NEW ZEALAND RESEARCH

Providing rural and remote rural midwifery care: an 'expensive hobby'

Susan Crowther[A, B] PhD, MSc, BSc (Hons), RM, RN

[A] Corresponding Author: s.a.crowther@rgu.ac.uk

[B] Robert Gordon University, Aberdeen, Scotland, UK

ABSTRACT:

Background: Providing midwifery care in rural and remote rural regions can be challenging in many ways. This includes financial arrangements for midwives in New Zealand. This paper draws from a larger study exploring the lived experience of rural and remote rural families, midwives, general practitioners (GPs) and ambulance crews.

Aim: The focus of this paper is on the financial lived experiences of the rural midwife participants in this study.

Method: A qualitative study using hermeneutic phenomenology was used to explore the experiences of six rural midwives. Participants were from two regions in the South Island and two regions in the North Island and interviewed following ethical approval. Interviews were interpretively analysed.

Findings: Several tensions surfaced in the study. Across these tensions it was evident that the current funding for rural and remote rural midwifery is not working well. The participants revealed the challenges and financial hardships which they as rural midwives experience in maintaining a local midwifery service and how these challenges adversely affect their wellbeing and safety. The themes, 'cost of distance', 'spirit of generosity exploited', 'being treated unfairly' and 'working rurally can be an expensive hobby', are uncovered through stories of rural and remote rural midwives.

Conclusion: The current financial system does not serve these midwifery practitioners working in rural and remote areas. Without more financial support reflecting local needs, midwifery services in some of these rural regions are not sustainable and recruitment and retention will continue to be a challenge. There are Lead Maternity Carer (LMC) midwives working in rural, and in particular, remote rural regions who are concerned about the inequality and unfairness of remuneration. This may result in increasing the vulnerability of the maternity service for these regions. Rural and remote rural midwives' need for improved financial support is urgent and requires immediate attention at national level.

Keywords: Remote rural, midwifery, inequity, experience, sustainability, finances

INTRODUCTION

The current financial reimbursement arrangements for LMC midwives in New Zealand are being challenged ("The Claim" NZCOM, August 31st 2015). The issues of LMC midwives working in rural, and in particular, remote rural regions are of particular concern in terms of inequality and unfairness of remuneration. There is emergent research exploring the sustainability of New Zealand midwifery practice in general (Gilkison et al., 2015; McAra-Couper et al., 2014), yet much remains unclear about the experience of rural midwives' financial sustainability, in particular.

It is apparent that rural and remote rural communities in New Zealand have specific needs and concerns that often remain unheard at macro or national strategic level. This paper draws from the findings of a larger study which asked "What are the lived experiences of maternity in rural and remote rural New Zealand?" (Crowther, 2015). These included the experiences of rural midwives providing services in these regions. The focus of this paper is on the significant financial concerns which were uncovered for some rural and remote rural LMC midwives across two regions in the South Island and two regions in the North Island. The themes, 'cost of distance', 'spirit of generosity exploited', 'being treated unfairly' and 'working rurally can be an expensive hobby', emerged from the stories of these rural and remote rural LMC midwives.

BACKGROUND

Out of New Zealand's total population of 4.6 million, approximately 576,000 people live in rural areas, generating two-thirds of New Zealand's export wealth (Kletchko & Scott-Jones, 2012). Approximately 55,000 women give birth annually in New Zealand; nearly a third of whom live in rural areas (Simmers, 2006). Rural communities are diverse with small populations living over large geographical areas (National Health Committee, 2010). The issue of defining what is rural is complex. The definition of rural is far from universal and there continues to be no general agreement (Williams, Andrews, Zanni, & Fahs, 2012).

The nature of New Zealand's rural and remote rural maternity services is related to proximity to obstetric and paediatric hospital care. For example, rural is defined as 30 minutes or more travel from a base hospital and remote rural 60 minutes or more (Hendry, 2009; Kyle & Aileone, 2013). Yet, the taxonomies of

urban, semi-rural, rural, remote rural simply do not reflect the contextual reality of these regions. The experience of rurality is subjective and includes knowledge of local geography that limits access, feelings of social and cultural isolation as a result of infrastructure, environmental and weather conditions, distances from urban areas, communication and resource issues (Malone & Cliffe, 2013). Hart, Larson and Lishner (2005) contend that defining what is, and is not, rural for research purposes requires researchers to name which aspects of rurality are most pertinent to the topic being researched and then to formulate an appropriate definition. The definition of remote rural used for this current study is:

> *A locality in which experiences of maternity (mothers, families and health care professionals) occur 60 minutes or more by road (in optimal weather conditions) from secondary hospital services as determined by those who live and/or work (families and midwives) in these regions who have local knowledge of actual lived travel times.*

This definition serves as baseline. It is acknowledged that one may live and work only 30 minutes from secondary services yet, due to local staffing and transport issues, this may extend to and beyond 60 minutes. It is also important to acknowledge that some LMC midwives in rural areas domicile in urban areas and travel to rural regions to provide care.

Midwifery in rural regions

The New Zealand Ministry of Health directly funds LMCs, who are either midwives or doctors with obstetric qualifications. The delivery of maternity services in New Zealand is underpinned by the requirements of the national Section 88 Maternity Notice regulated by the Ministry of Health (Department of Internal Affairs, 2007). This institution oversees the service and payments for primary maternity care provision. Rural and remote regions have unique funding concerns beyond the requirements of Section 88, leading to initiatives focussing on these issues in recent years (Table 1).

Rural and remote regions have unique funding concerns beyond the requirements of Section 88.

Continuity of care underpins New Zealand maternity care in all regions and is mainly provided by LMC midwives and a few General Practitioners Obstetrics (GPOs). Continuity of midwifery care studies demonstrate good outcomes and it is the model of care desired by women and families (Sandall, Soltani, Gates, Shennan, & Devane, 2015). Maternity care in remote areas is often provided by midwives working in isolation (Adair, Coster, & Adair, 2012). These rural LMC midwives provide 24/7 on-call services. All rural primary maternity facilities are required to have a midwife available on site or on-call. If a woman is in labour and her LMC midwife is providing care, the core/facility midwife is expected to provide back-up and support in the facility and on-call services to women when they stay postnatally. Not all rural health facilities are the same. Some LMC midwives also provide the core midwifery service to maternity facilities under a separate contract. In some primary rural units, nursing staff are employed to ensure the service remains viable when there are insufficient midwives.

Table 1: Additional payment and resources available to New Zealand rural LMC midwives

Establishment grant	Available for two or more midwives to establish a LMC midwifery practice in a rural locality in which there are no LMC midwife practices currently established. May involve midwives moving to the rural locality to commence LMC practice, or it may involve midwives already living within the locality changing practice type. The establishment grant is a one-off grant to support setting up rural practice. However, exceptions can be considered on a case by case basis for further establishment funding. Payments are made in 3 separate instalments over a 12-month period (subject to meeting contract requirements) and paid to the midwives as a collective, into a bank account nominated by the practice.
Placement grant	Available for an experienced individual midwife who is re-locating to a rural locality to join an existing midwifery practice or an individual LMC midwife who is currently practising within the area. This is a one-off grant. Ideally, no Placement Grant will have been previously provided to any midwives practising within the same locality, but case by case exceptions can be considered. Payments are made in 3 separate instalments over a 12-month period (subject to meeting contract requirements).
Locum support for annual leave and emergencies	Since 2009 rural LMC midwives are entitled to 9 days locum cover per year. In addition there is provision to fund 5 days emergency locum cover. Rural midwives do not lose earnings from missed maternity episodes while on leave from their caseload practice.
Mentorship programme/ support	Mentoring service designed to provide up to 22 hours of mentorship within a 12-month period to a rural LMC midwife from an experienced midwife mentor who is on the National Rural Midwifery Recruitment and Retention Service register. Provides an opportunity to explore sustainability within rural settings and the midwife's own professional development, especially in geographically isolated areas of New Zealand. Mentor is paid for this service.
Recruitment	RMRRS works closely with key stakeholders (including midwives, district health boards (DHBs) and other local service providers) in these localities to identify recruitment needs. This is supported by the Establishment and Placement Grants.

Recruiting and sustaining an adequate rural maternity professional presence in these sparsely populated areas are ongoing challenges (Adair et al., 2012; Engel, 2000; Steed, 2008), despite an array of recent initiatives (see Table 1). The numbers of midwives in rural localities have remained stable since 2012 and numbers of midwives in remote regions remain low (Kyle & Aileone, 2013). Kyle and Ailone found that the smaller the population, the less likely there would be an available local midwife and recommended a focus on succession planning for rural LMC midwives. Despite various incentive packages and allocated rural funding, many remote areas continue to have insufficient maternity care provider availability.

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The Rural Midwifery Recruitment and Retention Service (RMRRS) has been established as a joint venture between the Midwifery Maternity Provider Organisation (MMPO) and the New Zealand College of Midwives (NZCOM), funded by the Ministry of Health. It is recognised as a landmark organisation that continues to work for, and highlight the needs of, rural midwives. RMRRS provides various forms of funded support for rural midwives in the hope that this will help sustain safe available midwifery services for rural communities. Current payment and resources available to New Zealand rural LMC midwives through RMRRS are wide-ranging (Table 1).

Travel costs

The need to travel to provide midwifery care and the challenges and costs of that travel have not previously been explored in detail. The travel costs and other financial concerns of rural and remote LMC midwives cannot be underestimated. This paper focuses on the potential financial impact of distance on the experience of rural and remote rural LMC midwives. The complex nature of rural maternity care provision has been examined in New Zealand (Barnett & Barnett, 2003; Patterson, 2007; Patterson, Foureur, & Skinner, 2011; Patterson, Skinner & Foureur, 2015). What needs to be further understood is how these financial realities are experienced.

METHOD

A qualitative methodology was used, based on the need to gather data that provided in-depth and rich stories of the lived experience of rural maternity, including the working experiences of midwives in these regions. Listening to the everyday lived experiences of rural and remote rural midwives provided opportunity to review and reflect upon the practice realities of midwives in the field. This also offers an opportunity to learn lessons that will help ensure sustainable, safe and effective rural and remote rural services into the future. The theoretical framework of interpretive hermeneutic phenomenology, guided by the writings of Heidegger, Gadamer and van Manen, informed the approach to data collection and analysis (Gadamer, 1976; Heidegger, 1927/1962; van Manen, 2014).

Following ethical approval from Auckland University of Technology Ethics Committee (AUTEC) (No. 15/18), thirteen unstructured, in-depth interviews with women, midwives, ambulance crews and doctors were conducted across four regions in New Zealand; two in the South Island and two in the North Island. This paper focusses on the six rural and remote rural midwives from this participant group. Recruitment was by purposeful sampling to hear the voices of those 'living the reality' of rural and remote rural midwifery. Professional and social networks were used. Through a process of snowballing, participants were continually recruited. A direct approach to participants was not used unless prior interest had been indicated. Participants were able to withdraw themselves, or any information they had provided for this research, at any time prior to the completion of data collection. Due to the complexity and sensitive nature of data gathered in small population regions, constant efforts were made to ensure anonymity. For example, all participants were given pseudonyms and place names were deleted from their transcripts.

The interviews, conducted locally, lasted one to two hours. The midwife participants were asked to share their experiences of rural midwifery. Interviews were transcribed by a professional transcriber who signed a confidentiality agreement. Interviews were then analysed for themes and patterns that highlight areas of concern, in an iterative process. The focus of the analysis was on surfacing meaning from lived experience descriptions. When I moved between the parts and the whole of each individual interview, and all the interviews together, new horizons of understanding emerged, as clusters of stories revealed commonalities and resonant qualities. What is reported here focusses particularly on one area of concern that emerged from the midwife stories: the financial costs incurred in providing rural midwifery services.

I came to the study with pre-understandings about rural and remote midwifery. I have worked in various rural midwifery roles in several countries, including LMC practice in Northland, and continued to provide rural locum support during this study. I was interviewed by a colleague at the start of this study so that I was able to identify my own assumptions and pre-reflections. This ensured my own pre-understandings would not be discounted and ensured transparency in my interpretive analysis of the data. Therefore within the findings my own voice is made explicit.

FINDINGS

Cost of distances

The cost of distances when living and working as LMC rural/remote rural midwives can be considerable. Sally's (midwife) story illustrates:

> *I had a lady with really awful vomiting and diarrhoea at 40 weeks. I went to see her at home. She was dehydrated and unwell all night. I sent her to the GP to get some IV fluids. The medical practice refused to give her fluids. So we went to the hospital where we all stayed overnight. I had to transfer at that point otherwise I would have been criticised. When we got to the hospital four hours later they gave her a bag of fluids. I stayed the night in town and came home the next day. She went home and we returned a week later for an induction. I went all the way down to the hospital just to have a litre of fluids! (LMC Midwife, Sally)*

Sally travelled the eight hours round trip to secondary services on two occasions for her client; once for IV fluids and then returned a week later to provide intrapartum care. She transferred her client due to local pressure and fear of being criticised. Sally's assessment and the need for her client to have treatment was confirmed on admission to the secondary services. Sally had to stay nearby overnight in case of labour onset and a week later returned to

provide intrapartum care. The financial cost to Sally included 16 hours of travel and an overnight stay near the secondary facility. The costs extend beyond money to a personal disruption for Sally and presumably for her family. In addition, her own practice is left potentially vulnerable because she is out of the area.

Transfers and the amount of travelling to maintain continuity of care can have financial implications that impact on a local sustainable midwifery service. At times other local midwives are unable to provide cover or live far away. This was certainly the reality in my own rural practice on occasions. This is an excerpt from my transcribed pre-understandings interview prior to the study:

> *I was busy attending to the paper work after a helicopter transfer for a sudden birth at 32 weeks from a remote location when my phone rang; another mother was in early labour! I dreaded this situation. My husband was organising to come and get me once I had handed over care but that would take time. I was stranded due to the type of transfer. I knew my practice partner was busy with another mother in labour. It is really stressful when this happens.*

The tyranny of distance is a lived reality for rural midwives (a theme more fully explored in the larger study (Crowther, 2015)). Appropriate, prompt transfers from rural regions can reduce adverse perinatal outcomes (Grzybowski, Stoll, & Kornelsen, 2011; Patterson et al., 2015). Yet there are a myriad of costs which need to be covered and which include accommodation, food expenses, car maintenance and petrol, cost of extended time away from home and disruptions to family life. Enabling continuity of care and ensuring safety and equity of access to services in rural regions come at a personal financial cost and with potential risk for midwives like Sally.

Participants in this study reported that they provided intrapartum care in facilities many hours from their homes, so that they could claim the intrapartum fee through Section 88 and receive an adequate salary. Petrol costs are high and not sufficiently reimbursed. This is particularly an issue for non-emergency intrapartum care when the midwife travels to a hospital out of her region in order to provide non-emergency intrapartum care.

The potential for anxiety, disruption and stress related to some transfers to secondary units may not be preventable, yet the financial burden could be alleviated. There were local systems in place in some regions within this study, such as taxi payments for LMC midwives so that they could return to their rural homes after facilitating an ambulance transfer, but these did not apply everywhere.

Spirit of generosity exploited

The personal cost to providing rural and remote services often remains invisible. The spirit of generosity that is often inherent within midwifery, and in rural life, was thought to be exploited at times. Sally (midwife) gave an example:

> *I do get stranded quite a bit. I had a primip, she ruptured membranes at 34 weeks, and the ambulance driver took me back as far as they could, they're not supposed to bring us back, and my car was over in a remote area. I had to call my husband out about 4 o'clock in the morning saying, "can you come and get me?" Another time I was transferring a tourist to the area who had ruptured her membranes and was contracting at 30 weeks. I took her down to the neighbouring town, an hour from here, where a helicopter came to pick her up. The ambulance driver was told he had to leave me there and go to another emergency. Effectively it was on the way so he stopped on the side of the road and I got out of the truck. Again my husband had to come out and pick me up and take me back to my car. I get stranded and need picking up quite a bit when I think about it. Also getting back to my car in the middle of the night and it is cold and it's dark, I'm tired but still have to drive home. (LMC midwife, Sally)*

The disruption and financial strain for Sally and her husband in this story are reflected numerous times through the participants' stories; these also resonate closely with my own rural experience. Remote rural midwives can struggle to get home following an emergency transfer and are often left stranded without return transport; this issue often remains unseen. LMC rural midwives, like Sally, often work beyond the call of their roles, resulting in considerable personal sacrifice. Rural midwives may transfer in an ambulance leaving their car behind (or by air transfer such as my own example above) and need a way to get home; sometimes they follow a woman in their own car but may be too tired to drive home after providing care. Provision of continuity of midwifery care comes at a personal cost to remote rural midwives which may at times lead to unsustainable working practices.

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Ensuring continuity of care can lead to taking unsafe personal risks that are not acceptable. Caroline and Sally (midwives from different regions) describe sleeping rough.

> *I always have everything in my car all the time – just in case. I sleep anywhere and everywhere. Even a sleeping bag and overnight bag, a little goody bag of nuts and muesli bars. I'm a good power napper, I have a power nap app on the phone and so I pull over anywhere and power nap. Luckily I have learnt to be really good at power napping. (LMC midwife, Caroline)*

> *So if I am really exhausted I'll pull off the road and have a sleep in the car. Once you've had your birth you're all kind of hyped up and busy and you've got so much to do and then you get in the car and drive; then tiredness hits. I've got a sleeping bag in the car for when this happens. I am set up for this. I've woken up with all sorts of people staring into the car at me. There was a dustbin man at one small town. I had obviously parked my car in front of someone's drive. I was in a pub carpark at one point, I had no idea, but I was so tired I didn't care. (LMC midwife, Sally)*

The time, inconvenience, disruption to personal lives, effects on health and extent of travel expenses are revealed in these midwives' stories. Sleep deprivation affected all midwives at times, but added to this were the vast distances they often needed to cover to return home after extensive hours of providing midwifery care far from home. The subsequent need to sleep 'rough' is unacceptable and the consequences are unsustainable. Physically and emotionally this takes its toll and raises several serious concerns and questions about the midwives' safety and wellbeing:

- Do Caroline and Sally feel valued, and acknowledged as they sleep on the back seat of their car away from family and home?
- Are Caroline and Sally safe?
- Are their clients left back in the rural community kept safe in their absence? Are Caroline and Sally still accountable for their care?
- Do policy makers, professional organisations and regulators of the service 'see' Caroline's and Sally's costs?
- Do their clients fully appreciate their midwives' commitment?
- What about Caroline's and Sally's families left wondering about their safety and wellbeing?
- The challenges to wellbeing, professional dignity and safety for these midwives need addressing.

Being treated unfairly

Some remote rural midwives spoke of being treated unfairly by a system that did not understand local context. Paula (LMC midwife) came back from holiday to find she was expected to take on the sole responsibility for providing caseloading care as a self-employed service provider in her remote region:

> *I had to get my own equipment, get a car and do all my business stuff. The Trust just went boom off you go. It was horrible. I actually took out a personal grievance against them just because it was hideously stressful. (LMC midwife, Paula).*

Paula explained that the local trust, her former employer, which had been set up to maintain a birthing service, came to the decision that the service was financially unsustainable. It was unclear if this decision was a governmental funding issue or about promotion of continuity of care. Paula explained in the interview that she was not consulted about these changes. Paula had to set up business systems, buy her own means of transport and her own equipment - all at considerable personal expense. Prior to this she was on a regular salary, and had a car and equipment provided. She had had the support of the Trust Board who had arranged cover for annual leave or sickness, had funded her study leave and offered her moral support. The potential income from the current caseload in Paula's community did not cover such costs. The service was thus deemed unsustainable.

There was no thought as to the unsustainability of such a practice for Paula who was 'forced' to take on the financial burden if she wished to remain working as a midwife in her rural community. Paula's story draws attention to the current fiscal challenges that some remote rural LMC midwives working in isolation encounter. These fiscal challenges appear discriminatory compared to the costs and remuneration urban LMC midwives experience.

Working rurally can be an expensive hobby

There are invisible costs in time, money and wellbeing in provision of remote midwifery services, as Caroline's story illustrates:

> *It is not just the caseload it's the expense of being a rural midwife. I don't get any extra for going to hospital for my study days. I don't get any extra for going to the maternity homes for their meetings or for their education sessions, meeting up with colleagues who live far away. I don't get anything. There is no extra if somebody needed weekly CTGs. In the city they'd go to the secondary care facility and have weekly CTGs. There is nothing up here that pays me to do weekly CTGs. Sometimes they request twice weekly CTGs. I had a really compromised baby and I needed to do twice weekly CTGs on behalf of the obstetricians. There is nothing that pays me any extra to go out and do that. There is a lot more expenses up here; constant maintenance on the car! The only extra is that remote rural payment for postnatal. You can get an initial set up payment which is great but there are ongoing costs – there is no payment for them. The one off transfer fee which doesn't really cover your petrol or time. Not at all. I would give up midwifery because of the finances; it is an expensive hobby! - it really does cost me to be a remote midwife LMC. (LMC midwife, Caroline)*

Running a small business is a relentless struggle for Caroline. Part of the essential equipment is a functioning car, yet car maintenance can be high when mileage is high and the terrain challenging. Maintaining and purchasing equipment are expensive.

All LMC midwives, whatever the caseload number and location of work, are required to demonstrate ongoing professional development and updating. Caroline is happy to do her professional updates but she encounters several barriers: geographic location, on-call demands, travel, accommodation, course costs, lack of or poor local resources (libraries, broadband access) and lack of provision of locum cover for mandatory and elective educational days. These difficulties are unsurprising and have been previously identified (Ireland et al., 2007). Yet this self-responsibility for maintaining continuing professional development adds an extra burden to the rural practitioner (MacKinnon, 2010).

The need to maintain financial stability can oblige a rural midwife to travel long distances to provide intrapartum care if the woman chooses (or is required) to birth at a secondary facility. This is pertinent when caseloads are significantly small due to the size of rural communities and with the ongoing popularity of hospital births amongst low risk women.

There are travel and time costs in providing safe antenatal care. For Caroline and the mother the nearest primary unit with a cardiotocograph machine (CTG) is a two-hour round trip plus the time required at the unit. CTG machines are found in some primary units across New Zealand but not all. The financial burden can be considerable when twice weekly CTGs are ordered by an obstetrician who may not appreciate the local logistical difficulties involved. Sometimes the costs are met by the LMC to keep a quality local service. Michelle (rural LMC) describes 'I just bought a CTG machine to ensure local women got what they needed here', however this cost was never reimbursed and came from her limited income.

Rural midwives, such as Caroline, cannot afford to forego a mother's intrapartum care payment. The need to maintain financial stability can oblige a rural midwife to travel long distances to provide intrapartum care if the woman chooses (or is required) to birth at a secondary facility. This is pertinent when caseloads are

significantly small due to the size of rural communities and with the ongoing popularity of hospital births amongst low risk women. Some of the midwifery participants felt criticised for providing secondary intrapartum care by those who do not understand rural circumstances and needs.

Yet, despite the many challenges, rural dwellers and their health care providers protect and enjoy the uniqueness of their region, as Michelle (LMC) explains:

> *I do enjoy being a rural midwife otherwise I wouldn't do it. The advantage is that you are your own boss and I'm out of all that political hullaballoo that goes on in big cities. I mean you've got to be a bit mad to do this but I do enjoy working in this small community. (LMC midwife, Michelle)*

During the interviews it became apparent that the rural midwives enjoyed their work despite the challenges they described. The midwives in this study, for the most part, enjoy what they do and provide a service that prevents poor outcomes to the best of their abilities.

Internationally, it is recognised that when skilled midwives provide the majority of maternity care they can reduce mortality and morbidity if the infrastructure is also supportive (Day-Stirk, Laski, & Mason, 2014). My interpretation of what constitutes such 'supportive infrastructure', arising from my analysis of the midwives' stories, is that it should include fair remuneration for midwifery services provided in rural and remote rural regions in New Zealand. It appears that the national maternity payment arrangement for rural (particularly remote rural) midwives is largely supplemented by the midwives' generosity of spirit. As Caroline states, "it is an expensive hobby to be a remote rural midwife". The payment schedule for rural midwives appears incongruent with local realities, leaving midwives like Caroline feeling exploited and vulnerable.

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DISCUSSION

Some of the financial remuneration inadequacies and personal costs of some rural and remote rural midwives have been revealed in this paper. The toll taken by this being invisible but the midwives 'doing it anyway' speaks of fortitude – a strength and bravery to just keep going no matter what. The feeling of accountability and responsibility to their local regions, as well as the need to adhere to their professional ethos, speak loudly of the midwives' daily, unseen, personal commitment. There is a host of challenges ranging from professional tensions, climatic conditions, and a constant potential need to travel distances at all times of night and day and be continuously on-call. Yet often many of these experiences remain unseen and unappreciated by those stakeholders within macro level organisations who do not live the daily realities of rurality.

The continuation of rural midwifery services is seemingly dependent upon midwives' spirit of generosity. This spirit of generosity is in constant tension with the feelings of being undervalued and invisible. Exploiting rural LMCs' spirit of generosity is unjust and can be construed as abusive. Midwives in this study feel that the current generic payment for maternity care across New Zealand is inadequate for rural midwives' ongoing needs. Addressing the optimal model of care and optimal payment processes in sparsely populated regions is essential. It would seem, from this small study, that the greater the remoteness the greater the costs and the lower the income.

Reducing the provision of maternity care to a matter of economics and commerce has consequences for the rural midwives in this study. They are forced to maintain a self-employed business in often sparsely populated regions with few clients to ensure a stable income.

Reducing the provision of maternity care to a matter of economics and commerce has consequences for the rural midwives in this study. They are forced to maintain a self-employed business in often sparsely populated regions with few clients to ensure a stable income. Participants explained in the interviews that competition for business between midwives in small communities can be harsh; this was also my own experience working in a sparsely populated region. The balance is constantly being sought between caseload numbers and ensuring adequate available rural midwives. Childbirth is unpredictable and numbers of clients can fluctuate over time, thus making guarantees for regular income challenging. Whether the midwife is paid by regional trusts, district health boards (DHBs) or directly from the Ministry of Health (MOH) makes no difference to local families. The important thing for them is that there is a locally based midwifery service that is safe, accessible, acceptable and of good quality (Day-Stirk et al., 2014).

On-call commitments are part of LMC midwifery care across New Zealand, yet these on-call responsibilities can be more complex for rural practitioners. Rural midwives (like all LMCs) remain on-call 24/7 and get paid to provide episodes of care. This may work well in urban areas and some rural regions where there is capacity to have larger caseloads, but in remote regions with small caseloads this system can prove financially unsustainable. A rural or remote rural midwife may only have one woman per month and be unable to earn for much of the time.

Arguably, the rural and remote rural midwives could take other employment, yet they must be available at all times to attend women in their caseload as required. Being on-call restricts mobility and inhibits a rural LMC from supplementing her income when caseloads are small. Obtaining other paid employment that is local and flexible at short notice may also prove difficult in many regions. Costs related to maintenance and replacement of equipment and recertification requirements continue regardless of the income generated by the midwife. Her income from her client base has to cover these expenses yet in rural regions there is little ability to supplement costs when caseload numbers are low. This is not to imply that rural and remote caseload midwifery is not feasible but that the present set-up in some regions is not working well.

Keeping all midwifery services philosophically congruent with the continuity of care model appears difficult to realise for rural regions

in the longer term, unless the payment and support processes are better aligned with midwifery practitioners' needs locally. It is not the intention of this study to undermine universal coverage of continuity of midwifery care. However, the stories presented in this paper clearly show that one size does not fit all. Concern regarding how the present system is financially unsustainable in some rural regions has been raised and needs to be acknowledged. The LMC continuity of care model of care has been shown to be sustainable (McAra-Couper et al., 2014) yet the stories in this paper show that the personal financial sustainability for some rural midwives requires urgent re-evaluation of how funding is organised and distributed.

There is a need to explore alternative models and funding improvements for rural maternity services. The midwives in this study have described feeling disempowered, disenfranchised and exploited and have described the ongoing personal costs of providing maternity care in their rural community.

New Zealand midwives are enabled by government policy to set up small private businesses, to work autonomously and be self-determining in how they work as self-employed practitioners. However, this does not work for all midwives in all regions. At present the funding fails to fairly reimburse all rural midwives for their time, equipment and distances they need to travel to provide maternity care to their remote rural maternity population. Some remote LMC midwives in this study reported being duty-bound to provide care in their regions despite it being 'an expensive hobby'. Alexandra (2013) stated that "One person's resilience may be another's vulnerability, and one would not want the concept to be used as a means of reinforcing unethical practices or hegemonies" (p. 2714). The poor reimbursement and ensuing necessity for a spirit of generosity revealed in this study may help guarantee quality midwifery services continue to be delivered yet could be leading to unhealthy resilient behaviours. The systemic unethical hegemony of the current funding arrangement is unsustainable and could result in the vulnerability of services. Current remuneration fails to account for the additional requirements that are inherent when working within a rural community. Although this is a small study, this needs addressing if the New Zealand rural LMC midwifery workforce is to be sustained and equitable across all regions. There is a need for the Ministry of Health to consider the daily social and cultural situations for rural and remote rural midwives and consider how it can improve financial support through its policies.

The systemic unethical hegemony of the current funding arrangement is unsustainable and could result in the vulnerability of services.

Patterson (2002) found that maintaining the New Zealand rural midwifery service was strained by the funding processes. A report on rural health eight years later recommended that new and innovative models of services to meet the unique challenges of rurality are needed (National Health Committee, 2010). Unfortunately, more than a decade after Patterson's warning and despite several welcome initiatives, this study found that some midwives continue to have concerns related to a lack of financial support for remote rural maternity services. This current study suggests that funding processes for all regions continues to be insufficient, leaving some regions with midwifery services struggling to survive and vulnerable. If these six midwives, and potentially other rural and remote rural midwives in similar circumstances, are to sustain their services innovation to the structure of funding is required.

There is a need to explore alternative models and funding improvements for rural maternity services. The midwives in this study have described feeling disempowered, disenfranchised and exploited and have described the ongoing personal costs of providing maternity care in their rural community. There is now a need for discussion and collaboration between the New Zealand College of Midwives and the Ministry of Health to identify strategies that will support these and other rural midwives in New Zealand.

It is not the purpose of this paper to critically analyse the neoliberal ideals of New Zealand maternity service funding or impose neoliberalism onto rural health and maternity care organisation; these have been described and critiqued elsewhere (Mackinnon, 2012; McIntyre, Francis, & Chapman, 2011). What is proposed here is a refocussing on the responsibilities of the State for the needs of not just the woman but also the individual midwife in such a system:

> *…human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework....The role of the state is to create and preserve an institutional framework appropriate to such practices" (Harvey, 2005, p.2).*

The current generic payment schedule for rural and remote rural midwives across New Zealand does not cover long term costs for midwives. This is a small study so it is not possible to generalise, yet the findings are potentially transferable to similar rural situations. Rural midwives, in whatever region they live and work, deserve their expectations and needs to be attended to for the current midwifery model of care to be sustainable. If the systems and remuneration to support the LMC model of care do not work in their region then changes to funding are imperative. Rural maternity health care professionals need to be consulted and involved in any national policy that influences their professional and personal lives.

Potential Solutions

Inequitable unfair financial structures have been highlighted in this study. The New Zealand College of Midwives (NZCOM) is taking legal action against the Ministry of Health unfair pay based on gender inequalities ("The Claim" NZCOM, August 31st 2015). It is hoped that this legal action will identify and include ways of addressing the serious rural and remote rural funding issues identified in this study. I have suggested several potential solutions that may address some of these financial issues (Table 2). In addition, they could bolster recruitment and retention of midwives in the rural regions, whilst acknowledging that rural and remote rural midwifery are not the same in all New Zealand regions. For example, positive lasting change around transfer costs (emergency and non-emergency) that are easily accessible and traverse all New Zealand rural regions is justified. The above

Table 2: Issues identified by rural midwives and potential solutions	
Rural midwives' issues	**Potential solutions**
Limited ability to have a full caseload	Rural loading to support a smaller caseload
Current payment for intrapartum care disadvantages remote rural midwives who may not be able to provide this for all their caseload leading to reduced income.	Improve financial support through a rural loading system that recompenses midwives for working in rural and remote rural regions.
A fuller range of equipment, including more emergency equipment is needed.	Financial support for rural equipment
Transfers from rural area to secondary hospital facilities are time consuming and financially complex.	Increase financial remuneration to cover the costs that arise when transferring a woman to a base hospital some hours' drive away. Current emergency transfer fees do not cover the travel for induction of labour (IOL) and normal labour and birth episodes of care. Renumeration could cover costs including provision to sleep over night when the midwife is sleep deprived and assistance in finding transport home.
Lack of availability and need for alternative midwifery cover for the caseload of women who are 'left behind' while the LMC is in 'town' needs further exploration.	The solution to this situation requires exploration and resolution at a local needs level. Promotion of intra-professional and multi-professional support structures as well as an increase in on-call financial support and locum services. Secondary services need to acknowledge rural midwives' need to get back to their regions as soon as practicable.
Limited locum support	Increase in locum services. For example a 'floating' rural midwife locum employed by the local DHB could provide cover for regular weekends off, time off sick and provide cover for educational needs. In addition the current locum service for taking annual leave (only 9 days) needs re-visiting. The 5-day emergency cover per year is welcomed and should be maintained.
Maintaining professional competence and ensuring compliance with annual practising certification requirements for remote midwives can be challenging in terms of time, distances and finance. It is crucial that professional requirements are met without loss of income.	Provision of paid cover when required to leave their regions for mandatory study days. One solution would be to provide locum cover for one week while the remote midwife sourced and participated in a week-long series of updates. This would be less disruptive to locum services and the community. It could be a planned supportive process connected to local DHBs and NZCOM. The remote practitioner would be able to receive peer support and network beyond her region.

table lays out what I understand to be rural midwives' needs and potential solutions based on this research and that I suggest require immediate review.

Rural midwives, in whatever region they live and work, deserve their expectations and needs to be attended to for the current midwifery model of care to be sustainable.

Table 2 is not an exhaustive list of needs and potential solutions but offered as a beginning. A larger study is required to gather the practice realities of other rural and remote rural midwives, including the island communities. The experiences, in the rural and remote island communities these midwives serve, also need to be known. Any future research requires a transdisciplinary focus involving multiple stakeholders to ensure all have an equal voice. Any change to services requires audit and research incorporating rural and remote rural midwives who are immersed in local practice realities.

STRENGTHS AND LIMITATIONS

This is a small New Zealand study and is focussed on producing findings that are not generalisable, but are potentially transferable. There are always more voices to be heard, always more perspectives. There are many regions in New Zealand that were not included. There is no final truth, only a pointing to what is happening within the experiences of the midwives in this study. However, the study highlights concerns and vulnerabilities about rural midwifery practice funding arrangements that require further research and thinking.

CONCLUSION

The rural and the remote rural midwives may be running small businesses which can be construed as an 'expensive hobby'. This paper has shared some amazing stories of skill, resilience, and sheer grit in provision of exemplary rural midwifery care despite personal costs. Although there are stories of midwives enjoying the specialness of rural practice, there are some midwives that are just surviving. The purpose of this paper was to provide a rich uncovering of a phenomenon to provoke further thinking and incite a call to action. The current systems for funding appear to be unfair for some rural and remote rural midwives. This midwifery workforce needs to be understood and be self-directed in how they work. Their commitment and contributions need to be seen and valued. The financial and personal costs made daily by many rural and remote rural midwives need to be addressed urgently if safe and equitable maternity services are to be sustained for all regions across New Zealand.

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REFERENCES

Adair, A., Coster, H., & Adair, V. (2012). *Review of International and New Zealand Literature Relating to Rural Models of Care, Workforce Requirements and Opportunities for the Use of New Technologies.* Commissioned by The New Zealand Institute of Rural Health. Cambridge, New Zealand

Alexandra, D. E. (2013). Resilience and disaster risk reduction: an etymological journey. *Natural Hazards & Earth System Sciences, 13,* 2707-2713. doi:10.5194/nhess-13-2707-2013

Barnett, R., & Barnett, P. (2003). If you sit on your butt you'll get nothing! Community activism in response to threats of rural hospital closure in southern New Zealand. *Health and Place, 9*, 59-71.

Crowther, S. (2015). *All is not as it first may seem: Experiences of maternity in rural and remote rural regions in New Zealand from the perspectives of families and health care providers.* Unpublished Post-Doctoral study, AUT University.

Day-Stirk, F., Laski, L., & Mason, E. (2014). *The state of the world's midwifery: A universal pathway. A woman's right to health.* USA: International Confederation of Midwives, WHO, UNFPA.

Department of Internal Affairs. (2007). *Maternity Services Notice Pursuant to Section 88 of the New Zealand Public Health & Disability Act 2000.* Wellington, NZ: Department of Internal Affairs [DIA].

Engel, C. (2000). *Towards a sustainable model of midwifery practice in a continuity of carer setting: The experience of New Zealand midwives.* Unpublished Master's thesis, Victoria University of Wellington.

Gadamer, H. G. (1976). *Philosophical hermeneutics.* Berkeley: University of California Press.

Gilkison, A., McAra-Couper, J., Gunn, J., Crowther, S., Hunter, M., Macgregor, D., & Hotchin, C. (2015). Midwifery practice arrangements which sustain caseloading Lead Maternity Carer midwives in New Zealand. *New Zealand College Of Midwives Journal, 51*, 11-16.

Grzybowski, S., Stoll, K., & Kornelsen, J. (2011). Distance matters: A population based study examining access to maternity services for rural women. *BMC Health Services Research, 11: 147*. DOI: 10.1186/1472-6963-11-147

Hart, L. G., Larson, E. H., & Lishner, D. M. (2005). Critical concepts for reaching populations at risk. Rural definitions for health policy and research. *American Journal of Public Health, 95*(7), 1149-1155.

Harvey, D. (2005). *A brief history of Neoliberalism.* Oxford: Oxford University Press.

Heidegger, M. (1927/1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.). New York: Harper.

Hendry, C. (2009). Report on mapping the rural midwifery workforce in New Zealand for 2008. *New Zealand College of Midwives Journal, 41*, 12-19.

Ireland, J., Bryers, H., van Teijlingen, E., Hundley, V., Farmer, J., Harris, F., . . . Caldow, J. (2007). Competencies and skills for remote and rural maternity care: a review of the literature. *Journal of Advanced Nursing, 58*(2), 105-115. doi:10.1111/j.1365-2648.2007.04246.x

Kletchko, S., & Scott-Jones, J. (2012). *Rural Ranking Score: The case for change:* RRS Governance Group, NZRGPN. New Zealand

Kyle, M., & Aileone, L. (2013). *Mapping the rural midwifery workforce in New Zealand.* Health Workforce New Zealand, Wellington

MacKinnon, K. (2010). Learning maternity: The experiences of rural nurses. *Canadian Journal of Nursing Research, 42*(1), 38-55.

Mackinnon, K. (2012). We cannot staff for 'what ifs': The social organization of rural nurses' safeguarding work. *Nursing Inquiry, 19*(3), 259-269.

Malone, G., & Cliffe, C. (2013). *Framework for remote practice* (version 2) CRANA plus. Accessed Dec. 2015 https://crana.org.au/files/pdfs/Framework_Remote_Practice_Version_2_June_2013.pdf

McAra-Couper, J., Gilkison, A., Crowther, S., Hunter, M., Hotchin, C., & Gunn, J. (2014). Partnership and reciprocity with women sustain lead maternity carer midwives in practice. *New Zealand College of Midwives Journal, 49*, 27-31. doi:http://dx.doi/10.1278/nzcomjnl49.2014.5.27-31

McIntyre, M. J., Francis, K., & Chapman, Y. (2011). National review of maternity services 2008: Women influencing change. *BMC Pregnancy and Childbirth, 11*(53).

National Health Committee. (2010). *Rural Health: Challenges of Distance, Opportunities for Innovation.* Wellington, NZ: National Health Committee.

New Zealand College of Midwives (NZCOM) (2015) "The Claim" NZCOM, August 31st 2015.

Patterson, J. (2002). *Off the Beaten Track: a Postmodern Feminist Analysis of Rural Midwifery and Rural Media Health Discourses.* Unpublished Masters thesis. Victoria, Wellington, New Zealand.

Patterson, J. (2007). Rural midwifery and the sense of difference. *New Zealand College of Midwives Journal, 37*, 15-18.

Patterson, J., Foureur, M., & Skinner, J. P. (2011). Patterns of transfer in labour and birth in rural New Zealand. *Rural and Remote Health, 11*(2), 1-12.

Patterson, J., Skinner, J., & Foureur, M. (2015). Midwives decision making about transfers for 'slow' labour in rural New Zealand. *Midwifery, 31*(6), 606-612. doi:10.1016/j.midw.2015.02.005

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2015). Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews (9). doi:10.1002/14651858.CD004667.pub4

Steed, R. (2008). *Moving forward in rural health:* NZ Institute of Rural Health. New Zealand.

Simmers, D. (2006). The few: New Zealand's diminishing number of rural GPs providing maternity services. *The New Zealand Medical Journal 119* (1241):U2151, 02/2006.

van Manen, M. (2014). *Phenomenology of Practice: Meaning-Giving Methods in Phenomenological Research and Writing.* Walnut Creek, Ca: Left Coast Press.

Williams, M. A., Andrews, J. A., Zanni, K. L., & Fahs, P. S. S. (2012). Rural Nursing: Searching for the State of the Science. *Online Journal of Rural Nursing & Health Care, 12*(2), 102-117.

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Crowther, S. (2016). Providing rural and remote rural midwifery care: an 'expensive hobby'. *New Zealand College of Midwives Journal, 52*, 26-34.

http://dx.doi.org/10.12784/nzcomjnl52.2016.4.26-34