that the majority of the tension arises between mothers and fathers, midwifery and obstetrics, management and funders. Most of the time trust and negotiation between all parties removes the tension but sometimes it is difficult to get the balance right. Balancing the social and medical needs of women and their families is essential. It is also important the parties do not over- or under-complicate or compromise both set of needs. The challenge for New Zealand maternity services has been to incorporate a community-based model into the traditional hospital-based service. As women are actively involved in decision-making, boundaries between levels of care and who provides that care are no longer as clear and differing world views on what is 'normal' continue to arise. Sometimes some LMCs 'take on' too much 'obstetric' care and sometimes some obstetricians over-react and interfere with what is essentially normal. While these boundary issues are encountered worldwide and not unique to New Zealand, there is a reasonable equilibrium or consensus most of the time and the majority of midwives and obstetricians enjoy good working relationships.

It would appear there is a lot of misinformation circulating in Australia about New Zealand's maternity services and most seems to be underpinned by the belief that a midwife cannot provide a safe service without medical supervision. Yet there is ample and longstanding evidence for the safety and effectiveness of midwifery care (Montgomery, 1969, Levy *et al*, 1971, Hinds, 1985, Flint and Poulengeris, 1989, Heins *et al*, 1990, Rowley *et al*, 1995, Homer *et al*, 2001, Tracy *et al*, 2004). For 15 years, tens of thousands of New Zealand women have had a midwife as their primary care giver (this is now constant at around 73 per cent). All published data where LMCs are identified by profession, both prior to and post-1996, confirms midwifery outcomes to be the same or similar to general practitioners (Ministry of Health, 1999, 2001, 2002; National

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the woman. In 1996, continuity of maternity care as a one-on-one service across the full maternity experience was formalised into a lead maternity carer (LMC) model where one health professional took responsibility for co-ordinating care and was funded accordingly.

General practitioners have never been excluded from lead maternity care but they have consistently complained that the funding model does not reward them adequately. The reality is that funding is designed to remunerate the person who actually provides the service. The average fee a midwife LMC earns is based on a minimal service for a woman going to full term without complications (includes between ten and 12 30-minute antenatal visits, eight hours on average attendance at labour and birth, and between seven and ten 45-minute postnatal visits). For this, a midwife works a minimum of between 17 and 24 hours per woman and the fee is around \$NZ1535. The reality of 24-hour care is far in excess of these hours. Midwives' overheads are all self-funded, unlike general practitioners who have access to considerable allowances under their Ministry and PHO contracts. According to Pieter Mourik's information, the average fee for general practitioner LMCs is \$NZ780. Based on data supplied by the New Zealand College of Midwives and the New Zealand Medical Association to Maternity Benefit (Section 88) negotiations in 2002, general practitioner ante- or postnatal visits are ten minutes and the average birth attendance is two hours. They provide 12 antenatal and three postnatal visits on average and the six week visit for the baby is claimed from a different budget. For the average fee of \$NZ780, the general practitioner works four to five hours per woman. If anyone has a genuine complaint about remuneration it quite clearly should be the midwife.

Women's Hospital Annual Reports, 1996-2000; Ministry of Health, 2002; and District Health Board data [NWH,2001-2003]) on outcomes traditionally used to measure a maternity service, indicate continuing improvement in the following:

- continuing decrease in perinatal mortality (and in SIDS),
- decreased antenatal admissions for serious complications, and
- a sustained decrease in admissions of very sick babies to neonatal intensive care.

Immunisation rates at six weeks are 95 per cent, but decrease markedly once out of the maternity service. Furthermore Professor Mantell's recent trend research from 1980 to 2001 confirmed decreased rates of prematurity and SGA babies for Maori, Pacific Island and lower socioeconomic groups of women (Mantell *et al*, 2004). Outcomes for young Maori women have significantly improved over these years also. Maori, young women and women from lower socio economic groups are significantly more likely to choose a midwife for their LMC (Ministry of Health, 2002). Women's satisfaction with maternity services has increased over three national surveys (Ministry of Health, 1999-2001).

While it is argued by some that New Zealand outcome data is variable in quality, this is also true of most countries against which it is measured (Thornton, 2004). The New Zealand data on mortality and morbidity does not concur with Pieter Mourik's opinion. Many comments made about perineal injury, postnatal depression and various neonatal conditions can only be anecdotal generalisations, as there is no mechanism for recording or comparing this level of information either on a regional or national basis.

Many of the issues around maternity services such as rural access, midwife and doctor shortages and stretched resources are present in all health systems and services. Midwifery would argue that the change in New Zealand to a largely midwife-led maternity service has equipped it to manage these issues more effectively and has done so in a way that women appreciate without compromising their outcomes. Any major change however brings dismay and resistance from many.

If Australia were contemplating similar changes on a national level it would do well to acknowledge and disseminate its already highly successful midwifery pilots demonstrated throughout Australia. Such pilots should reassure and the information they bring provide the impetus for a strong education campaign to inform the public of new choices that could be more widely available in Australia. All providers could also be given the opportunity to be involved in the developing of alternative models of care that will sustain the maternity service and its workforce.

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