Australian Nursing & Midwifery Federation

ANMF Information Sheet

Midwifery Continuity of Care

Background

Midwife-led continuity of care models, in which a known midwife is the lead healthcare practitioner providing care from the initial booking appointment up to and including the early weeks of parenting, are recommended for pregnant women[1].

These models have been shown to lead to reductions in preterm birth, epidural, episiotomy or instrumental births, and neonatal deaths[2]. They also result in increases in spontaneous vaginal birth and women's satisfaction with no increased risk of harm[3].

Continuity of care models represent a cost reduction for health services. These models reduce medical interventions such as caesarean section, instrumental births, episiotomies, and epidurals[4]. This results in a shorter hospital stay, reducing staffing requirements and bed block.

In rural areas, continuity of care models can staff a maternity service that is entirely self-managed, removing the requirement for 24-hour rostering. High-risk women receive comprehensive care managed by a known midwife, reducing specialist appointment times. Continuity of care models result in fewer preterm births, reducing high-cost neonatal care requirements[5].

In 2022, around 15% of national maternity care models offered midwifery group practice caseload care[6]. Under a third of maternity care models offer continuity of carer for the duration of the maternity period including antenatal, intrapartum, and postpartum care[7].

Government intervention is required to improve the accessibility of continuity of care for women and babies.

Actions

1. In order to improve Australia's continuity of care provision, geographical accessibility to these models must be increased. Improving service provision will enhance the sustainability of rural birthing services. Women birthing in rural or remote areas are less likely to have access to private maternity care, and so only have the geographical option of the public maternity service.
2. Many women are transient between towns and states, and so developing national pathways to support smooth transitions for women between maternity care providers and other services is necessary.
3. All reproductive health care must be financially accessible. Private midwifery care exclusively offers continuity of care, while private obstetrician specialist care offers approximately 88% continuity of care. Women from migrant or refugee backgrounds, who are not eligible for Medicare, are less likely to receive continuity of care in part due to the cost restriction. These women require access to continuity of care models to ensure the best outcomes for them and their babies.

4. Improved data collection systems will progress continuity of care provision in Australia. More research into these models is required to assist with their effective expansion. The creation of a national, digital pregnancy health record will allow pregnant women to transfer seamlessly between services.
5. Birthing women should be surveyed with a nationally comparable set of questions regarding outcome, wellbeing, and experiences. The results of this survey should be publicly reported, and included in the planning and ongoing monitoring of maternity services[8].
6. Public awareness about available models of maternity care will further drive the implementation of continuity of care services. Currently available resources, such as the Pregnancy, Birth and Baby website, should be updated to include information about the benefits and availability of continuity of care models[9]. Health practitioners also need access to education about available models of care.
7. Midwives must be attracted to work in continuity of care models, particularly rurally[10]. Students should be recruited from rural areas. Students should have opportunities for placements with continuity of care models[11]. From career outset, midwives should be supported to work and study in rural and remote areas. New graduates should be offered supported rotations to work in rural continuity of care models.
8. Continuity of care models need to offer flexible work arrangements and appropriately cover recreation, personal, and professional development leave. Midwives who work within these models need to be offered clear career paths, with incentives for time spent rurally. Supportive supervision, peer mentoring opportunities, and continuous professional development are necessary for the ongoing health of the workforce.

Midwifery led continuity of care models are the gold standard for maternity care. Supporting these models results in better outcomes for women and babies, and reduces the cost to the health care system.

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[1] The World Health Organisation (2021). *State of the world's midwifery 2021.* Available at https://www.unfpa.org/sowmy.
[2] Sandall, J., Soltani, H., Gates, S. et al. (2016). *Midwife-led continuity models versus other models of care for childbearing women.* Cochrane database of systematic reviews, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5. Available at https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004667.pub5/full.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Australian Institute of Health and Welfare (2022). *Maternity models of care in Australia, 2022.* Available at https://www.aihw.gov.au/reports/mothers-babies/maternity-models-of-care/contents/about.
[7] Ibid.
[8] COAG Health Council, Department of Health (2019). *Woman-centred care: strategic directions for Australian maternity services*. Available at https://www.health.gov.au/sites/default/files/documents/2019/11/woman-centred-care-strategic-directions-for-australian-maternity-services.pdf
[9] https://www.pregnancybirthbaby.org.au/
[10] Kashani, A., Ingberg, J.L., Hildingsson, I. (2021). *Caseload midwifery in a rural Australian setting: A qualitatitve descriptive study*. European Journal of Midwifery, Issue 5. No.:2 DOI: 10.18332/ejm/131240.
[11] Kuliukas, L., Warland, J., Cornell, P., et al. (2023). *Embracing the continuity of care experience: A new Australian graduate entry master of midwifery course with a student caseload of 15 women per year*. Women and Birth, Vol. 36, Iss. 2. DOI: 10.1016/j.wombi.2022.11.011.