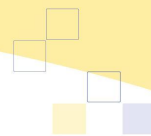


MCP²

Multidisciplinary
Collaborative Primary
Maternity Care Project

Projet de soins
primaires obstétricaux
concertés



SUMMARY OF

Current Practice in Europe and Australia

A Descriptive Study

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Overview

As stated in the document produced by the International consultants, the objective of their work was to describe in detail the collaborative models of maternity care as documented in the five selected countries. These countries are France, Germany, The Netherlands, Sweden and the United Kingdom. Australia was added to the list because of the important role that GPs play in the Australian models of maternity care.

The following tables summarize the report highlighting specific topics for those who are interested in collaborative maternity care models.

The specific topics are:

- Most common current model of maternity care – a comparison of the various health care providers in each of the selected countries.
- Population comparison by country – a comparison of the overall population and the female population (childbearing years) in each of the selected countries. Data from Canada has been included in this comparison. As well, additional information follows the table that provides country specific statistics.
- Health Care Providers comparison by country – a comparison of the maternity health care providers in each of the selected countries. Information from Canada has also been included in this comparison. As well, additional information follows the table that provides country specific statistics.
- Models of Collaborative Maternity Care by country – this table provides the examples of collaborative models by selected country in summarized form.
- Barriers to Collaboration – This table highlights eight barriers to collaboration and identifies which ones affect each of the selected countries.
- Remuneration of Care Provider – a comparison of the remuneration system for care providers in each of the selected countries.

Most Common Current Model of Maternity Care

Country	Target population	Antenatal	Intrapartum	Postnatal	Continuity of care*
Netherlands	Low-risk pregnancies	Independent midwife	Independent midwife	Independent midwife, maternity home care assistant	Yes
	High-risk pregnancies	Referred from independent midwife to Obstetrician (and midwives) in hospital	Obstetrician (and midwives) in hospital	Obstetricians and nurses in hospital, independent midwife and maternity home care assistant at home	Partly
United Kingdom	Low-risk pregnancies	Community midwife or midwives in hospital	Midwives in hospital	Midwives in hospital and community midwives at home	Partly
	High-risk pregnancies	Obstetricians and midwives in hospital	Hospital obstetricians and midwives	Midwives and hospital and community midwives at home	No
Sweden	Low-risk pregnancies	Midwife in maternity care centre	Midwives in hospital	Midwife in maternity clinic	Partly
	High-risk pregnancies	Obstetricians and midwives in hospital	Midwives, obstetricians in case of instrumental delivery or CS	Midwives in hospital and midwives of the maternity clinic at home	No
Germany	Low-risk pregnancies	Private practice obstetrician and/or sometimes independent midwife	Hospital midwives and obstetricians or midwives or obstetrician with hospital privileges	Hospital midwives or midwives with hospital privileges (if necessary also obstetrician) and independent midwives at home	No
	High-risk pregnancies	Gynaecologist and sometimes midwife in private practice or in hospital	Midwives in hospital, obstetrician almost always attend the birth	Midwives and obstetrician in hospital, independent midwives at home	No
France	All pregnancies	Midwife and/or medical gynaecologist and/or gynaecologist-obstetrician and/or GPs	Midwives and gynaecologist-obstetricians in hospital	Independent midwife or hospital-based midwife, at home	No
Australia	All pregnancies	Midwife and/or obstetricians and/or GP	Midwives and obstetrician in hospital	Midwives in hospital and independent midwives or midwives employed by the hospital, at home	Partly

*Continuity of care indicates the intention of continuity in the type of care provided in the model (this entails good communication between the various care providers) and not necessarily continuity in care provider.

**Population Comparison by Country
(2005 Estimates)**

Statistics	Netherlands	United Kingdom	Sweden	Germany	France	Australia	Canada
Total Population	16,407,491	60,441,457	9,001,774	82,431,390	60,656,178	20,090,437	32,805,041
Female *(% of total population)	8,283,131 *(50.5%)	30,558,236 *(50.6%)	4,542,962 *(50.5%)	41,986,461 *(50.9%)	31,069,475 *(51.2%)	10,090,754 *(50.2%)	16,589,088 *(50.6%)
0 – 14 years	1,453,232 ** (17.5%)	5,229,691 ** (17.1%)	747,621 ** (16.5%)	5,766,065 ** (13.7%)	5,440,060 ** (17.5%)	1,943,563 ** (19.3%)	2,869,244 ** (17.3%)
15 – 64 years	5,491,802 ** (66.3%)	19,855,862 ** (65.0%)	2,904,873 ** (63.9%)	27,003,958 ** (64.3%)	19,752,432 ** (63.6%)	6,695,189 ** (66.3%)	11,244,356 ** (67.8%)
65+ years	1,338,097 ** (16.2%)	5,472,683 ** (17.9%)	890,468 ** (19.6%)	9,216,438 ** (21.9%)	5,876,983 ** (18.9%)	1,452,002 ** (14.4%)	2,475,488 ** (14.9%)
Estimated # of Births	182,779	651,559	93,258	686,653	736,973	246,309	355,607

* Percentage of country's total population.

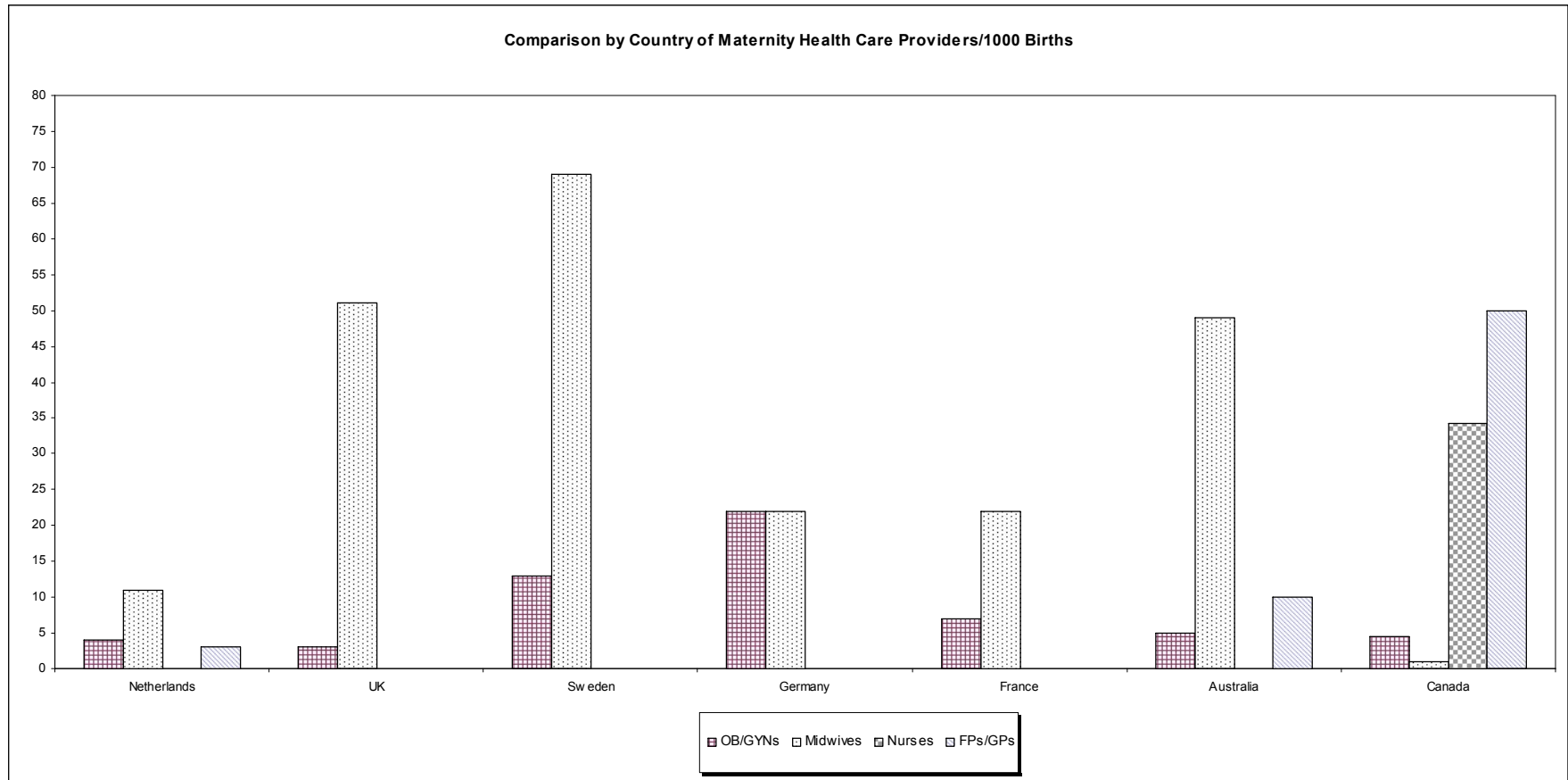
** Percentage of country's total female population.

Netherlands - 66% of the population (10,828,944) lives in urban areas.

Sweden - 85% live in the southern part of Sweden (7,651,508) and are largely concentrated in three cities.

Germany - One-third (27,477,130) of Germany's population lives in 84 large cities. The balance (54,954,260) live in small towns and villages with populations of 2,000 – 100,000.

Comparison by Country of Maternity Health Care Providers/1000 Births



Maternity Health Care Providers – Comparison by Country

Country	Health Care Providers			
	Obstetricians/Gynaecologists	Midwives	General Practitioners*	Nurses/Nurse Practitioners
Netherlands (2004)	806	1,955	594	Not Applicable
United Kingdom	1,676	33,142	0	Not Applicable
England	1,466	26,617	Not Applicable	Not Applicable
Northern Ireland	57	1,311	Not Applicable	Not Applicable
Scotland	153	3,554	Not Applicable	Not Applicable
Wales	Included in England	1,763	Not Applicable	Not Applicable
Sweden (2001, 2005)	1,202	6,400	Not Applicable	Not Applicable
Germany (2003)	15,384	15,000	Not Applicable	Not Applicable
France (2004)	5,207	16,134	Not Applicable	Not Applicable
Australia (1999, 2003)	1,245	11,985	2,500	Not Applicable
Canada**	1,270	430	17,615	12,167

*General Practitioners who practice obstetrics/midwifery.

**Statistics for Family Physicians in Canada taken from the NPS 2004. The statistics for Obstetricians/Gynaecologists and Nurses in Canada providing some form of maternity care comes from ‘Giving Birth in Canada – Providers of Maternity and Infant Care’ produced by the Canadian Institute for Health Information.

Netherlands – 20% of midwives are hospital employed and there are 450 midwifery practice associations.

United Kingdom - 44 midwives have a private practice (forty in England, one in Northern Ireland and three in Scotland). 61% of midwives (20,217) work part-time. 10% of consultants do not practice obstetrics only gynaecology.

Sweden – 99% of midwives work in the public sector.

Germany - One third of midwives work independently, one third of midwives are hospital employed and one third of midwives work independently and in a hospital.

France – 44% of midwives are employed in hospitals, 18% are employed in private institutions and 11% practice independently. 60% of OB/GYNs work in private practice and 32% work in hospitals.

Australia – 10% of OB/GYNs are not in active practice and half are practising obstetrics in the private sector.

Models of Collaborative Maternity Care by Country

Country/Model	Providers within the Model	Highlights
Netherlands		
Maatschappen (practice association)	Midwives	<ul style="list-style-type: none"> •Royal Dutch Organization of Midwives has developed a standard contract of association. •Collaboration between practices of midwives is a model that is being seen more and more. •Midwives are entering agreements with colleagues in neighbouring practices, which define the terms of collaboration and the reimbursement for services rendered.
Verloskundige Samenwerkingsverbanden, VSV (midwifery/obstetrics collaborative partnerships)	Independent Midwifery, clinical midwifery, midwifery GPs providing maternal care, obstetricians, paediatricians and home maternity care assistants.	<ul style="list-style-type: none"> •Concentrates on agreements concerning the quality of care provided to mothers and newborns during the entire childbearing period. •Agreements concerning the organization of the local chain of maternity care. •Makes transparent agreements between the various providers in the various levels of care.
Districts Verloskundige Platforms, DVP (district midwifery/obstetrics platforms)	Independent midwifery, clinical midwifery, midwifery GPs providing maternal care, obstetricians, paediatricians, home maternity care assistants, consumer groups, regional policy makers and insurers.	<ul style="list-style-type: none"> •Provides a forum for making agreements about long-term policy and information sharing and discussions in areas of shared interest within the region. •Topics that could be placed on a DVP agenda are; proposed hospital mergers, availability of ambulance and emergency services and regional agreements with insurers.
Independent Midwifery Practice (addition of Practice Assistant)	Midwife, practice assistant	<ul style="list-style-type: none"> •takes care of all administrative work and can sometimes carry out some examinations (weight, blood pressure) depending on previous training. •Costs for a practice assistant have recently been included in the newest national agreements of midwifery reimbursements.
Parent and Child Centre	Midwives, maternity home care assistants, well-baby clinics and care providers of parental support and child development stimulation.	<ul style="list-style-type: none"> •The midwives are not employed by the partnership, but work with the centre from their private practices.
United Kingdom		
Ashington Model of Care (Northumberland)	Midwives, advanced neonatal nurse practitioner and a specialist department.	<ul style="list-style-type: none"> •This service was developed to accommodate the needs of this particular geographic area.
Edgware and Crowborough Birth Centres	Midwives	<ul style="list-style-type: none"> •Environments which allow midwives to use their skills effectively and provide an alternative to home or hospital births. •The Edgware Birth Centre is a stand alone, NHS midwife-led unit for women, selected according to strict risk criteria.

Country/Model	Providers within the Model	Highlights
Guy's and St. Thomas' Hospital	Midwife, obstetric consultants	<ul style="list-style-type: none"> •Developed a strategy to modernize the maternity services provided. •Work is undertaken by a multidisciplinary group, in consultation with local user groups, staff and Primary Care Groups. •Vision is of a community-based service, with 17 integrated midwifery practices closely allied to primary care staff. •Midwives provide continuity of care. All women receive one-to-one care in labour from a midwife from their midwifery practice. •There are two birth centres: a home-from-home birth centre led by consultant midwives and a hospital centre for requiring complex care.
South Manchester/Mancunian Community NHS Trust	Special needs midwife	<ul style="list-style-type: none"> •Provides domiciliary family planning and maternity care to vulnerable women, such as women who are homeless, very young, disabled, suffering domestic violence, or with mental health problems. •Provides continuity of carer and individualized care to meet each woman's needs. •Liaises with relevant agencies, works with primary healthcare team, develops training packages and provides a point of expert advice.
King's College Hospital (two different systems of maternity care working alongside each other)	Midwives	<ul style="list-style-type: none"> •The first model of care is a traditional model with midwives working in the hospital and in the community. •50 hospital-based midwives work in shifts at the antenatal clinic, labour ward or the antenatal and postnatal ward. •There is virtually no continuity of care. •The second model involves eight midwifery practices linked to the Hospital. •Midwives work in small teams providing antenatal and postnatal care in the community. Midwives follow their patients into hospital for delivery. •Most practices also perform home births, with average home birth rates up to 57%.

Country/Model	Providers within the Model	Highlights
Whittington Hospital	Community midwives, obstetricians and GPs	<ul style="list-style-type: none"> •The first model of care is a traditional model with the community midwives taking care of antenatal and postnatal care and attending some homebirths (overall homebirth rate is three percent). •Community midwives are attached to GP surgeries. Check-ups occur in the surgery and non-pregnancy related medical problems are referred to the GP. •Obstetricians take care of antenatal care in complicated pregnancies, obstetricians and midwives provide intrapartum care and midwives take care of postnatal care in the hospital. •The second model of care involves two teams of eight midwives providing team-midwifery care for around 35 women per midwife per year. •The midwives work in partnerships of two midwives taking on a caseload together providing antenatal and postnatal care and attending the birth in the hospital or at home.
Sweden		
Södra BB	Midwives and obstetricians	<ul style="list-style-type: none"> •A unit within a hospital in Stockholm where a team of midwives provide antenatal, intrapartum and postpartum care to women with low-risk pregnancies and births.
BB Stockholm	Midwives, obstetricians, paediatricians and anaesthetists	<ul style="list-style-type: none"> •A freestanding unit in a hospital that is a labour ward for normal pregnancies. •The midwives there provide intrapartum care for women with an uncomplicated pregnancy in a more home-like environment. •The unit is prepared to handle complications by having obstetricians, paediatricians and anaesthetists available 24 hours a day.
Family Centres	Midwives, child health nurses, social workers, nutritionists and physiotherapists	<ul style="list-style-type: none"> •All health care professionals are easily accessible to each other and pregnant women who attend the maternity clinic in the Family Centre.
Youth Centres	Midwives and social workers	<ul style="list-style-type: none"> •Provides care to adolescents and deals with a wide range of problems and issues concerning body and soul; gynaecological check-up, contraceptive help, assessment and treatment of STDs etc. •Midwives in these youth clinics are mainly involved in sexual counselling, contraceptive advice and assess and treatment of STDs. •Young pregnant women might first visit their midwife in the youth clinic when they discover they are pregnant, after which they are subsequently referred to a maternity clinic.

Country/Model	Providers within the Model	Highlights
Germany		
Birth Centres	Midwives	<ul style="list-style-type: none"> •Provides a continuum of care throughout pregnancy, childbirth and postnatal period. •The teams of midwives working in birth centres collaborate with each other.
Midwifery-led unit in Munster	Midwives and obstetricians	<ul style="list-style-type: none"> •Independent midwives provide parental education for pregnant couples and share prenatal care with an obstetrician. •The midwives in this unit are also employed part-time in the obstetric unit in the hospital, so they are personally familiar with the management of the hospital.
France		
Hospitals in the Paris-area	Private practising midwives and gynaecologist-obstetrician practices	<ul style="list-style-type: none"> •Share antenatal care. •This program has resulted in the integration of independent midwives into antenatal maternity care.
Perinatal Plan	Midwives and other maternity professionals	<ul style="list-style-type: none"> •Ministry of Health intends to improve the psychological environment of births, by improving the medico-psychological collaboration in maternity clinics. •Introduce a consultation with a midwife or other maternity professional in the fourth month of pregnancy. Its intent is to provide the environment for women/couples to express their expectations, needs, questions and problems.
Perinatal Networks	Private and public maternities, private practice gynaecologists, obstetricians and midwives, territorial midwives, medico-social and social care providers and children psychiatrists.	<ul style="list-style-type: none"> •These networks are partnerships made up of different maternity facilities working collaboratively to provide women and their babies with the care they need.
Maternal and Child Protection (PMI)	Physicians, midwives, nurses, psychologists and marriage counsellors.	<ul style="list-style-type: none"> •Implemented to promote the social well-being and health of all inhabitants of France. The service focuses on families, pregnant women and children under six years of age. •It consists of medical, psychological, social and health educational preventative measures to benefit future parents and their children.
Australia		
General Practitioner Shared Care Programs in New South Wales	General Practitioners, hospital midwives and doctors	<ul style="list-style-type: none"> •Women have the option of having their pregnancy care shared between a general practitioner and a hospital. •Hospital midwives and doctors mostly attend the birth and give postnatal care. In some cases, particularly in the rural areas, GPs may also attend the birth.

Country/Model	Providers within the Model	Highlights
Western Australian Community Midwifery Program (CMP)	Management Board (professionals and consumer representatives), Clinical Advisory Group (obstetrician, general practitioner, independent midwife, Program midwife manager and a Program midwife)	<ul style="list-style-type: none"> •Provides strong networking advocacy for a range of birth and parenting related consumer groups and opportunity for professional development for all midwives in the community. •The broader community is able to have an input into the Program's services through representation on the board of management and through community consultation processes.
Shared Maternity Care Victoria (three hospitals, several divisions of general practice)	GP, midwife, obstetrician and shared care coordinator	<ul style="list-style-type: none"> •A model of care in which the majority of antenatal care visits take place in the community. •Responsibility is shared for a woman's care, including communication and management of results and abnormal finding. •A Shared Care Coordinator is the key person for non-urgent contact.
Community Midwifery Program Victoria	Community Midwives	<ul style="list-style-type: none"> •Five part-time community midwives provide antenatal, intrapartum (at home or in the hospital) and postnatal care. •All the midwives in this program are now employed by Northeast Health Wangaratta.

Barriers to Collaboration

	Netherlands	UK	Sweden	Germany	France	Australia
Different vision and philosophy of pregnancy and birth	X	X		X	X	X
Lack of mutual recognition of each others' competencies		X		X	X	X
Difference in education level	X			X		X
Financial reimbursement	X	X		X		X
Human resource shortages		X			X	X
Not willing to follow others' standards				X		
Lack of funding for collaborative networks/partnerships	X				X	X
Gender inequality					X	

Remuneration for Care Provider

Country	Type of Care	Fee-for-Service	Salaried
Netherlands			
Midwives		√	
United Kingdom			
Maternity Care Providers	Public		√
Midwives	Private	√	
Sweden			
Midwives	Public		√
	Private	√	
Gynaecologists	Public		√
Germany			
Midwives	Public		√
	Private	√	
Obstetricians	Public		√
	Private	√	
France			
Midwives	Private	√	
Gynaecologists/Obstetricians	Private	√	
Australia			
Midwives	Public		√
	Private	√	
Physicians	Public		√
	Private	√	

As we have shown, from the six countries we have collected information on a number of models and some of the important barriers to their successful implementation. We have also seen that these models of care are often tailor-made to fit existing systems and sometimes to changing circumstances. They reflect historical and cultural changes throughout time. They also reflect professions that have historically and culturally become ingrained in the maternal and newborn health care systems in the countries we studied. It is important to realise that these 'divisions of tasks and responsibilities' can not be integrally and explicitly exported to other systems of care as in Canada as such.