

Lead maternity care needs to be embedded in general practice

YES

Lead Maternity Care model has limitations

The Lead Maternity Care model fails to provide good maternity care for the most vulnerable women. Whilst in 2011 87% of all women had a lead maternity carer (LMC), only 65% of Samoan women had an LMC, and for all women who had an LMC only 61.8% (45% of Māori and 35% of Pacific) registered in the first trimester.¹ Satisfaction with maternity care has been assessed by the Ministry of Health through consumer surveys.² Over three-quarters (78%) of women surveyed were satisfied with the overall maternity care they received. This fails to give an accurate picture, however. In the most recent survey, only 9 out of the 3235 women who responded did not have an LMC.² Response rates for Māori and Pacific were significantly lower than average, and despite being the district health board (DHB) with the largest number of births, the response rate from Counties Manukau DHB was only 26%, compared with 42% for the whole survey.

Important factors behind these failings are the structure of the Lead Maternity Care model and

the funding of this programme. There is no system to ensure universal access to maternity care. LMCs are only responsible for the women that they accept for care, unlike childhood immunisation, where every baby in the country has a general practice responsible for their immunisation.

Funding and availability

The LMC is paid the same amount for every pregnancy, apart from a small subsidy for mileage for postnatal visits. The fee is the same for an educated, English-speaking, motivated, multiparous woman with a car, as it is for an illiterate, non-English speaking, 'chaotic', addicted, primiparous woman with no transport. Flat funding may be alright if it applies to a large enough population so that the average fee is adequate, and each provider has women with the full range of needs from low to high needs. Most LMC midwife providers have small populations, so this is unlikely to apply. Given that there is not an oversupply of LMC midwives and that their sole income is from government, it would be surprising if there were not some selection bias by LMC midwives towards women not requiring so much input. It would be hard to get reliable data on individual LMCs, but on a national level availability of LMC midwives is lower in areas of higher deprivation (in Counties Manukau DHB 66.8% have an LMC), and of geographical spread (in

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BACK TO BACK this issue:



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While evidence can help inform best practice, it needs to be placed in context. There may be no evidence available or applicable for a specific patient with his or her own set of conditions, capabilities, beliefs, expectations and social circumstances. There are areas of uncertainty, ethics and aspects of care for which there is no one right answer. General practice is an art as well as a science. Quality of care also lies with the nature of the clinical relationship, with communication and with truly informed decision-making. The **BACK TO BACK** section stimulates debate, with two professionals presenting their opposing views regarding a clinical, ethical or political issue.

West Coast DHB 34.3% have an LMC), compared to a national average of 87.3%.¹

Effects on efficiency and accessibility

The small, single professional, business model of midwifery care precludes some advantages of working with a larger team. A particular limitation is that, in my experience, midwives are still using paper-based records, at least to some degree. This makes communicating between midwives and other practitioners harder (our DHB uses electronic referrals; copies of notes cannot be transferred electronically between midwives and general practice) and receiving reports (such as discharge letters, laboratory reports etc.) more time consuming.

Finding a midwife can be problematic. The study by Makowharemahihi et al.³ of the pregnancy experience of 44 young Māori women observed that, whilst pregnancy was diagnosed by other primary care providers (general practitioners [GPs], youth health, school clinics), the transition to an LMC was often fragmented and a seamless pregnancy pathway was inhibited.

Maternity care in Counties Manukau DHB has been reported in an external review as not always easy to access.⁴ If LMC care were embedded in general practice, it could have a significant impact on all of these problems.

Population care

General practices care for a registered population. If LMCs were embedded in general practice, then in the same way as every baby has a practice responsible for their immunisation, every pregnant woman would have a practice responsible for their maternity care. This would make transparent where 'job vacancies' were (those practices with insufficient midwives). It would also mean that from the time of pregnancy diagnosis, the woman would know who would care for her pregnancy.

General practice already has funding targeted towards higher needs people and a larger budget to cushion some of the budgetary 'ups and downs'. Embedding LMCs in general practice would allow for some economies of scale in providing

management services, information technology support, reception services and premises. Sharing a medical record would decrease some duplication of effort and improve communication with other practitioners.

Teamwork

General practices have increasing access to a larger primary care team, either within the practice or through the primary health organisation (PHO). Midwives working at Newtown Union Health Service regularly used our staff interpreter, the social worker, and had easy access to other staff, particularly the practice nurses and doctors who already had relationships with the mothers.

Pregnancy does not happen in isolation. It is part of a life. Integrating services makes it easier to maintain accurate contact records and to opportunistically ensure care occurs; an antenatal check when another child is brought in, or a follow-up of a mental health problem when a woman presents for antenatal care, for example. The fragmented transition to an LMC could be overcome. It seems anachronistic to have a model of antenatal care that is disintegrated, at a time when we are trying to increase the integration of primary care.

I have spent most of my practising life working at Newtown Union Health Service in Wellington, with a team of midwife colleagues a part of my practice team working under the same roof. I better understood the nature of their work, and valued the corridor consultations and the ease of discussion when a pregnant woman presented to me with other medical issues. Despite being one of the more challenging maternity practices in the country, our evaluation of consumer satisfaction with the service indicated high levels of satisfaction.⁵

The current model fails to meet the needs of our most vulnerable women. Midwives are an essential element of primary care. Embedding midwives in general practice, to be part of a primary care team, has the potential to improve the pregnancy care for these vulnerable women in particular.

References

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NO

The suggestion that lead maternity carer (LMC) care needs to be embedded into general practice requires a considered response. The *Collins Concise Dictionary* definition of ‘embedded’—‘to become fixed firmly and deeply in a surrounding solid mass’—does not sound like the ideal world for most women who are excited to be pregnant and looking forward to becoming a parent. Parenting opens a new world of responsibility that requires enormous amounts of decision-making and some would say courage. If a fixed surrounding is what is meant by embedded, then this would not work for community midwifery services, or indeed pregnant women and their families. If it means a fixed emphasis on general medical practice, rather than primary maternity care, then this is not helpful to primary health service either. Pregnancy is not a medical event but a fundamental life event.

On the other hand, to be integrated or ‘made into a whole, to amalgamate or mix with an existing community’ sounds a much healthier prospect and a better platform for developing good health habits and self-determination for a lifetime of parenthood. Integrated health services don’t require a fixed abode or a ‘one size fits all’ approach. It requires access, collaboration, cooperation and respect between services.

Integration is a commonly used term and there has been much emphasis on ‘integrating’ services

within the health sector. However, the focus of this integration has often been at an organisational level, rather than integrating services around the individual who is the recipient of health services. The ideal platform for all health services is that the person is in the centre of all activity and that they can make the transition from one service to another in a seamless fashion. For the New Zealand (NZ) pregnant woman and her family, this integrated woman-centred service is manifested in the role of the LMC. The LMC is the specialist organiser or navigator of care during the maternity episode, much like general practice is the navigator for access to specialist medical care for patients. For most women, the LMC will also be the provider of the primary health midwifery services, and for over 89% of women, the LMC will be a midwife.¹ This enables most women to have continuity of midwifery care from a known midwife chosen by the woman for the duration of her maternity care. The LMC (or her ‘back-up’) is responsible for that woman’s care on a 24-hour basis. Most general practices would struggle to provide this level of coverage.

Midwifery education is the equivalent of a four-year degree programme, where the last student year is spent almost entirely apprenticed or working with experienced LMCs and hospital midwives across all settings. The first year of practice for all new graduates is a mentored one. All midwifery degrees have a strong biomedical, physiological, behavioural and evidence-informed curriculum that is provided in a cultural and

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