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SHORT REPORT

Midwifery-led care embedded within primary care: consumer satisfaction with a model in New Zealand

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ABSTRACT

INTRODUCTION: Providing quality maternity care for high-needs, socially deprived women from ethnic minority groups is challenging. Consumer satisfaction with maternity services is an important aspect of service evaluation for this group. This pilot study aimed to investigate the feasibility of using focus groups and interviews to gauge consumer satisfaction of maternity care by high-needs women, and to explore their perceptions of the Newtown Union Health Service (NUHS) model of a midwifery-led service embedded in primary care in Wellington, New Zealand (NZ).

METHODS: Following a previous audit of consumer satisfaction surveys collected over a six-year period, a qualitative pilot study using a thematic analytic approach was conducted at the NUHS in late 2011. The study assessed use of focus groups and interviews, interpreted where necessary, and considered the experiences reported by women about the model of care.

FINDINGS: Interviews and focus groups were successfully conducted with 11 women: two NZ European (individual interviews), six Cambodian (five in a focus group, one interview), and three Samoan (focus group). Using a thematic analytic approach, key themes identified from the focus group and interviews were: issues with survey form-filling; importance of accessibility and information; and relationships and communication with the midwifery team.

CONCLUSION: Interviews and focus groups were well received, and indicated positive endorsement of the model of care. They also revealed some hitherto unknown concerns. Good quality feedback about satisfaction with a range of maternal and child health services helps service providers to provide the best possible start in life for children in high-needs families.

KEYWORDS: Interprofessional; maternity care; New Zealand; patient care team; primary health care

Introduction

Reducing health inequalities is a major New Zealand health service goal,[1,2] and providing quality maternity care for high-needs, socially deprived women from ethnic minority groups is challenging.[3] The predominant model for care is the Lead Maternity Carer (LMC) system. Midwives work independently of other primary care providers and are free to accept women for care on a case-by-case workload basis[4] to provide continuity of maternity care. In contrast to other primary care services funded on a registered-population basis,[5] midwives are not responsible for a particular population of women. Hospital-based care is provided for high-risk/emergency maternity care, but also acts as the 'default' when women are unable to access LMC care for whatever reason, including those who have 'fallen through the cracks' and received no antenatal care. Disadvantaged women and those from ethnic minorities are less likely to receive LMC care; over a third of Samoan women had no LMC care in 2010.[6] Half of all New Zealand women who register with an LMC do so late (after 13 weeks' gestation), thereby compromising antenatal care.[6]

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The LMC system of fixed-funding-per-woman for primary maternity care is appropriate for the majority, but is not well suited to women with high health or social needs and/or complex pregnancy-related problems, when a coordinated range of health professional expertise is needed.[3,7] Unlike other primary care funding, there is no weighting for high-needs, deprivation or ethnicity; patient co-payment is neither desired nor permitted. Considerable health inequalities exist in New Zealand, most affecting children, ethnic minorities, and low-income, high-needs people,[8] so this is an important problem.

Newtown Union Health Service (NUHS) has provided very-low-cost primary health care services for low-income, high-needs people for 20 years. Seventy percent of registered patients fall in the most deprived quintiles (4/5) of the New Zealand Deprivation 2006 Index (NZDep2006).[9] Ethnic minorities are over-represented, particularly Pacific, Asian and African migrants.[10,11] As part of a 'wrap-around service', a small team-based approach[12] to midwifery care (where women have one 'main' midwife but may on occasion see another midwife in the five-person team) was developed, integrated with child health and other primary care services.

The New Zealand College of Midwives (NZCOM) consumer satisfaction survey[13] had been distributed for several years at NUHS, but use had not been critically reviewed for a high-needs population. Consumer satisfaction surveys of maternity care are known to have methodological limitations,[14] and low return rates make findings unreliable. Problems identified elsewhere include the lack of an agreed definition of 'satisfaction',[14] and a tendency to be satisfied with the status quo without a point of comparison.[15]

An audit of consumer satisfaction data collected over the six-year period 2006–2011 at NUHS had been undertaken. This confirmed that for the 878 women cared for by the maternity service over the period (including 592 [67%] women from ethnic minority groups), response rates were unacceptably low (192/878; 22%).

This subsequent pilot study investigated the feasibility of using focus groups and interviews to gauge maternity care satisfaction by high-needs women, and explored their perceptions of the NUHS model—team-based midwifery, embedded within a primary care service serving an inner city, high-needs population.

Table 1. Questions used in focus groups/interviews

List of questions (with prompts as necessary) used in focus groups/interviews

1. **Overall, how did you find your experience with the NUHS midwives?**
   a. Prompts: During pregnancy? Birth? After the birth?
   b. How was the amount of information given?
   c. How did you find the team structure?
2. **How did the midwives treat you and your family?**
   a. Prompts: What were some positive things? What were some more negative aspects?
   b. How did you find the balance between medical tests and checks and allowing natural processes to occur?
3. **How well did the midwives work together with the other health professionals involved in your care?**
   a. Prompt: For example, the transfer to GP and Well Child provider after discharge?
4. **How accessible were the midwives to you?**
   a. Prompt: How easy or difficult was making contact to get help when needed?
5. **How did you find the written survey forms?**
   a. Prompts: Did you receive one? Did you return it?
   b. Were there any issues with language?
   c. Were there areas for improvement?
6. **How did you find other sources of advice or health care?**
   a. For example, family/friends/traditional cultural methods of care?
   b. GP, social worker, community worker?
   c. Lactation consultant?
7. **How did you find out about NUHS midwifery services? For example,**
   a. GP referral?
   b. Family/friends?
8. **What could be improved about the midwifery service?**

NUHS Newtown Union Health Service

GP General practitioner

Methods

Women from three ethnic groups were selected, to gain further insight into satisfaction

with the service. New Zealand European (NZE) women, Samoan women (migrants) and Cambodian women (recent migrants) were contacted in consecutive order from a list of eligible women. Eligible women were those who had used NUHS midwifery services between 2006 and 2011 throughout pregnancy and, starting with recent users, were invited to participate in an interview or focus group. Information sheets and consent forms were sent out to interested women until at least two were recruited from each ethnic group. Each was contacted days later to confirm involvement and focus group or interview choice. Co-facilitators, able to interpret and address cultural needs, ran the Cambodian and Samoan groups; researchers themselves played no active part. For telephone interviews, a copy of the consent form was sent to participants and verbal consent obtained. All recruitment and data collection took place over five weeks. Question topics related to overall experiences, positive and negative aspects of care, the midwifery service and structure, and sources of advice and information (Table 1).

Interviews and focus groups were audiotaped, transcribed and coded to identify key themes, using Boyatzis' thematic analytic approach.[16] Themes were derived wholly from the qualitative data, and analysed horizontally across each group to create categories. Themes and categories were reviewed and discussed by the research team until consensus was reached.[16,17]

Ethical approval for the study was obtained from the Central Regional Ethics Committee (Ref. CEN/11/EXP/065).

Findings

Interviews and focus groups were successfully conducted with 11 women; two women were NZE (individual interviews), six women were Cambodian (five in a focus group, one interview), and three women were Samoan (focus group).

Key themes identified were: issues with form filling, information, accessibility to midwifery advice and care, relationships and communication, and midwives working as a team. Within themes, categories emerged. Quotes from focus groups and interviews illustrate each of the themes (Table 2). Of note are negative perceptions of the value of written surveys, a preference for oral feedback, appreciation of good communication and the collaborative nature of the embedded service, and mixed responses to the team approach, especially from the most recent migrant (Cambodian) women.

WHAT GAP THIS FILLS

What we already know: Providing quality maternity care for high-needs, socially deprived women from ethnic minorities is challenging. Such women often face language and cultural barriers, which can compromise care, and this makes gauging their satisfaction with health services difficult.

What this study adds: Gauging consumer satisfaction for high-needs women's maternity care is important and requires attention; a variety of methods are needed. Focus groups and interviews can provide valuable feedback about care experiences. Women enrolled in a high-needs primary care service engaged with a qualitative evaluation process and indicated satisfaction with a primary care–embedded model of maternity care.

Discussion

This study has explored satisfaction with maternity care among women from ethnic minority groups cared for by a midwifery team, embedded within a primary care service catering for a high-needs population. Interviews and focus groups, interpreted where necessary, show promise in gaining important information about the value (or otherwise) of the service. The use of facilitator–interpreters to conduct focus groups and interviews allowed for frank verbal exchange in a fluent language.

This pilot study was limited by the small number of participants, and a need to give choice to participants about interview or focus group participation. Nevertheless, data quality proved sufficient to reach data saturation for key themes. Communicating with non-English-speaking women was inevitably more difficult than with English-speaking women, but was mitigated as far as possible by using professional interpreters who were carefully briefed to encourage discussion.

Overall, consumer satisfaction with the service was extremely positive, but some previously

Table 2. Focus group/interview themes and categories, with illustrative quotes

Themes and categories	Quotes
Issues with surveys and form filling	
• The survey forms were not considered important. • They were described as too long and unlikely to be filled in even when English was well spoken. • When English was not good or a second language, form filling would be even less likely.	'The survey forms put people off if there is lots of writing on it... being Pacific people we are very oral. I want someone to tell me and give you an answer right now... someone else will have to write it ...paperwork is not in our Pacific culture.' (Samoan #1)
Information about pregnancy and birth	
• The base level of information given was described as excellent. • When anything happened outside of the normal birth plan, the women felt relatively unprepared.	'You get as much information as you need for a textbook birth.' (New Zealand European #1) 'Please try to put [yourself] in our shoes... that this is our very first baby and we haven't had any experience... and that [you] are full of experience. Please pass on that experience.' (Cambodian #1).
Accessibility to midwifery advice and care	
• The midwives were described as always nearby; Saturday clinics and home visits were a highlight of care. • Collaboration across the whole service was appreciated.	'[They were] there for me any time of the day or night.' (New Zealand European #1) 'Travelling over to see us make us feel really... really make the memory.' (Cambodian #2). 'It's so good knowing that if something happened... I've got my doctor just around there... and they've got my record.' (Samoan #1)
Relationship with midwives	
• Overall, the women described the midwives as providing a friendly, supportive and encouraging environment. • There was preference for having a midwife of the same ethnicity or background.	'They were like a big part of our family.' (New Zealand European #1)
Communication	
• Communication was considered very good overall. • Poor communication was more likely with a midwife from a different ethnicity or background from the woman.	'I [now] just stay quiet and never ask any questions.' (Cambodian #1) 'You felt like she should have listened to you more... because that was my number six baby and I know my body.' (Samoan #2)
Midwives working as a team	
• The New Zealand European women saw the benefit of the team structure as acting as a 'safety net' to ensure a high quality of care. • The team approach was described by the Cambodian refugee group as a potential barrier in forming a strong relationship with the midwives.	'First pregnancy I see [an independent midwife] all the time... so she knows my history... don't need to repeat myself. ...But when I come here [NUHS] I see a few different women... I try to arrange to get the same one... but it's hard so most of the time [I] have to repeat what is happening.' (Cambodian #3)

unrecognised concerns emerged. In contrast to NZE and Samoan women, the Cambodian group found midwives (none of whom were of similar ethnicity) more difficult to relate to, consistent with other studies about contrasting ethnicity of health professionals and patients.[18]

Cultural competence is recognised as a necessary skill for health professionals in New Zealand.[19] Participants spoke of this being excellent in many aspects of care but needing attention in others. Cross-cultural care is challenging at NUHS because of the wide range of ethnicities repre-

sented; it is not possible to have a midwife of the same ethnicity for every woman. NUHS already lead professional development in this area;[10,11] findings indicate that further attention to more complex aspects of cultural competency may still be needed.

However, additional services provided (e.g. interpreters, health and social service coordination) have proved difficult to sustain within the current funding model. The standard LMC flat fee makes no allowance for the complex coordination of care and/or interpreting/translation services required, yet such care is especially important for these women if their children are not to be further disadvantaged. Well-received, quality primary care services, with embedded midwifery services and modest additional funding for high-needs people, has the potential to provide excellent continuity of maternal and child care. This model ensures that all women enrolled in the primary care practice automatically access an LMC midwife. Such services are likely to be considerably cheaper than the default hospital-based care with limited continuity.

Further research is warranted to further investigate and develop effective, culturally sensitive, interview-based models for assessing consumer satisfaction among high-needs women about their maternity care experiences in New Zealand.

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COMPETING INTERESTS
None declared.