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Australian private midwives with hospital visiting rights in Queensland: Structures and processes impacting clinical outcomes

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ABSTRACT

Background: Reporting the outcomes for women and newborns accessing private midwives with visiting rights in Australia is important, especially since this data cannot currently be disaggregated from routinely collected perinatal data.
Aim: 1) Evaluate the outcomes of women and newborns cared for by midwives with visiting access at one Queensland facility and 2) explore private midwives views about the structures and processes contributing to clinical outcomes.
Methods: Mixed methods. An audit of the 'all risk' 529 women receiving private midwifery care. Data were compared with national core maternity variables using Chi square statistics. Telephone interviews were conducted with six private midwives and data analysed using thematic analysis.
Findings: Compared to national data, women with a private midwife were significantly more likely to be having a first baby (49.5% vs 43.6% p = 0.007), to commence labour spontaneously (84.7% vs 52.7%, $p < 0.001$), experience a spontaneous vaginal birth (79% vs 54%, $p < 0.001$) and not require pharmacological pain relief (52.9% vs 23.1%, $p < 0.001$). The caesarean section rate was significantly lower than the national rate (13% vs 32.8%, $p < 0.001$). In addition fewer babies required admission to the Newborn Care Unit (5.1% vs 16%, $p < 0.001$). Midwives were proud of their achievements. Continuity of care was considered fundamental to achieving quality outcomes. Midwives valued the governance processes embedded around the model.
Conclusions: Private midwives with access to the public system is safe. Ensuring national data collection accurately captures outcomes relative to model of care in both the public and private sector should be prioritised.

Statement of significance

Issue

Little is known about the outcomes for women accessing maternity care from private midwives with visiting rights in Australia, and there are no studies to date analysing factors impacting on clinical outcomes.

What is already known

Compared with other models of care, public sector midwifery caseload care is safe for women and babies. Women report higher maternal levels of satisfaction in continuity of midwifery care models, and it is cost-effective.

What this paper adds

This study contributes to knowledge about the outcomes for 'all risk' women using private practice midwives with visiting rights and extends understanding of the context of care affecting clinical outcomes.

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1. Introduction

The 2016 updated Cochrane systematic review of midwife-led continuity models (caseload) versus other models of care for childbearing women and their infants found midwife-led care leads to better outcomes.[1] Women who received caseload midwifery care were more likely to have a spontaneous vaginal birth and less likely to experience a pre-term birth. Women also experienced less overall fetal/neonatal death and required fewer interventions during labour and birth than women whose care was provided by different obstetricians, General Practitioners (GPs) and midwives.[1] All studies included in the Cochrane review were of services provided in the public health service with no 'point of service' hospital costs to women.

However, despite improved outcomes for women and newborns and national maternity policy prioritising improved access to caseload midwifery most of Australia's maternity care is still delivered in tertiary, rather than primary care settings.[2,3] In addition, even though caseload midwifery provides significantly improved outcomes, national, state and territory perinatal data collection systems do not yet routinely collect and record the model of maternity care and therefore outcomes cannot be evaluated relative to this important variable.[4] The proportion of women receiving caseload midwifery in Australia is unknown, however a recent survey of 149 health services identified that only 8% of women were provided with continuity of midwifery care.[5]

To enhance women's access to continuity of midwifery care the Federal government legislated for midwives to have access to Medicare in 2010.[6] Medicare is Australia's national health insurance system. It is intended to provide universal access to health care. Predominantly Medicare provides a specified rebate for health care services provided by medical practitioners. However since 2010, women cared for by a midwife with access to Medicare have been able to obtain a rebate for the cost of the midwife's services. Under the reforms, Medicare eligible private practicing midwives (referred to in this paper as private practice midwives [PPM]) with visiting access to a hospital may admit and care for their clients during labour and birth as private patients in public hospitals. Gaining hospital visiting access or 'visiting rights', as it is commonly referred to, is essential for private practice midwives as this is the only mechanism by which women using their services can be assured continuity of care regardless of place of birth.

In the private midwifery caseload model a pregnant woman engages her own midwife who provides care throughout pregnancy, birth and early parenting. The midwife uses the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral to guide decision making and clinical care.[7] Models such as these provide childbearing women with the unique and personalised experience they have been demanding for many years.[6,8–12]

One state in Australia, Queensland, utilised the national reforms earlier and more fully than other Australian states and territories. To date, approximately 12 of the 42 public maternity facilities in the state provide visiting access to Medicare eligible private practice midwives whereas most other states and territories have not, or have only very recently, implemented visiting access agreements. One of the first maternity units to facilitate access for private practicing midwives was located in South East Queensland. At this hospital a Steering Committee was established with representatives of stakeholders including consumers, to oversee the development and implementation of visiting access arrangements. The maternity unit developed an Access Licence Agreement (ALA), a Clinical Guideline, and a number of work instructions to support the ALA for private practice midwives.

In October 2012 the first four midwives were credentialed using processes that aligned with clinical privileges for medical practitioners and signed the ALA. In June 2013 another seven midwives obtained visiting access bringing the total to 11. In 2014/5 four more midwives gained access. Subsequently five midwives have decided not to seek reaccreditation for a range of reasons (such as relocation, gaining access elsewhere and deciding to cease private practice). Women booked with private midwives are cared for in either the Birth Centre or Birth Suite depending on the complexity of the woman and/or her baby. If medical care is required, the midwife consults with and/or refers to the obstetric team employed by the health service. The private midwife continues to provide midwifery care regardless of the involvement of other members of the health care team.

The governance processes embedded around the model include a fortnightly case review and reflection session that also includes an opportunity for obstetric consultation and referral, monthly, six-monthly and annual outcome reporting (written), inclusion of private practice midwives in professional development both as participants and facilitators, and annual assessment of evidence of competency across the full scope of midwifery practice. The private practice midwives have access to all the educational opportunities afforded to the staff within the service. The Clinical Midwifery Consultant responsible for managing the public caseload practice provides clinical leadership to the private midwives and is their initial point of contact within the service.

Reporting the outcomes for women and newborns accessing private midwives in Australia is important, especially since this data is not able to be disaggregated from routinely collected perinatal data at state and national levels. At the time this paper was written there was only one other article reporting maternal and newborn outcomes of private midwives, with hospital access, since the introduction of the 2010 reforms.[13] In addition, understanding the structures and processes contributing to clinical outcomes may enhance our ability to develop sustainable quality services. As previously highlighted realigning maternity services with the evidence has been slow. Existing structures and processes are likely to impact on this progress. However little is known about how midwives and maternity organisations transition towards caseload care or the sustainability of caseload services.[14] There is significant evidence that despite excellent outcomes, caseload services in Australia and in other OECD countries not only struggle to expand but are also frequently threatened with closure, downsized, degraded or closed either permanently or temporarily.[14,15] Understanding the organisational factors surrounding the provision of caseload midwifery care, both public and private, may be key to reforming maternity service delivery.[16–20]

Therefore the aims of this study were to evaluate the outcomes of the women and newborns cared for by private midwives with visiting access to a large tertiary referral centre in South East Queensland and to explore the midwives views about the structures and processes contributing to these clinical outcomes.

2. Method

This was a two-phase mixed methods study using clinical audit and a descriptive qualitative approach.[21]

2.1. Phase 1: maternal and neonatal outcomes

A retrospective audit of the clinical outcomes of all women and newborns cared for by private midwives with visiting access was undertaken at one South East Queensland maternity unit between 1 October, 2012 to 31 May, 2016 ($N = 529$). De-identified outcomes were retrieved from an Excel database that is updated every fortnight and forms part of the routine governance process around

the model. Data was compared with national perinatal data using ten core maternity indicators.[22,23] Maternal variables included parity, onset of labour, pain management, mode of birth, perineal tears and/or episiotomy. Neonatal outcomes included gestation, weight and complications requiring transfer to the Newborn Care Unit [Neonatal Intensive Care (NICU) and Special Care Nursery (SCN)].

The de-identified data were imported into an SPSS database (version 20) to facilitate statistical analysis. Descriptive statistics (frequencies, means, standard deviation and range) were calculated. Data were compared with national perinatal data using Chi square test where only proportions and denominators were available. Continuity correction was used to calculate probabilities of error in a 2-group comparison.

2.2. Phase 2: structures and process underpinning clinical care

In phase 2 the private midwives were invited to participate in an individual interview with the intent of producing a richer understanding of the organisational structures and processes affecting their clinical outcomes.

Guiding the data collection and analysis process was Donabedian's[24] theoretical framework for evaluating the quality of health care. According to Donabedian the connection between human resources and organisational structures affect the processes of care (actions of health providers) which subsequently determine the quality of care received by the patient. Well-structured health care systems increase the likelihood of positive processes, which in turn increase the possibility of quality clinical outcomes.

All 11 private tice midwives with visiting access were invited to participate in an individual interview by email with an information sheet attached and were given an opportunity to ask questions about the planned study. Once written consent was provided a time for the interview was organised. Six midwives were interviewed. Of the five midwives not interviewed, two indicated that they were willing to participate but had cared for less than four women at the study site because the women they cared for predominantly used another hospital for consultation, referral and birth. The remaining three midwives had also cared for less than 5% of total births, had closed their practice in 2014, and did not respond to email invitations to participate.

The interviews lasted between 90 and 140 min. As Litoselliti[25] suggests a list of pre-determined open-ended questions, focused around Donabedian's[24] three elements of outcomes, process and structure, were used to guide the interviews. Each session was digitally recorded and later transcribed verbatim. Field notes were completed during and after each interview.

Thematic analysis was used to analyse the data set. Thematic analysis is a process of identifying, analysing and then reporting patterns (themes) within a data set.[26] The thematic analysis process began with hard copies of the transcripts being read to garner initial general impressions. The process of line-by-line coding then commenced.[27] Here specific words and/or phrases were underlined and meaning concepts generated. Subsequently 'like' concepts were grouped or clustered together. Data were continually compared and moved as the analysis process continued. Eventually seven themes became apparent; two related to outcomes; three related to process; and two related to structure (see Box 1).

Decisions around concepts and clustering were discussed among the research team as the analysis progressed. Preliminary findings were shared with the midwives in an effort to enhance the trustworthiness and credibility of the analysis process. Audit trails documented the decision making process.[25]

Approval was obtained from the Griffith University Human Research Ethics Committee (No: NRS/29/15/HREC). The clinical audit was lodged as a Quality Improvement Activity within the Health Service and tabled with the service's HREC committee (HREC/17/QGC/7).

3. Results

3.1. Maternal and neonatal outcomes

Five hundred and twenty nine women booked with and receiving care from a private practice midwife (PPM) with visiting access gave birth at the study site between 1 October, 2012 and 31 May, 2016.

All pregnancy and birth characteristics are shown in Table 1. There were equal numbers of nulliparous (49.5%) and multiparous (50.5%) women. Nationally, nulliparous women only make up 43.6% of the total birthing population ($p = 0.007$). This statistically significant finding is an important consideration when comparing other outcomes given that women having their first baby are more likely to require some form of assistance and/or intervention during the labour and birth.[28,29] Table 2 shows a comparison between the sample and national perinatal data using the ten core variables.

The PPM model was an 'all risk' model with 25% of women ($n = 132$) identified as having a complexity in pregnancy (see Table 3 for a detailed breakdown). The most common complexity was a history of a previous caesarean section (12%). Women with diabetes were the next largest group ($n = 13$, 2.3%). Six women had a multiple pregnancy (twins) and two women had a therapeutic termination at 20 weeks. Two women experienced an intrauterine

Box 1. Qualitative themes.

Clinical outcomes: midwives reflections.
- I'm so proud.
- It's proof to others.

Processes of care: quality is all about enacting continuity.
- Prioritising the relationship.
- Working with others: Being able to follow the pregnant woman through/across the system.
- Continuity facilitates flexible and fluid care during labour and birth.

Organisational structures: support and belonging.
- A private caseload practice.
- Visiting rights: facilitating access to the system.

Table 1
Pregnancy and birth characteristics (N = 529).

	n	% (SD)
Parity		
Nulliparous	262	49.5
Multiparous	267	50.5
Number of babies	535	
Singleton	523	98.9
Twins	12	1.1
Mean gestation (weeks) (live births) onset of labour		39.4 (1.9)
Spontaneous	448	84.7
Augmented	*86*	*16.3*
Induction	74	14.0
No labour	7	1.3
Birth mode		
Spontaneous vaginal[a]	418	79.0
Vacuum extraction	24	4.5
Forceps	18	3.4
Caesarean section (CS)	69	13.0
Caesarean section category[b] (N = 69)		
Planned (cat 4)	7	10.1
Unplanned	62	89.9
Cat 1	16	25.8
Cat 2	42	67.7
Cat 3	4	6.5
History of previous CS (N = 64)		
Birth mode		
SVB[c]	36	56.3
Assisted vaginal birth	6	9.4
CS-unplanned	18	28.1
CS-planned	4	6.3
Perineum (vaginal birth only)	460	
Intact	189	41.1
First degree	108	23.5
Second degree	123	26.7
Third and fourth degree	17	3.7
Episiotomy[d]	23	5.0
Pain relief	529	
None	276	52.2
Nitrous oxide and oxygen	101	19.1
Opioid	10	1.9
Epidural	80	15.1
Pudendal block	4	0.8
Spinal in theatre	51	9.6
General anaesthetic	7	1.3
Vaginal birth only		
Pharmacological pain relief	460	
None	276	60.0
Nitrous	101	22.0
Opioid	10	2.2
Epidural	50	10.8
Spinal	15	3.3
General anaesthetic	4	0.9
Pudendal block	4	0.9
Place of birth		
Birthed prior to admission to hospital	6	1.1
Birth centre or birth suite	453	85.6
Operating theatre	70	13.2
Birth weight (grams)	523	3563.4 (509.9)
Apgar at 5 min (live birth only—includes first twin only)		
<7	6	1.1
>=7	524	98.9
Baby admitted to neonatal services (includes first twin only)		
No	477	90.0
Yes[e] (cared for on maternity ward with mother)	25	4.7
Yes SCN	20	3.8
Yes NICU	8	1.5
Babies breastfed		
No	14	2.7
Yes	512	97.3
Early discharge—after birth directly from BC/BS		
No	323	61.1
Yes	206	38.9
Water birth[f]		
No	241	58.6
Yes	170	41.4

[a] Includes 7× vaginal breech.
[b] RANZCOG[44].
[c] Includes 1× vaginal breech.
[d] Includes 3 extension to 3rd/4th degree tears.
[e] Babies receiving antibiotics + blood sugar monitoring were admitted to SCN but are cared for in the maternity ward.
[f] Excludes 7 breech births.

fetal demise at 40 and 41^{+} weeks prior to labour or admission to hospital. Both stillbirths were subject to the service's normal review processes and categorised as 'unavoidable'. The sample size was too small to statistically compare the two fetal deaths with the 530 live births. The national stillbirth rate is, however, two stillbirths for every 270 births.[30] For one set of twins, twin 2 died in utero at 18 weeks.

Approximately 40% of women ($n = 222$) were noted to have a complexity during labour and/or birth (see Table 4 for a detailed breakdown). Of this group 13.5% ($n = 30$) had prolonged rupture of membranes (PROM), 13.5% ($n = 30$) did not progress in labour, 11.2% ($n = 25$) had multiple complexities, 10.8% (n = 24) had meconium stained liquor and 9.5% ($n = 21$) were diagnosed with fetal distress. The preterm birth rate was 3% ($n = 16$) (less than 37 completed weeks).

Nearly 85% of women ($n = 448$) entered labour spontaneously compared to only 52.7% in the national perinatal data set which was statistically significant ($p < 0.001$). Seventy nine percent of women ($n = 418$) had a spontaneous vaginal birth (cephalic or breech). Once again this is a statistically significant finding given the national spontaneous vaginal birth rate was only 54.8% ($p < 0.001$). Some 41% of those having a spontaneous vaginal (cephalic) birth gave birth in water ($n = 170$).

The PPM service also had a significantly higher number of women using no form of pharmacological pain management (52.9%) than that reported nationally (23.1%) ($p < 0.001$). The epidural rate across the whole cohort was 15.1% ($n = 80$) with 9.6% of women ($n = 51$) having a spinal anaesthetic in the operating theatre.

Just under 8% of women ($n = 42$) had an assisted vaginal birth. Significantly more women accessing a private practice midwife had an intact or grazed perineum after vaginal birth (41.1%) compared to national data (27.4%) ($p < 0.001$). The rate of episiotomy (5.0%) was also statistically lower to that reported in the national data set (20.4%) ($p < 0.001$). The 3rd and 4th degree tear rate, however, was higher (3.7%) ($p = 0.023$). Half ($n = 10$) of the 3rd or 4th degree tears were in women having a spontaneous birth and half ($n = 10$) were in women requiring an assisted birth (vacuum or forceps). Three episiotomies extended (1 × 3A, 2 × 3B) (see Table 5).

The overall caesarean section rate was 13.0% ($n = 69$) compared to the 32.8% reported nationally ($p < 0.001$). The postpartum haemorrhage rate across the whole group was 3% ($n = 16$) with 2%

Table 2
Comparison of birth outcomes: private practice midwives and national perinatal data (2013).

	Private practice midwives		National data[a]		p
	N = 529		*N* = 304,777		
	n	%	*n*	%	
Parity					
Nulliparous	262	49.5	132,797	43.6	0.007
Multiparous	267	50.5	171,980	56.4	
Onset of labour					
Spontaneous	448	84.7	160,526	52.7	<0.001
Induction	74	14.0	84,109	27.6	
No labour	7	1.3	60,080	19.7	
Pain relief[b] (N = 522)					
Yes	246	47.1	188,045	76.9	<0.001
No	276	52.9	56,406	23.1	
Mode of birth					
SVB[c]	418	79.0	167,088	54.8	<0.001
Forceps	18	3.4	14,404	4.7	
Vacuum	24	4.5	23,368	7.7	
Caesarean section	69	13.0	99,862	32.8	<0.001
Planned	7	1.3	60,079	19.7	
Unplanned	62	11.7	39,778	13.1	
Perineum[d]					
Intact	189	41.1	55,433	27.4	<0.001
1st degree tear	108	23.5	47,859	23.7	
2nd degree tear	123	26.7	53,475	26.5	
3rd/4th degree tear	17	3.7	4192	2.0	0.023
Episiotomy[e]	23	5.0	41,345	20.4	<0.001
Neonatal outcomes					
Apgar (≥7 at 5 min)	524	98.9	301,255	98.0	0.224
Transfer to SCN or NICU	27.0	5.1	43,159	16.0	<0.001

[a] AIHW 2015.
[b] Labour only (excludes elective caesarean).
[c] includes vaginal breech with no instrument for delivery.
[d] Vaginal only.
[e] 3× extended episiotomies (1 × 3A, 2 × 3B).

of women ($n = 11$) requiring a manual removal of placenta in theatre.

The neonatal admission rate to the Newborn Care Unit was 5.1% (SCN 3.6%; NICU 1.5%). The low admission rate was statistically significant when compared to the national figure of 16.0% ($p < 0.001$).

Table 3
Pregnancy complications.

	N	%
Pregnancy complications		
No	397	75%
Yes	132	25%
Condition		
Previous caesarean section	64	12.0
Twins	6	1.1
Diabetes diet/insulin	13	2.3
Hypertension/PET	6	1.1
Cholestasis	4	0.8
Antepartum haemorrhage	3	0.6
Multiple complications	9	1.7
Breech	9	1.7
Therapeutic termination	2	0.4
Reduced fetal movements	5	0.9
Preterm prelabour rupture of membranes	3	0.6
Intrauterine growth restriction	2	0.4
Intrauterine fetal death	2	0.4
Other	4	0.8

Table 4
Labour and birth complications.[a,b]

	N	%
Labour complications		
No	307	58.0
Yes	222	42.0
Complication		
Multiple conditions	25	4.7
Preterm	16	3.0
Twins	6	1.1
Prolonger rupture of membranes	30	5.7
Augmentation	15	2.8
Meconium liquor	24	4.5
Fetal distress	21	4.0
Undiagnosed breech	13	2.5
Prolonged 2nd stage	7	1.3
Failure to progress	30	5.7
Difficult shoulders/dystocia	3	0.6
Primary post-partum haemorrhage	16	3.0
Manual removal of placenta	11	2.1
Perineal repair in theatre	4	0.8
Other	1	0.2

[a] Includes pre-existing and pregnancy related complications.
[b] Classified according to Australian College of Midwives (2013) National Midwifery Guidelines for Consultation and Referral.

Approximately 40% of women were discharged home within a few hours of birth and not transferred to the postnatal ward.

4. Qualitative findings

4.1. Participant characteristics

The mean age of the participating six midwives was 45 years (range 36–54 years). This is just less than the national average age (47.9 years).[31] All the midwives were married with children aged between 7 and 35 years. Four of the six midwives still had dependent children living at home. On average midwives had been registered for 18.6 years (range = 13–24 years). All held tertiary qualifications with five having a Master of Midwifery degree.

The six midwives had been in private practice between 2.5 and 3 years although one midwife had provided a homebirth service for

Table 5
Breakdown of 3rd and 4th degree tears (N = 20).

Total 3rd and 4th degree tears 2012–31st May 2016	N	%
Parity		
Primiparous	15	75
Multiparous	5	25
Mode of birth		
SVB	10	50
Instrumental	10	50
Category[a]		
3A	13	65
3B	4	20
3C	2	10
4th	1	5
Episiotomy		
Episiotomy extended	3	15
1 × 3A		
2 × 3B		
Clinician		
Midwife	10	50
Doctor	10	50

[a] Australian Council on Healthcare Standards[45].

many years, caring for a few women each year as a private practitioner while employed by a public health service.

Seven themes were developed from the qualitative data that reflected the midwives views about the structures and processes contributing to clinical outcomes. Two were specific to the clinical outcomes achieved and four spoke to the processes and structures underpinning quality outcomes (Box 1).

4.2. Clinical outcomes: midwifery reflections

The interviews began by presenting the positive maternal and neonatal outcomes which included a number of statistically significant results (as per Table 2). The midwives were then asked to share their thoughts and opinions.

4.2.1. I'm so proud

All expressed being extremely pleased with the clinical outcomes achieved. Midwives considered the results to be '*excellent*' using words such as '*fantastic*' and '*great*'. In addition all expressed a sense of '*pride*' in what had been achieved by the group; '*I mean the caesarean section rate! that's the World Health Organisation's figure. I mean that's fantastic*' (PPM5). The positive nature of the outcomes also '*affirmed*' to midwives that providing continuity of midwifery care to women, within a caseload model, was the catalyst for such good results: *'The outcomes reflect the difference that continuity of care makes for the woman. Having a midwife she knows and trusts and has the relationship with*' (PPM1).

4.2.2. It's proof to others

In addition the midwives considered the positive outcomes to offer '*others*' a level of '*proof*' that the model produced quality: '*We know that continuity of care does give you good outcomes but it's actually good to see it written down particularly in light of us being under the microscope with everybody watching*' (PPM2). Midwives reflected that the results provided '*reassurance*' to others and as such made private practice caseload midwife a credible and viable alternative; '*We know that private midwives can do a great job. We know that continuity works*' (PPM5). Midwives considered the clinical outcomes to be a positive reflection on the midwifery profession and served to role model quality service provision to peers, students and newly qualified midwives. They also saw it as a way to '*encourage*' other midwives to consider private midwifery practice.

4.3. Processes of care: quality is all about enacting continuity

The processes of care describe what actually takes place in the giving and receiving of care. Included is the woman's decision making in choosing and accessing a model of care as well as the practitioners decision making in care provision. It is important to acknowledge that the strength of the quality, however, is interdependent on the structural influences such as the setting in which care takes place[24] which is described later. Regarding processes, the overarching message from the midwives was that quality care, and as such good clinical outcomes, were all related to the process of providing continuity and relationship based care. The relationship the midwife shared with the woman was both the context and method by which she provided care.

4.3.1. Prioritising the relationship

The midwives held strong views that their ability to care for women '*over time*' within a '*trusting*' relationship was the basis from which quality clinical outcomes were achieved. Midwives talked about how the extended relationships they shared with woman facilitated access to intimate knowledge about the woman's expectations and her life experiences that were likely to impact on the childbirth experience. Coming to understand the woman's worldview assisted midwives tailor care to her individual needs.

Positive longitudinal relationships with pregnant women subsequently became the vehicle through which midwives '*worked*' with women and partners to prepare them from labour, birth and the transition to parenthood. The ability to build a woman's knowledge, understanding and confidence for labour and birth was considered paramount in producing quality outcomes; '*By the time birth comes we've gone through everything*' (PPM4).

Extended care in the postnatal period was also mentioned by the midwives. All the private practice midwives provided individualised care generally up to six weeks after birth. The following quote from one midwife is reminiscent of others;

> '*Six weeks gives us time to get them through. For them to gain their confidence, bond with their babies and become parents and move on regardless of what actually happened through the birth. I think knowing someone is going to be there for them through that time makes a huge difference as well*' (PPM 6).

4.3.2. Working with others: being able to follow the pregnant woman through/across the system

The ability of midwives to '*officially follow*' women across the interface of care, ensuring continuity was maintained and prioritised, was considered an important element of producing quality outcomes. The midwives acknowledged the importance of working in partnership not only with women but also other health care providers. The midwives drew on their '*established*' informal and formal relationships with other midwives, obstetricians and doctors to assist and '*advocate*' for women as they '*negotiated*' a way forward and/or an '*alternate pathway of care*' (PPM 3).

Midwives considered this especially important within the context of women who had or developed complexities and/or were vulnerable or in some way disadvantaged. Using their expertise to help focus, where possible, on keeping things '*normal*' was considered an important part of their role.

Midwives perceived that working in this way again facilitated a woman's knowledge and understanding of '*all the options available to her*'. Supporting women to make informed decisions and '*take ownership*' was also part of this process. Midwives also believed that travelling 'with women' in this way reinforced to women their commitment to provide individualised care. As one midwife said, '*She knows someone is there for her*' (PPM 2).

4.3.3. Continuity facilitates flexible and fluid care during labour and birth

The ability to provide continuity of care across the intrapartum period to women in their care was considered '*absolutely paramount*' in producing quality clinical outcomes. Intimate knowledge of the woman gained through the midwife–woman relationship was used to focus on the women's strengths. Midwives perceived that women felt '*reassured*', '*supported*', '*confident*', and '*powerful*' when they had a 'known' midwife with them. Because of continuity midwives perceived they had an increased '*clinical awareness*' of the woman. Midwives also felt this gave them an ability to help the women adapt to the changing nature of labour. One midwife put it like this '*because they trust us more . . . we develop a better rapport throughput the pregnancy so that when it comes to birth it is much more fluid when it comes to caring for them at birth*' (PPM4).

Midwives talked about employing multiple care strategies to support and promote the normal physiology of labour and birth. In addition midwives stated that this type of care produced feelings of '*security*' and '*safety*', which they deemed important for normal birth. Within this context midwives felt women were much more

able to '*relax*' and '*work with their body*' increasing the benefits of the body's normal hormonal responses to labour. As one midwife said, '*If a woman feels secure and safe during her labour then that reduces fear. Reducing fear reduces sensations of pain*' (PPM1).

4.3.4. Organisational structures: support and belonging

Organisational structures relate to the clinical attributes of health personnel and the settings within which care occurs.[24] Midwives were therefore asked to talk about the 'structures' that facilitated their quality clinical outcomes. Two main themes emerged. The first was related to the midwives ability to form and sustain a 'successful' private caseload practice and the second was access to 'visiting rights' which facilitated their ability to offer continuity of midwifery care to women regardless of their choice of birth environment and/or developed complexities.

4.3.5. A private caseload practice

The midwives in this study were among the early adopters of the 2010 national maternity legislative reforms, which enabled midwives to access Medicare, the Pharmaceutical Benefits Scheme (PBS) and professional indemnity insurance product for women giving birth in hospital. When discussing the structures that supported quality outcomes midwives talked about their ability to access Medicare funding, the support they received from their professional indemnity insurance provider (MIGA), and their ability to prescribe medications. Being able to set up practice with other midwives they were aligned with and '*on the same page*' was also considered an important aspect of providing quality care.

4.3.6. Visiting rights: facilitating access to the system

Gaining 'visiting rights/access' (credentialing and a licence agreement) was considered an important part of being able to facilitate quality clinical outcomes for women wishing to engage the services of a private practice midwife. Midwives firstly acknowledged the work of Queensland Health in establishing processes across the state that facilitated midwives access to public maternity hospitals. Secondly, they paid tribute to local facilities that '*worked tirelessly*' to implement the government's recommendations.

> '*I am really grateful for the level of support and the processes that are in place in Queensland because it certainly makes a difference to the level of care that we are able to provide women. It makes a difference to their outcomes, it improves their outcomes. I think the outcomes we are seeing here is an accurate reflection of this*' (PPM1).

Being able to admit women to a maternity facility increased the woman's ability to '*move in and out of the mainstream system*' as well as improve access to '*seamless consultation and referral*' pathways that may be required. Being able to have '*early*' conversations with the multidisciplinary team about the care of women with potential complexities was an important component of this. For example one midwife said,

> '*We usually discuss women that are at high-risk prior to birth. I will usually take these clients to a meeting (complex care) and we discuss them and talk about a plan. I feel that's a good meeting. Everyone becomes aware before birth and we've made a plan and discussed it with the client*' (PPM 2).

Working positively with other health care professionals when providing midwifery continuity of care, as outlined above, was a characteristic of quality health care processes. Access to visiting rights, however, was the structural organisation unit that enhanced women's access to multidisciplinary care as well as facilitated positive working relationships.

> '*I've had four sets of twins, three of which gave birth vaginally. I facilitated this with the support of the medical team. I feel like I've built a trusting relationship with the medical and midwifery staff which means they tend not to worry*' (PPM 4).

In addition, as a result of visiting access private practice midwives were considered a '*recognised*' model of care within the service; '*When we do hospital tours and we walk around with women everyone says hello to you because they know who you are. They know us all. We don't always know them but they know us. The women feel safe and comfortable about that*' (PPM1).

Midwives also described becoming part of, and contributing to, the governance processes the service enacted. This again raised their visibility and profile within the service. Midwives were often asked to share their knowledge and expertise in different forums as well as being afforded access to educational opportunities and professional development through activities such as case reviews and reflections.

> '*It's great to be able to discuss things as a collective group of private practice midwives, other midwives and managers within the organisation and work out processes and improve pathways*'. (PM6)

However, the midwives acknowledged that not everyone '*was on board*' and working on widespread cultural change was a difficult task for any organisation; '*I think there are lots of clinicians who tolerate the model and there are some who openly verbalise that they don't support the model . . . we have to work around this*' (PPM5). At times this created difficultly and confusion for women and was equally not helpful to the private practice midwives who were focused on '*doing their best*' to support individual woman in their decisions and choices. One midwife shared how she dealt with these particularly difficult encounters when trying to facilitate quality care;

> '*There are some doctors that don't like working with us . . . some won't see our clients . . . they are difficult. It's hard but I try to challenge this. I try and force myself to see them because the more I see them and the more I work with them the better they'll understand how I work*' (PPM4).

There was also a hint of '*nervousness*' in the midwives dialogue. Having worked hard to build their practices midwives felt somewhat '*at the mercy*' of the organisation's leadership and worried what might happened if significant change at this level took place. This was definitely considered a '*threat*' to their existence and ability to offer women access to continuity of care.

Some of the material or resource inhibitors to quality related to not being able to remotely access the hospital systems and/or records. This was considered potentially problematic for ensuring effective and timely communication and contemporaneous documentation when working '*outside*' the system.

5. Discussion

This study reports on the maternal and neonatal outcomes of 529 women accessing a private midwife with visiting rights/access at one South East Queensland maternity facility. Although the sample size was small, when compared to the 300,000 women that give birth nationally each year, the clinical outcomes were extremely positive. For example the rates of spontaneous vaginal birth, in in this all risk model, were higher than those reported nationally, across Queensland[32] as well in the M@NGO trial[33] and COSMOS trial,[34] which was classified as a low risk model. While our results show more positive outcomes than those reported in randomised control trials (RCTs) the overall picture was consistent. The reduction in medical interventions thus lends weight to the generalisability of these trials and should give policy makers and

health service funders' confidence that the findings of the RCTs reflect outcomes from midwifery continuity models implemented in everyday practice. Rates of spontaneous birth, induction of labour and use of pharmacological pain management were, however, very similar to the only other published clinical outcome data for women provided with continuity of care by a private midwife with visiting access to a public maternity facility.[13] In the Wilkes et al study the outcomes of 323 women were similarly compared to core variables using national data. The stand out difference between this study and the Wilkes et al data was the lower caesarean section rate (13% vs 22%).

Routinely reporting and publishing clinical outcomes needs to become the norm for private maternity care and distinction should be made between private medical care and private midwifery care. Furthermore, regardless of whether care is provided in the public or private sector, the model of care women received should be defined and routinely reported. Developed as part of the National Maternity Data Development project, the recently published Maternity Care Classification System Data Collection Tool (MaCCS) aims to provide a comprehensive classification system for maternity models of care in Australia.[35] Once implemented, the new data reporting guideline should consistently identify and track the model of care the woman receives over her maternity journey[35] and facilitate more accurate analysis of outcomes relative to model of care.

5.1. Continuity and prioritising relational knowing

The midwives in this study were unequivocal and unanimous in attributing the positive outcomes to the depth and quality of the relationship between a woman (and family) and her midwife that develops over the course of the pregnancy, labour and birth and the transition to motherhood. The way midwives worked with women may be explained by the relational knowing that develops within the woman/midwife—dyad across pregnancy. Lyons-Ruth et al.[36] described relational knowing as a form of procedural knowledge regarding how to do things with 'intimate' others. Drawing on this theoretical stance, the implicit relational or mutual knowing that occurs between the woman and her caseload midwife intersect to create an intersubjective space in which both parties develop a sense of each other's ways of being.[36] In this way the midwife has an opportunity to come to understand and appreciate the way the woman interacts with others and her world and vice versa. Lyons-Ruth et al.[36] terms this the "real relationship". This allows the midwife to adapt her interactions to maximise the woman's learning as she works with the woman to build cultural knowledge and confidence for labour, birth and motherhood. In this way new ways of understanding are developed, expressed and elaborated on. Over time repeated interactions have the potential to shift expectations and anticipations facilitating the woman's own sense of agency or control over her body and the labour and birth process. The importance of 'relationship' to women choosing private practice caseload midwives has been recently confirmed in work undertaken by Davidson et al.[37] In this modified grounded theory the Western Australian authors concluded that women constructed their relationship with the private practice midwife as 'everything' and that feeling in control was paramount to having a positive experience.

5.2. Taking a salutogenic approach to providing maternity care

The findings of this study also suggest that clinician philosophy and approach was fundamental to achieving positive clinical outcomes. The private practice midwives identified a commitment to woman-centred care and a philosophy that values normality, inclusive of normal birth. Midwives clearly focused on the childbirth experience as a normal but significant life event. This approach is supported by Downe[38] who argues that 'salutogenesis' offers a framework for modern maternity services.

Individuals with a salutogenic orientation focus on health and wellbeing rather than illness and disease[39] and draw on internal and external resources to continually reframe their world as manageable, comprehensible and meaningful. It is suggested that midwives who work in this way are likely to support a woman's ability to harness her own internal resources (known as sense of coherence) to resolve tension and promote wellbeing.[38,40] Support for this hypothesis has been recently provided by Australian researchers Ferguson et al.[41] In their longitudinal study they explored associations between pregnant women's sense of coherence (SOC), their birth outcomes and factors associated with any change in SOC. Pregnant and postpartum women with high levels of SOC displayed flexibility in decision making that helped them manage stress.[41] In addition these women were more likely to seek out useful support, have comparatively better emotional health, including a reduction in symptoms of depression, anxiety and stress. Women with high levels of SOC were also more likely to make choices that were consistent with wanting a normal birth. Furthermore women with high SOC were half as likely to experience a caesarean section than women with low SOC.[41] Adopting a salutogenic approach may, therefore, be critical to providing maternity care that achieves high rates of spontaneous vaginal birth and acts as a point of counter-culture in an otherwise heavily medicalised maternity system.

Relational knowing that is fostered within continuity and adopting a salutogenic orientation to maternity care is also likely to explain how midwives and women construct and negotiate 'risk' and thus how outcomes were impacted. There is support for this in the qualitative work of Dove and Muir-Cochrane.[42] Using a critical ethnographic approach, these Australian researchers examined how midwives ($n = 8$) and women ($n = 17$) within a continuity of care model conceptualised childbirth risk and the extent to which this influenced women's choices and midwives' practice. The authors reported that the midwives in their study assumed a risk-negotiator role in order to mediate relationships between the women in their care and hospital-based maternity staff. They suggested that this role relied heavily on the trust cultivated within the ongoing midwife—woman relationship. Dove and Muir-Cochrane[42] developed this line of thinking further by hypothesising that the mutual trust afforded by the relationship acted as a catalyst for the complex processes of identity work, defined as the '*processes through which the relationship facilitates the active and collaborative construction of identities as "safe mothers" and 'safe practitioners' in response to mainstream perceptions of riskiness*' (p1066). As a result the authors argued that midwives were able to re-order existing obstetric risk hierarchies thus redefining risk conceptualisations. In this way midwives established greater scope for the negotiation of normal within the context of obstetric risk mitigating the effects of obstetric risk practices and improving the outcomes for the women in their care.[42] The authors concluded, however, on a cautionary note stating that midwives undertaking a risk-negotiator role must simultaneously work hard to negotiate their own professional credibility as the current maternity setting is likely to interpret their practice as risky; something that the private midwives in this study alluded to.

5.3. Supporting visiting access for private practice midwives—promoting safety

Finally, the findings of this study make it clear that providing private midwives with hospital visiting access promoted multi-disciplinary care, facilitated women's access to appropriate resources, when required, ensured continuity of care was achieved

and supported quality clinical outcomes. A significant enabler to the sustainability and quality of private caseload midwifery models may be the health service's quality improvement systems and processes. In this study the midwives mostly felt well supported, integrated into the service and valued the governance processes around the model; none of which especially singled them out. Midwives considered the governance processes fostered effective teamwork, interdisciplinary relationships, promoted problem solving, communication and information sharing. Having said this, there was evidence that there was some continued resistance to private midwives and philosophical differences that others have reported.[43] Midwives were clearly cognisant of the challenges they faced. In line with Reiger and Lane's[43] suggestion that mutual learning can take place in these contested interactions, midwives used collaboration as an opportunity to employ strategies to help foster trust, mutual respect and accountability.

6. Conclusion

Facilitating Medicare eligible private practice midwives access to the public maternity system enables women's access to safe continuity of midwifery care. Although the numbers are still small the outcomes of women accessing this model were extremely positive when compared to national perinatal data and other published data sets. High rates of spontaneous labour and vaginal birth and low rates of intervention as well as low rates of neonatal admissions to the nursery, within the context of a high nulliparity profile, are notable. Midwives perceived continuity of care to be fundamental to the development of positive midwife—woman relationships through which relational knowing was enacted and a salutogentic approach adopted. Governance processes around the model that supported and promoted a sense of belonging to, and identity within the service were acknowledged as important and highly valued by the midwives. The potential impact of private practicing midwives to align maternity care with the best available evidence is significant.

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