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From Kiwis to Kinder: How New Zealand's Lead Maternity Carer Model Could Deliver Better Perinatal Care in Germany

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Abstract

Background: Germany's maternity system is currently fragmented, lacking woman-centred continuity of care, which contrasts with the global recommendation for midwifery-led systems. In comparison, New Zealand's Lead Maternity Carer (LMC) model, which focuses on personalized, midwifery-led continuity of care, has been linked to improved maternal and neonatal outcomes and higher satisfaction among women and families.

Objective: This work explores how adapting elements of the LMC model could address gaps in Germany's maternity care system, improve the quality of care, promote midwifery-led continuity of care, and enhance the overall birth experience.

Method: A comparative analysis reveals significant differences between the maternity systems of New Zealand and Germany, highlighting factors that must be considered when implementing a midwifery-led system like the LMC model.

Findings: Key considerations for implementing the model include the need for comprehensive data to assess the current system, the establishment of national frameworks and guidelines, and the creation of a unified midwifery association. The importance of political support, public awareness, and ensuring the sustainability of the midwifery profession are highlighted as critical factors for success.

Conclusion: This research argues that with the right policies and resources, Germany can transition to a more holistic, midwifery-led maternity care system that prioritizes the well-being of both women and midwives, leading to better maternal and neonatal outcomes.

Key words: midwifery-led continuity of care, Lead Maternity Carer (LMC) model, Germany maternity care, midwifery practice

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List of Abbreviations

C-Section	Caesarean Section
DHV	*Deutscher Hebammenverband e.V.* (German Midwifery Association)
ICM	International Confederation of Midwives
LMC	Lead Maternity Carer
MLCC	Midwife-led Continuity of Care
WHO	World Health Organization

1 Introduction

The acceptance of midwife-led continuity of care (MLCC) as an effective model for improving maternity services is gaining traction worldwide. Major global health organisations such as the World Health Organization (WHO) and the International Confederation of Midwifes (ICM) promote the practice of MLCC, asserting that it can reduce pre-term birth and improve maternal and neonatal outcomes (WHO, 2024b). Along with the ICM underlining in their Position Statement that “midwifery led care is the most appropriate model of care for childbearing women” since it provides “safe and high quality care and is associated with more efficient use of resources and improves outcomes” (ICM, 2017). Crucially, MLCC infers that a pregnant woman is cared for by the same midwife or a small group of midwives throughout the pregnancy, labour, birth, and postpartum period which allows for personalized, women-centred care.

By contrast, the current maternity care system in Germany is characterised by fragmentation. A woman might be handled by different healthcare providers at various stages of pregnancy, birth, and postpartum care. This lack of continuity can lead to incoherent care experiences and increase stress and dissatisfaction for expectant families. The maternity care system is neglecting the aim of personalised and holistic care demonstrated by MLCC.

On the other hand, New Zealand offers a progressive alternative through its unique Lead Maternity Carer (LMC) model. With this approach, New Zealand managed to enhance continuity of care at a national level (Bradford et al., 2022) resulting in a high level of satisfaction expressed by the majority of New Zealand women (Research New Zealand, 2015). The LMC model is valued due to its ability to deliver personalized, consistent, and culturally appropriate care, significantly improving perinatal outcomes.

By examining the structure and outcomes of New Zealand's LMC model, this thesis explores the potential for similar improvements in the German maternity care system. Could the LMC model promote continuity of care and therefore improve the quality of maternity care in Germany? What factors would need to be considered for potential implementation in the German maternity system?

This thesis will provide insights by comparing the two maternity systems and analyse the benefits and challenges of midwife-led continuity of care. It then offers a model for which Germany could adopt the LMC model, thereby enhancing maternity care in Germany.

2 Background

This background will explore the concept of midwife-led continuity of care, review the current state of maternity care in Germany, and assess New Zealand's maternity system, focusing on the LMC model.

2.1 Midwife-led Continuity of Care

Midwife-led continuity of care is a model of maternity care that ensures a pregnant woman is attended to by the same midwife or a small team of midwives throughout her entire pregnancy, labour, birth, and postpartum care. This women-centred approach emphasizes consistent and personalized support. For example, allowing midwives to develop strong relationships with the families, enhances trust and communication, supporting physiological birth and ultimately minimizing interventions (Sandall et al., 2016).

The importance of MLCC in comparison to other care models is highlighted by its considerable advantages for maternal and infant health, as noted by Sandall et al. in their Cochrane Review (2016). Women are less likely to experience interventions like epidurals, episiotomies or instrumental birth and have an increased chance of spontaneous vaginal birth. Additional benefits are a reduced risk of preterm birth and a lower chance of babies dying before 24 weeks of gestation. Furthermore, those who receive this type of care are nearly eight times more likely to be attended to during birth by a familiar midwife. In fact, when compared with other models of maternity care, MLCC has zero negative effects.

A recent narrative systematic review by Cibralic et al. (2023) collected evidence suggesting that MLCC helps reduce anxiety and depression in pregnant women during the antenatal period. It may also serve as a preventative measure to lower maternal anxiety and depression throughout the perinatal period.

The two leading global organisations in midwifery, the WHO and the ICM, firmly advocate for enhancing the quality of antenatal care through MLCC. The WHO endorses this concept in its *Recommendations on antenatal care for a positive pregnancy experience* (2016), while the ICM (2017) emphasizes it in their position statement as followed:

> "ICM believes that midwifery led care is the most appropriate model of care for childbearing women. It provides safe and high-quality care and is associated with more efficient use of resources and improves outcomes."

MLCC plays a crucial role in addressing gaps in maternity care, ensuring that women receive the individualized attention they deserve. As healthcare systems globally seek to

improve maternity services, MLCC is a viable and effective model that prioritizes women's health and empowerment, leading to improved outcomes for mothers and their newborns alike.

2.2 Maternity Care in Germany

The German maternity care system is characterized by a structured collaboration between hospitals, midwives, and obstetricians. Women can choose between hospital births, midwife-led birthing centres, or home births, although about 97% (*Krankenhausentbindungen in Deutschland*, 2024) opt for hospitals. The system operates within both public and private healthcare frameworks, offering a variety of services to expectant mothers that are partially paid for by the government. Women are eligible for midwifery assistance from the beginning of pregnancy through to labour and up to one year postpartum. Health insurance covers services for up to 12 weeks after birth without additional justification.

In Germany, a midwife is legally required to be present at every birth, yet there is significant fragmentation of care throughout the entire process of pregnancy, birth, and the postpartum period. Women often interact with three to four different healthcare professionals, who are not always midwives. Many women receive midwifery care only during labour at the hospital, having seen only their gynaecologist for prenatal check-ups and often struggling to find a midwife for postpartum support. This is due to the fact that midwives are not considered primary care providers in Germany, and midwifery care is not part of basic medical care (Deutscher Hebammenverband e.V. [DHV], 2023a).

Like many other countries, Germany faces a shortage of midwives, leaving midwifery care for each woman uncertain. This shortage impacts the midwifery-led continuity of care model and enables only very few women the experience of MLCC throughout pregnancy, labour and birth and the postpartum period.

Several issues exacerbate these shortages, including high burnout rates, rising insurance premiums, and challenging working conditions. Hospital closures, particularly in rural areas, further limit access to maternity care. These challenges place strain on staff and reduce the system's ability to provide personalized care, highlighting the need for reform (DHV, 2023a).

2.3 New Zealand’s Maternity System and the LMC Model

New Zealand's midwifery-led primary maternity system integrates primary, secondary, and tertiary care that is free for eligible women unless they select a private obstetrician.

Midwives work either as core midwives in hospitals, providing secondary or tertiary care, or as caseloading LMC midwives within communities, offering comprehensive primary care in birthing units or in women's homes.

Indeed, New Zealand's maternity care historically faced similar fragmentation issues as seen in Germany in a medical led system. This changed in the 1990s, when legislation passed to support changes in the maternity care system by prescribing Midwifery as an autonomous profession, with its own scope of practice and standards. New Zealand midwives today provide a comprehensive primary maternity care and demonstrate a "woman-centred and midwife-led [system] with continuity of care as its core tenet" (Grigg & Tracy, 2013). This event marked the birth of the Lead Maternity Carer (LMC) model.

Women in New Zealand are able to choose their own LMC, most of whom work self-employed and are contracted by the Ministry of Health (Dixon & Guilliland, 2019). LMC midwives care for 93.4% of women, providing community-based care for a caseload of women and working independently while collaborating with other professionals when needed. They have legal access to maternity facilities to support comprehensive care and are legally and professionally responsible for ensuring women receive appropriate maternity care during pregnancy, labour, birth, and up until six weeks after birth (New Zealand College of Midwives, 2024).

3 Method

The method section describes the research design, data collection methods, analysis techniques, and ethical considerations applied in this study.

3.1 Research Design

This study employs a comparative analysis framework to examine how the LMC model from New Zealand could inform and potentially enhance the quality of perinatal care in Germany. The research explores two primary questions: (1) Could the LMC model promote continuity of care and therefore improve the quality of maternity care in Germany? (2) What factors would need to be considered for potential implementation in the German maternity system?

The decision to use a comparative analysis approach stems from the significant differences between the two countries' healthcare structures, particularly in their approaches to maternity care. New Zealand's LMC model is built on a continuity-of-care framework, where midwives and healthcare providers maintain a consistent relationship with expectant mothers from pregnancy through to the postnatal period. Germany's system is more

fragmented, with care spread across different professionals, often leading to disjointed maternity experiences. The comparative framework allows for an in-depth exploration of how these differences impact outcomes and patient satisfaction, and what can be learned from the more unified LMC approach in terms of enhancing Germany's perinatal care.

This research design was chosen to provide a structured method for directly comparing key elements of each maternity care system, identifying both transferable aspects and challenges of implementation. The research questions were selected because they address the core benefits of continuity of care and explore the practicalities of introducing a model designed for a different healthcare and social context. By comparing the two systems, this study aims to offer actionable insights into how the LMC model could benefit the German system and what adjustments might be necessary for adaptation.

3.2 Data Collection

A comprehensive literature review forms the foundation of this research by investigating the current situation of Germany's maternity care and examining existing studies on the LMC model with its impact on maternity care in New Zealand. The data for this study are sourced exclusively from existing literature, relying on a systematic review of studies, reports, and articles from relevant databases. The selected academic databases for data collection include PubMed, CINAHL, and Google Scholar. These databases are widely recognized for their comprehensive coverage of health-related research, making them suitable for accessing scholarly work on both the New Zealand LMC model and Germany's maternity care system. Following an initial, unsystematic literature search to identify relevant keywords, the specified databases were systematically searched using terms like "Lead Maternity Carer", "LMC model", "midwifery-led continuity of care", "maternity care", "maternity system", "New Zealand" and "Germany" with additional sources identified through snowball sampling. Since this work is not a systematic review, exact search strings, Boolean operators, and a PRISMA flow diagram were not utilized. The inclusion criteria for selecting literature were:

- Research articles published in peer-reviewed journals (important source: New Zealand College of Midwives Journal)
- Studies conducted within the past 15 years to ensure relevance to current practices
- Articles focusing on (midwifery-led) continuity of care
- Literature that directly addresses New Zealand's LMC model or Germany's maternity care system

The literature review aims to identify key benefits, challenges, experiences and outcomes associated with the LMC model in New Zealand. A similar literature review was conducted to assess the current German maternity care situation including perspectives from healthcare providers and mothers on it. The primary sources of literature on the German maternity system were the websites of the German Midwifery Association (*Deutscher Hebammenverband e.V.*), the parent association *Mother Hood e.V.* and the German Society for Midwifery Science (*Deutsche Gesellschaft für Hebammenwissenschaft*).

To assess the current state of maternity care in Germany and New Zealand, up-to-date data were essential. However, the process of obtaining this data varied significantly between the two countries. For New Zealand, comprehensive, current, and robust data were easily accessible through official government sources, such as the Midwifery Council of New Zealand (Midwifery Council NZ, 2024), Health New Zealand (Ministry of Health, 2024), and StatsNZ (New Zealand Government, 2024). In contrast, Germany faces challenges in this regard, with no consistent, complete, or up-to-date data readily available. Relevant information was difficult to find and scattered across multiple websites, making it harder to obtain a clear picture of the maternity care landscape. The data used in this thesis were sourced from the following websites: Destatis (Statistisches Bundesamt, 2024a), Statista (Statistisches Bundesamt, 2021) and *Gesellschaft für Qualität in der außerklinischen Geburtshilfe e.V.* (QUAG, 2024).

This thesis relies on grey literature to provide a comprehensive approach to the research question. Most of this grey literature was identified and accessed through the search engine Google, using a snowball sampling method. It includes policy documents like position papers, blog posts, reports and corporate publications from websites of official health organisations and associations like Te Whatu/Health New Zealand, the New Zealand College of Midwives, the Midwifery Council NZ, the World Health Organization (WHO), the International Confederation of Midwives (ICM), the *Deutscher Hebammenverband e.V.* (DHV), the German parents' association (*Mother Hood e.V.*), and the German Ministry of Health (*Bundesministerium für Gesundheit*).

3.3 Data Analysis

The analysis of the collected data followed a thematic content analysis approach. This method involves identifying recurring themes and patterns within the literature that relate to the effectiveness of continuity of care, patient satisfaction and potential barriers to implementing a new model of care. Thematic content analysis allows for the comparison of

different models while focusing on critical factors such as structure, provider roles, patient experiences, and healthcare outcomes.

The analysis proceeded in three stages:

(1) Assessing the current situation of both maternity systems

In the first stage, an in-depth review of the current maternity care systems in New Zealand and Germany was conducted. This involved analysing existing literature, policy documents, and relevant data to understand each system's structure, provider roles, and patient experiences. Special focus was placed on identifying key characteristics of the LMC model in New Zealand and the midwifery care model in Germany, noting how each system facilitates or limits continuity of care. This initial assessment established a foundation for comparing the two systems in subsequent stages.

(2) Identifying Similarities and Differences

In the second stage, a systematic comparison of the two systems was undertaken to highlight key similarities and differences. This phase involved detailed examination of each system's approach to continuity of care, the roles and experiences of healthcare providers, and levels of patient satisfaction. This comparative analysis provided insights into the distinct strengths and limitations of each model, setting the stage for exploring possible adaptations.

(3) Identifying Implementation Factors

The third stage explored the practical considerations for implementing the LMC model in Germany. This involved analysing the structural, legal, and cultural differences that might influence the feasibility of such a transition. Factors such as healthcare provider collaboration, funding mechanisms, and public acceptance were considered to outline potential challenges and adaptations required for successful implementation. The sustainability of the midwifery profession was a crucial factor considered in this process.

By using a thematic content analysis, the study synthesized findings into coherent themes that address the research questions, ultimately offering a nuanced understanding of how the LMC model could improve continuity of care in Germany and what systemic changes would be necessary for its adoption.

3.4 Ethical Considerations

Since this study is based solely on literature review, it does not involve human participants directly and therefore does not require ethical approval. However, all sources will be properly cited to maintain academic integrity.

4 Findings

This chapter presents the main findings from the research, aligned with the study's objectives and research questions. It examines both maternity care systems, offering insights into the current practices and experiences of midwives and families. Through a detailed analysis, this section identifies key differences and similarities of both systems, offering a clear overview and solid foundation for addressing the research questions.

4.1 Assessment of the German Maternity Care System

In 2023, there were approximately 696,000 births in Germany (*Statistisches Bundesamt*, 2024a). Most of those births, about 98%, took place in a hospital, which leaves 1,98% happening in an out-of-hospital setting (QUAG, 2024). These numbers are uncertain due to variations in the data provided by different institutions. Despite the absence of comprehensive current data on the number of births and the number of midwives registered and actively working within their profession, the German maternity system faces a shortage of midwives (DHV, 2024c). The German Federal Statistics Office (*Statistisches Bundesamt,* 2021) counted about 27,000 registered midwives in 2021 with no specifications on the hours or the scope of their work.

4.1.1 Strengths and Achievements

Despite the challenges midwifery faces worldwide, certain aspects of maternity care in Germany have developed positively in recent years.

Academization

One of the most recent important achievements is the transition in midwifery education. As one of the last countries in the European Union, Germany changed their midwifery education to be a bachelor's degree program on January 18th, 2020. The German Midwifery Association (DHV) sees the academization as an upgrade of midwifery education in Germany that will improve the status of the midwifery profession through gaining its own place in research and therefore making it more attractive to prospective students. They

recognize a potential for resource allocation through an expansion of skill set and enabling midwifes to work evidence based with a prospective improvement in income. The degree will be recognized across Europe and comes with opportunities for postgraduate training (DHV, 2021b). Although this change has faced some criticism, it represents an overall improvement and brings practices closer to international standards.

Overall growing Workforce

Over the last 20 years, there has been a continuous trend towards an increasing number of midwives in Germany (*Statistisches Bundesamt*, 2021). Academization has made the profession more attractive, and the number of applicants has increased. In order to guarantee all those interested in the opportunity to study midwifery and to sustainably improve the care of women and children by midwives through a growing workforce, more study places must be created as soon as possible (Hövel, 2021). This growth is barely noticeable, as many midwives only work part-time or even leave their profession due to challenging conditions.

First Step of Establishing strong Frameworks

Another major achievement in the German maternity system is the establishment of a strong, evidence-based framework around vaginal birth at term. The *S3 Leitlinie Vaginale Geburt am Termin* (*Deutsche Gesellschaft für Gynäkologie und Geburtshilfe e.V. [DGGG] & Deutsche Gesellschaft für Hebammenwissenschaften [DGHWi], 2020)* came into effect on 22 Dec 2022 as a long awaited support pillar.

Postpartum Care

Globally, Germany has very good care options for the postpartum period. Postpartum care includes home visits by midwives, covered by health insurance for up to 12 weeks after birth, with extended coverage in complex cases without requiring further justification. Whereas in most countries the scope of midwifery ends at about 6 weeks postpartum.

4.1.2 Weaknesses and Current Challenges

In an interview with the ICM, Ulrike Geppert-Orthofer, the President of the DHV, summarizes well the main challenges that midwives in Germany are currently facing. She emphasizes “fair pay for both employed and freelance midwives” and “ensuring good working conditions in hospitals” while being challenged by “persisting strong hierarchies in hospitals, universities, and society”. Another major challenge is “achieving recognition for the quality and safety of out-of-hospital births” (Geppert-Orthofer & ICM, 2024).

The following data was gathered from two sources that reflect the perspectives of midwives and families on German maternity care in 2021. As there have been no major changes in the system, these sources remain current. The *Deutscher Hebammenverband e.V. (2021a)* is the biggest midwifery association in Germany and *Mother Hood e.V.* (2021) is an association of parents that advocates for the needs of expectant parents and families.

Shortage of Midwives

Between 10 - 50% of women in Germany can't find a midwife for pre- or/and postnatal care. As a resulting problem, women without a midwife go to the emergency-ward or/and paediatrics more often which leads to increased stress and risk of infections for both mother and child. In addition to the shortage of hospital-based midwives, there is a significant lack of community midwives providing MLCC. This shortage makes it challenging for women who wish to give birth at home or in a birthing unit to find available providers, as demand far exceeds supply. It is driven by low remuneration relative to the high responsibility and workload, along with prohibitively high insurance rates for self-employed midwives involved in out-of-hospital births.

No assurance of Continuity of Care

There is no guarantee of continuity of care due to a shortage of community and hospital-based midwives. Therefore, complications are often recognized late or not at all, leading to stress and danger for both the mother and child. This results in an increased need for pain relief medications and interventions, which can potentially lead to a traumatic birth experience.

High C-Section rate

In 2023, Germany's C-section rate stood at 32.6%, and continues to rise having doubled over the last two decades (*Statistisches Bundesamt*, 2024b). Since 1985, however, the WHO (2015) has recommended a C-section rate of 10 – 15%, as rates above 10% have not been shown to reduce maternal and newborn mortality.

Bad working conditions in hospitals

Hospitals are facing bad working conditions, with a staff shortage affecting both midwives and doctors, and nearly 80% of maternity wards struggling to fill positions. Midwives are often required to care for three or more women simultaneously, leading to increased workload and stress. Additionally, rigid hierarchies, lack of break time, and excessive overtime further exacerbate the challenges faced by healthcare professionals.

Closures of Birthing units & small/rural Hospitals

As part of the hospital reform in Germany (Bundesministerium für Gesundheit, 2024), more and more birthing units and small hospitals in rural areas are closing (Mother Hood e.V., 2024). The primary reasons for hospital closures are staff shortages and obstetrics being financially unviable for the hospital.

No actual free choice of birthplace

Temporary and final closures of hospitals and birthing units require women to spontaneously replan and adjust to a new birthing environment while sometimes enduring long journeys to a new hospital. Another fact that limits the choice of birthplace in Germany is that giving birth outside of a hospital is not free. The cost of an out-of-hospital birth ranges from 500€ to 1000€, with most health insurance companies covering 250 - 300€ (*Bundeszentrale für gesundheitliche Aufklärung*, 2024). Additionally, the availability of midwives for home births or spots in midwifery-led birthing centres is extremely limited, particularly in rural areas.

Limited awareness of out-of-hospital birth safety

Data has shown for years that out-of-hospital births are a safe option for women with low-risk pregnancies. Despite this, out-of-hospital births receive little societal recognition for their quality and safety, partly due to the lack of tradition and role models. The government therefore instructs the DHV to do more in the future to raise public awareness and knowledge about out-of-hospital birth and to resolutely counteract the prevailing misconception that home births and birth centre births are subject to particular risks (DHV, 2023b).

Lack of value for Midwifery profession

The midwifery profession lacks recognition from the government, political bodies, and other healthcare organisations. Midwifery is underfunded, and both employed and freelance midwives are not fairly compensated. This devaluation of the profession leads to significant challenges in attracting and retaining qualified midwives.

Lack of strong frameworks that support MLCC

Germany lacks strong, mandatory frameworks to support MLCC. While some guidelines exist, they are not consistently implemented. For instance, the *S3 Leitlinie zur vaginalen Geburt am Termin* (DGGG & DGHWi, 2020) was only published in 2022 and has not yet been widely adopted. The *Mutterschaftsrichtlinien* (G-BA, 2023a) for antenatal care, established in 1985, focus on medical care by gynaecologists and have not significantly evolved to support a more midwifery-led, physiological approach. Although national health

objectives like the *Nationales Gesundheitsziel* (Kuhn & Altgeld, 2017) express good intentions, they are not effectively enforced, hindering the development of comprehensive frameworks for continuity of care.

Lack of multidisciplinary collaboration

There is a lack of multidisciplinary collaboration, particularly in the allocation of resources for prenatal care, leading to conflicts between gynaecologists and midwives. Some gynaecologists refuse to accept shared prenatal care, further hindering effective teamwork.

Missing Comprehensive Data Collection

There is a lack of comprehensive data on the number of midwives and their work locations in Germany, resulting in insufficient insights into the overall care situation. This data gap is critical for developing an effective action plan for improvement (DHV, 2021a).

No strong unified midwifery association

Germany's largest association of midwives is the DHV. With approximately 22,000 members, it represents most of the about 27.000 midwives in Germany and it is the only organisation representing employed midwives (Hövel, 2024). But as it is not compulsory for midwives to register with an association and there are other associations, there is no uniform representation. Discussions about establishing a chamber of midwives have been ongoing for over 15 years, yet no decision has been reached (Michel-Schuldt & Villmar, 2024).

No prioritization on Obstetrics in politics

Obstetrics is not part of basic medical care in Germany (Mother Hood e.V., 2021). As a result, comprehensive maternity care cannot be guaranteed since it is not taken into account in the planning of the structural hospital reform (DHV, 2023a).

4.2 Insights from New Zealand’s Maternity System and the LMC Model

After accessing the current situation of the German maternity system, this section explores experiences and success stories as well as challenges and areas of improvement of the LMC model in New Zealand’s maternity system.

With 57,000 births in 2023 (New Zealand Government, 2024) and 3,364 midwives holding practicing certificate in 2024 (Midwifery Council NZ, 2024), it is clear New Zealand also suffers from the global midwife shortage. Nevertheless, the country has made some exciting advances in increasing MLCC through its LMC model. In 2022, most people giving birth in

New Zealand (95%) received care from a community-based Lead Maternity Carer (Ministry of Health, 2024).

4.2.1 Satisfaction and Experiences

The experiences and satisfaction with New Zealand's maternity care is displayed in a summary report by De Bonnaire et al. (2023). It is based on a survey with 4,355 birthing parents who had given birth between January and November 2021. Although Covid-19 significantly affected the health sector and women's care experiences during that time, "respondents expressed a relatively high level of satisfaction with every stage of the care they received during their maternity and perinatal journey." 95% of the respondents received care from a LMC and "in most cases, the LMC was a midwife LMC or group of (community based or self-employed) midwives (88%)". The results of this survey reflect the success of the LMC model as "90% [of the respondents] stated they were satisfied with the care and support they received from their LMC while they were hapū/pregnant; during their labour and birth (87%) and in terms of their postnatal care (88%)". As an important conclusion, De Bonnaire et al. (2023) states that "[c]ontinuity of care from a midwife appears to improve satisfaction."

A study by Dixon et al. published in 2023 reflects on the experiences of women with midwifery care in New Zealand in 2019. 7749 online feedback forms from January until the end December 2019 were evaluated, "demonstrating high levels of satisfaction overall" (Dixon et al., 2023). The study underpins three steps for building a positive relationship between the midwife and the women under the LMC model: "establishment and maintenance of trust, honouring decisions and empowerment".

The New Zealand College of Midwives highlights a "strong midwifery workforce and stable maternity service, strong advocacy for woman-centred services, high levels of consumer satisfaction, robust data collection and mortality review processes" (Dixon & Guilliland, 2019) as strengths of NZs maternity system. A key advantage of the LMC model is "[t]he ability to be self-employed [which] in particular has empowered midwives to be autonomous practitioners and provide woman-centred care" (Dixon & Guilliland, 2019). Not only do women report positive feedback after experiences with the LMC model but so do "LMC midwives report high levels of job satisfaction" (Dixon & Guilliland, 2019). "[W]orking in partnership with women and their colleagues" (Dixon & Guilliland, 2019) plays an important role in sustaining this satisfaction. This is a win for both the individual's quality of care and for the system's continuation and growth in its provision of care.

4.2.2 Challenges and Areas for Improvement

The summary report of experiences in the New Zealand maternity system mentioned in 4.2.1 suggests the following areas of focus for improvement: access to services (e.g. scans and tests), communication and information (“fit-for-purpose for the diverse range of mothers and birthing parents”), hospital experiences (for all priority groups in order to meet cultural needs of Māori and identity needs of LGBTQ+ families) and follow up and support (“ensure there are sufficient numbers of midwives” to ensure quality of care) (De Bonnaire et al., 2023).

The New Zealand College of Midwives states that the primary issue in New Zealand’s maternity system is that “midwifery care is not being valued appropriately by the Ministry of Health or the DHBs” (Dixon & Guilliland, 2019). This is shown by inappropriate remuneration and the act of “chronically under-staffing midwifery facilities” (Dixon & Guilliland, 2019). Further challenges are reflected in midwifery being “seriously underfunded” and the LMC role being “systematically marginalised by the government as its sole 'employer', either through conscious or unconscious gender bias in the treatment of this role” (Dixon & Guilliland, 2019). Despite the strong evidence of the benefits and safety of birth in community setting and the LMC model promoting this idea, women’s choice “is not based on evidence about where it is safest for healthy women to birth but from the notion that one is ‘safer’ in hospital”. Dixon & Guilliland (2019) pointing out this area of improvement with the need to “change the 'risk' rhetoric and provide women with information that supports them to give birth in their local community”.

While the LMC model is regarded as a best practice for women-centred care, it presents certain challenges for midwives. The high workload caused by the shortage of midwives combined with the demands of being on call 24/7 makes it difficult to take time off and manage a continuous work/life balance. These circumstances have created an unsustainable situation for LMC midwives that frequently results in burnout and leaving their profession (Cox & Smythe, 2011).

4.3 Comparative Analysis of Both Maternity Systems

This comparative analysis highlights the key differences and similarities between the two maternity systems, focusing on aspects relevant to MLCC.

4.3.1 Similarities

The maternity systems in Germany and New Zealand share several similarities. In both countries, midwives can work either self-employed or for an organisation, operating within the scope of midwifery practice. While midwives in both systems work autonomously, their level of independence differs slightly. In New Zealand, midwives have more autonomy due to; their prescribing rights, the ability to refer directly to specialists, a greater range of pain relief options in primary birthing settings and access to hospital facilities through generic access agreements (Dixon & Guilliland, 2019).

Both countries also have a significantly higher rate of hospital births compared to out-of-hospital births, with New Zealand leading at 12% (Ministry of Health, 2024), compared to 3% in Germany (QUAG, 2024). There is little societal recognition or understanding of the quality and safety of out-of-hospital births in either country, with limited public awareness of these options. Additionally, midwifery care is not sufficiently valued by governments and other relevant healthcare organisations in both Germany and New Zealand. This is evident in issues such as inadequate remuneration, chronic understaffing of maternity facilities, and poor working conditions. Both countries are also facing a shortage of midwives, further highlighting the challenges within the maternity care systems (Dixon & Guilliland, 2019; DHV, 2023a).

4.3.2 Key Differences

The key differences between the two maternity systems in terms of MLCC are summarized across four categories: the orientation of the maternity system, choice of birthplace, associations, frameworks and data collection, and continuity of care.

Orientation of Maternity System

The key difference between maternity care in Germany and New Zealand lies in the orientation of the system. In Germany, maternity care is medically led, whereas in New Zealand, the system is midwifery-led, with midwives serving as the primary caregivers. LMC midwives provide and co-coordinate women’s entire maternity care and refer to specialists if necessary. Supported by the government, New Zealand midwives must work along the entire scope of midwifery practice, providing antenatal and postpartum care as well as care during labour and birth (Dixon & Guilliland, 2019). In contrast, German midwives have the option to specialize in a specific area within the scope of midwifery practice, such as providing only postpartum care. Women can choose to see their gynaecologist only for antenatal care and give birth at the hospital that are mostly led by obstetricians (DHV,

2024a). The German maternity system is not aligned with MLCC and experiences a different allocation of resources than the New Zealand system.

Choice of birthplace

In Germany, 97% of births take place in hospitals, with only 3% occurring outside of hospital settings (QUAG, 2024). This low rate of out-of-hospital births is partly due to the fact that women must cover some of the costs themselves for out-of-hospital births, while hospital births are free of charge. Additionally, there is limited availability of midwives who can attend out-of-hospital births, as high insurance premiums and demanding working conditions - such as being on call 24/7 with no backup - make this option less feasible. Birthing centres, which could provide an alternative to hospital births, need to be self-arranged and organised by midwives. Furthermore, the increasing closure of hospitals, particularly in rural areas, limits birth options for women (Mother Hood e.V., 2024).

In contrast, New Zealand has a higher rate of out-of-hospital births, with 12% of births occurring outside of hospitals (New Zealand Government, 2024). One of the main reasons for this is that out-of-hospital births are completely free of charge, and women can choose their birthplace, even at the last minute. The country's system allows LMCs to support women at any maternity unit with a national access agreement. In addition, primary birthing units, which provide an alternative to hospitals, are established and funded by the government, ensuring more accessible choices for women across the country (Dixon & Guilliland, 2019).

Association, Frameworks and Data Collection

In Germany, there are multiple midwifery associations, but it is not compulsory for midwives to register with any of them. This results in a lack of a unified voice for the profession. Additionally, there is no strong, nationally established regulatory framework, leading to inconsistent quality of care. Germany also lacks comprehensive data collection on birth and midwifery work, making it difficult to gain a clear overview of the care situation and the needs of the system.

In contrast, New Zealand has a single, unified midwifery association - the New Zealand College of Midwives - that represents all the country's midwives. Registration with this association is mandatory for midwives working in New Zealand, which ensures a cohesive voice for the profession. New Zealand also benefits from strong national regulatory, professional, and cultural frameworks that guide practice. Robust data collection is a key feature of the system, with annual detailed reports generated to assess and improve

maternity care. Regular feedback and reviews are used to ensure quality assurance is maintained across the country (Dixon & Guilliland, 2019).

Communication and Data Transfer

In Germany, communication between care providers can be hindered by the involvement of multiple practitioners, as well as the lack of a centralized digital system for storing health data. The only document used to record maternity care-related information is the *Mutterpass (G-BA, 2023b)*, a paper-based document that is sometimes poorly organized, and its handwritten content can be difficult to read. There is no guarantee of a detailed handover between care providers, and women are responsible for collecting, managing, and keeping track of all their data and information, which can lead to potential gaps or errors.

In contrast, New Zealand has a more streamlined approach, with all health information stored digitally in one centralized system, accessible by all care providers involved in a woman's care. Women can easily access their own health information via a mobile app or online account at any time. When a referral or transfer of care is necessary, a detailed handover is always provided, ensuring seamless care during the transition between providers. New Zealand's system is also marked by excellent multidisciplinary collaboration, with healthcare professionals working closely together to ensure comprehensive and coordinated care. The LMC plays a central role in ensuring comprehensive data collection and clear communication throughout the entire pregnancy, labour, birth, and postpartum journey. This system ensures better coordination and more reliable access to important health information (Dixon & Guilliland, 2019).

Continuity of Care(er)

In Germany, continuity of care is not guaranteed. Antenatal care is often shared between different providers, with gynaecologists frequently involved, and there is no assurance that a midwife will be consistently present. Self-employed midwives, who play a significant role in the system, are typically not able to attend births in hospitals unless they have a specific access agreement with a particular hospital - a process that can be difficult to arrange. Additionally, due to a shortage of midwives, it is common for women to have different midwives for postpartum care, or in some cases, no midwife at all (Mother Hood e.V., 2021).

In contrast, New Zealand ensures continuity of care through the LMC model, where a midwife is responsible for the woman's care throughout the entire pregnancy, labour, birth, and postpartum period. This continuity is supported by a national access agreement that allows LMCs to work across various healthcare settings. In some cases, midwives may work in small groups or partnerships to provide additional support, but the central focus

remains on maintaining continuous care by the same midwife throughout the entire journey. This model promotes stronger relationships and a more consistent experience for women and their families (Dixon & Guilliland, 2019).

5 Discussion

Germany's maternity care system faces challenges in maintaining continuity of care due to poor working conditions, hospital closures, a shortage of midwives, and a lack of multidisciplinary collaboration. The midwifery profession is undervalued, with no unified association or strong frameworks supporting MLCC, and the lack of comprehensive data further complicates efforts to improve the system. New Zealand's LMC model addresses many of these challenges by offering continuous, personalized care throughout the entire scope of midwifery practice. This section discusses whether the LMC model could improve continuity of care in Germany by addressing current needs and explores the factors necessary for a potential implementation.

5.1 Potential Benefits of the LMC Model in Germany

The potential benefits of implementing the LMC model in Germany can be assessed based on the achievement of both national and international health and midwifery goals, as well as its effectiveness in addressing the needs of women and midwives.

Aligning with International Midwifery Standards

The ICM and the WHO, both strongly advocate for midwifery-led continuity of care (MLCC) as the most effective approach to achieving optimal neonatal and maternal outcomes while ensuring the highest standards of care. According to the ICM (2017), MLCC “provides safe and high quality care and is associated with more efficient use of resources and improves outcomes”. They recommend that Member Associations in countries where women lack access to midwife-led care should advocate for the establishment of such models, in collaboration with women and other stakeholders.

The WHO (2024) recently issued a position statement supporting the shift to midwifery models of care, highlighting that high-quality midwifery care saves lives, improves outcomes, and increases satisfaction with care. They state that “[t]ransitioning to midwifery models of care represents a cost-effective and urgently needed solution to save and improve the lives and well-being of women and newborns globally, while respecting human rights”.

Implementing a midwifery model of care, such as the LMC model, into the German maternity system would align with both key international recommendations for midwifery standards, thereby improving and enhancing maternity care.

Achieving National Maternity Care and Midwifery Goals

In 2017 the German Federal Ministry of Health published national health goals for maternity care (Kuhn & Altgeld, 2017). These goals aim to enable and promote both a healthy pregnancy and a physiological birth. Specifically, the focus is on supporting low-intervention births, strengthening health resources and skills, and enhancing the overall well-being of mothers. The goals emphasize the identification and reduction of stress factors, risks, and specific support needs, while fostering the development and communication of targeted services. Health professionals involved in the journey around childbirth are encouraged to work together constructively and in partnership, ensuring the best possible continuity of care throughout the process. Key measures to meet these goals include early counselling, case management, and strengthening multi-professional prenatal care and birth preparation. Collaboration between gynaecologists and midwives should be promoted, with the *Mutterpass* serving as a central tool for continuity of care. The woman-centred care model should be further developed and consistently applied across all care providers, with a focus on ensuring complete communication during handovers to maintain continuity and quality of care. The LMC model fulfils many of these requirements by ensuring continuity of care, improving communication, enhancing collaboration among healthcare professionals, and overall supporting the natural processes of pregnancy and birth.

Germany's largest midwifery association, the DHV, grounds its demands in the national health goals. In celebration of International Day of the Midwife 2024, the DHV published political demands focused on improving maternity care (Laskowski & DHV, 2024). These include promoting physiological birth, supporting out-of-hospital births for low-risk pregnancies, and reducing unnecessary interventions. The DHV calls for strengthened nationwide cooperation between private gynaecologists and freelance midwives, as well as significant improvements in the working conditions for self-employed midwives, including better pay and more autonomy. They also advocate for guaranteed one-on-one support for women, ensuring comprehensive, community-based obstetric care, and enhancing collaboration between out-of-hospital birth services, hospitals, and specialists. In their position statement on the centralization of inpatient obstetrics care as part of the hospital reform on 19 Jan 2023, the DHV (2023a) claims that obstetric care must be accessible 24/7 across the country, with women guaranteed the right to choose their place of birth, including quality-assured midwife-led facilities such as birthing centres and home birth support. They

advocate for the implementation of the national health goals for maternity care, with a particular emphasis on prioritizing physiological birth in the planning and development of nationwide maternity services.

Since continuity of care, the promotion of physiological birth, and ensuring equitable, comprehensive maternity care are central to these national health goals, the LMC model could provide an effective solution for achieving them.

Meeting Women's Needs

In 2023, Mother Hood e.V., a German association representing expectant parents and families, released an action plan advocating for greater focus on women- and family-centred maternity care (Desery, 2023). Their demands are based on several key principles: **choice**, allowing women to decide their place of birth, caregiver, and type of care; **control**, recognizing a woman's ability to make decisions and ensuring her right to self-determination in all aspects - social, emotional, physical, psychosocial, spiritual, and cultural; and **continuity**, ensuring women receive consistent care from one or a small group of familiar midwives. In addition, they emphasize the need for ensuring care structures, including a well-trained midwifery workforce and comprehensive access to maternity care. Strengthening interprofessional and intersectoral cooperation, further developing care quality, and improving information, education, and health literacy are also essential to achieving a more supportive, woman-centred maternity care system. This approach empowers women to be actively involved in the birth process, feel self-determined, and have their diverse needs and expectations respected. The LMC model, with its midwifery partnership approach based on equity, reciprocity, informed choice, shared decision-making, and mutual responsibility, fully aligns with these needs (Dixon & Guilliland, 2019).

In relation to the research question of this thesis, the LMC model could promote continuity of care in Germany by fostering a consistent, personalized approach to maternity services that benefits all those involved. By supporting physiological birth and a holistic care process, the model improves maternal and neonatal outcomes while elevating the overall quality of maternity care.

5.2 Factors to Consider for Implementation

This thesis will now explore implementation of the LMC model in Germany. The WHO (2024) announced in their position paper on transition to midwifery models of care that a guidance document, including case studies, is being developed to help countries implement midwifery models of care adapted to their unique contexts, supporting the transition to

improved health and well-being for their populations. This could serve as a valuable resource for enhancing the German maternity system.

The following section provides a summary of key factors to consider when implementing the LMC model. A comprehensive review is beyond the scope of this paper.

Research & Data Collection

Comprehensive and robust data are essential to assess the current state of the maternity system in Germany and accurately identify the specific needs, providing a solid foundation for effective change and improvement (DHV, 2024b). In their work on Continuity of Midwifery Care in New Zealand, Dixon and Guilliland (2019) highlight the importance of quality assurance processes, including regular reviews of midwifery standards and feedback from women.

Orientation, Infrastructure and Resource Allocation

Maternity care should be integrated into basic medical care in Germany, with a focus on women-centred, midwifery-led services and the promotion of physiological birth. Midwives should act as the primary caregivers within their scope of practice, publicly funded as LMC, including antenatal care predominantly managed by midwives making referrals to specialists when needed. Low-risk pregnancies should be promoted for delivery in out-of-hospital settings, which can reduce costs, minimize interventions, and support physiological birth. It is essential to ensure an adequate number of birthing facilities, including in rural areas, funded by the government and accessible to all midwives. Additionally, fostering good collaboration between midwives, obstetricians, and hospital staff, along with clear emergency plans, referral processes, and transfer arrangements, is crucial for effective maternity care (WHO, 2024).

Integrated Care

The LMC midwife should serve as the coordinator of the maternity care journey for women, ensuring seamless collaboration and communication among all health professionals involved, with an emphasis on sharing knowledge and skills. As Dixon and Guilliland (2019) note, "Integrated care means all health professionals working together to keep the focus on the needs of the woman.". Consistent and thorough communication, along with the sharing of information, is essential for integrated care. All caregivers involved, including the woman herself, should have continuous access to her maternity health record to ensure seamless care. The digitalization of the *Mutterpass* (German maternity health record) was an initial

step in this direction, but it is still far from being fully integrated into the national system (Peters et al., 2021).

Policy and Regulatory Adjustments

Dixon and Guilliland (2019) stress the need for personal and professional autonomy for midwives, including prescribing rights, access to diagnostic tests, the ability to directly refer to specialists, access to hospital facilities through a generic hospital access agreement for all midwives, and the right to speak on all important matters related to maternity care. Midwives should be publicly funded and employed by the Ministry of Health. It is essential to establish strong national frameworks, guidelines, and consistent standards to ensure quality of care. Another necessary step is the implementation of referral guidelines and workforce support contracts with the Ministry of Health. In their position statement, the DHV (2023a) emphasizes the need for public funding of primary birthing units, particularly in rural areas, to ensure accessibility for all women and support their right of free choice of birth place.

Training and Education for Midwives

To ensure comprehensive care, it is essential to promote the midwifery profession and expand education to build a larger workforce. The LMC model and the shift towards midwives as primary caregivers should be integrated into midwifery education programs, with standardization across the country. These programs should also adapt to the regulatory adjustments outlined earlier (e.g., prescribing rights, referrals, etc.). Emphasizing the importance of integrated care and collaboration with other healthcare providers, such as obstetricians and gynaecologists, should be a core part of the education curriculum. Ensuring sufficient placements with LMC midwives throughout the training program is vital, along with providing more support through mentoring programs. A program similar to New Zealand's government-funded Midwifery First Year of Practice Program (Pairman et al., 2016) could be valuable in supporting newly qualified midwives during their first year of practice and making the role of an LMC midwife more appealing.

Sustainability for Midwives

Sustainability for LMC midwives is particularly important, as it is a known weakness of the model, as highlighted in Section 4.2.2 on the challenges of the New Zealand system. While the LMC model offers ideal care for women, it is not always as sustainable for midwives. Dixon and Guilliland (2019) define sustainability in this context as:

- A manageable caseload, with approximately 40 women per year for full-time caseloading being optimal, though this may vary in rural areas due to travel time and distances.
- Teamwork and partnerships to share the on-call responsibilities, with clear practice arrangements, including similar caseload numbers, clear financial agreements, regular practice meetings, and a shared philosophy of care.
- Regular time off to prevent burnout.
- Setting professional boundaries and clearly communicating availability to women to ensure a balanced workload.

A qualitative descriptive study on the sustainability of the LMC model, featuring a thematic analysis of interviews with eleven LMC caseloading midwives in New Zealand, highlights the aspects mentioned above (Gilkison, 2015).

Cultural and Societal Acceptance

For the successful implementation of the LMC model, it is crucial that women, families, and all medical staff - including gynaecologists, obstetricians, and everyone involved in the maternity journey - accept midwives as primary care providers and recognize that out-of-hospital births are safe for women with low-risk pregnancies. This acceptance is essential for fostering good interprofessional collaboration and effective resource allocation. Given the current 98% hospital birth rate and the widespread belief that hospitals are the safest place to give birth, a cultural shift is necessary. Raising awareness and educating society on the safety of out-of-hospital births is key to changing these perceptions (DHV, 2023b).

5.3 Addressing Potential Challenges

Resistance to Change

Resistance to change is rooted in several factors, including a lack of appreciation for the midwifery profession, which leads to its low prioritization in political agendas. Currently, political focus is moving in a different direction with the *Krankenhausreform* (*Bundesministerium für Gesundheit*, 2024), which involves the closure of many birthing facilities, as maternity services are not prioritized in the reform. Gaining societal acceptance of out-of-hospital births as safe and of midwives as primary care providers may be challenging, given the significant shift required from the current situation, where 98% of births take place in hospitals (*Statistisches Bundesamt*, 2024b) and there is a widespread belief that hospitals are the safest place for women to give birth. Resistance to change is also evident among healthcare professionals, as many gynaecologists oppose reciprocal or

exclusive antenatal care by midwives, and many obstetricians do not support out-of-hospital births (Mother Hood e.V., 2021).

Financial and Logistical Constraints

A significant transformation of the entire maternity system is required, including redefining the role of midwives as primary caregivers, which may be challenging to implement. A major shift in midwifery remuneration is also needed, with maternity care becoming a part of basic medical care and publicly funded. The government must take greater responsibility for ensuring comprehensive maternity care. To achieve this, a financial shift is necessary to fund maternity services, which must be prioritized within political agendas (DHV, 2023a). Additionally, changes in midwifery education, including adjustments to accommodate the LMC model, and training for already registered midwives may present logistical challenges.

Ensuring Equitable Access

The current midwifery workforce is insufficient to provide nationwide coverage of MLCC. If working as a self-employed midwife became more appealing through improved working conditions and higher pay, some already registered midwives might choose to pursue this path. Additionally, the infrastructure for comprehensive MLCC is not yet in place, with many birthing facilities, particularly in rural areas, having closed (Mother Hood e.V., 2024). Establishing the necessary infrastructure may require significant time and financial investment.

5.4 Reflection Methodology

The methodology for this research involved a comparative analysis, complemented by an extensive literature search and review, which were considered the most suitable approaches for addressing the research questions.

There are several limitations to this study. Firstly, there is no current data available on neonatal and maternal outcomes specific to the LMC model in New Zealand, which led to comparisons with the general positive outcomes observed in midwife-led continuity of care models. In Germany, identifying and comparing birth data is complicated by inconsistencies in reporting, and there is no official data on the number of registered and actively practicing midwives, making it difficult to accurately assess the current situation of the German maternity system. Furthermore, this thesis offers only a brief outlook on the potential for implementing the LMC model, without a comprehensive exploration of the factors that would influence its implementation. Due to the scope of this thesis, a deeper examination would require further, more detailed research.

6 Conclusion

In conclusion, this thesis has explored how New Zealand's Lead Maternity Carer (LMC) model, with its focus on midwifery-led continuity of care, could be an effective means to improve perinatal care in Germany. The research has shown that midwifery-led continuity of care is directly linked to better maternal and neonatal outcomes, higher satisfaction for women and families, and overall improvements in the quality of maternity care (Sandall et al., 2016). These findings are well-supported by years of research and recommendations from major health and midwifery institutions globally (ICM, 2017). Given these benefits, a model like the LMC model could address many of the existing deficiencies within Germany's maternity system, particularly the lack of continuity, personalization, and woman-centred care.

Whilst the LMC model would undoubtedly raise the quality of maternity care in Germany, the complete implementation of this model as it is practiced in New Zealand may not be feasible. The structural and cultural differences between the two countries, particularly regarding the organisation of the healthcare system and the role of midwives, pose significant challenges. In contrast to New Zealand's practice of midwives as the primary caregivers, Germany's maternity care heavily depends on the obstetrician for the complete management of maternity care. This rigidity and formality would require strategic implementation of the LMC model and likely have to be adopted gradually into the existing system.

For the LMC model to be successfully integrated into Germany's maternity care system, several important factors must be considered. First, Germany needs comprehensive and up-to-date data on its current maternity care situation. This data will help identify the main areas of concern within the system and provide a foundation for developing a targeted action plan to address these issues. Only by understanding the gaps in care and the challenges faced by women and midwives can the country move forward with a plan that is both effective and sustainable.

In addition to data collection, the establishment of strong national frameworks and guidelines will be essential for guiding the implementation of midwifery-led continuity of care. One essential approach is the countrywide adoption of the Guideline on Vaginal Birth at Term (*S3 Leitlinie – Die vaginale Geburt am Termin; DGGG & DGHWi, 2020),* along with the continued development of more evidence-based guidelines to inform best practices in maternity care. Such frameworks would ensure that the transition towards a midwifery-led system is both structured and evidence-driven. This will also help to standardize care across

the country, ensuring that all women have access to the same high-quality care, regardless of where they live.

Another critical component of successful implementation is the need for a unified voice within the midwifery profession. The creation of a strong, cohesive national midwifery association or a Midwifery Chamber could provide the leadership needed to advocate for midwifery-led care, engage with policymakers, and secure necessary resources. This association would also be instrumental in raising awareness about the value of midwifery care and the importance of continuity of care in improving maternity outcomes.

For the LMC model to take root in Germany, maternity care must be integrated into the country's basic medical care system and treated with the importance and respect it deserves. This includes both valuing the role of midwives and ensuring that they are adequately compensated for their expertise and work. Political support will be necessary to create a cultural shift in how maternity care is viewed, with a greater focus on physiological birth and midwifery care. Politicians and healthcare professionals must be convinced of the importance of midwifery-led continuity of care and be willing to allocate the necessary resources to support its implementation.

The success of this transition also depends on raising public awareness and educating both women and healthcare providers about the safety and benefits of midwifery-led care, including out-of-hospital birth options. Social acceptance of these care models will be key to their widespread adoption. Public education campaigns that promote understanding of the physiology of childbirth and the safety of midwifery care will help shift societal attitudes and reduce any stigma surrounding alternative birth settings.

One of the most pressing challenges in implementing a midwifery-led care model is the sustainability of the midwifery profession. Midwifery in Germany, as in many countries, faces significant challenges related to workforce shortages, burnout, and poor working conditions. It is essential to ensure that midwives are not only properly remunerated but also have access to good working conditions that allow them to provide the level of care required by the LMC model. Creating a sustainable, supportive working environment for midwives will be crucial to the success of any reforms aimed at introducing midwifery-led continuity of care.

Equally important is the development of educational programs that train the next generation of midwives, ensuring that there is a strong and capable workforce to deliver midwifery-led care. Promoting midwifery as a respected and rewarding career is crucial for attracting individuals to the profession and ensuring the continuity and quality of care.

Ultimately, the focus must be on two key areas: establishing a women-centred model of maternity care that reflects the principles of the LMC model and protecting the well-being of midwives to ensure a thriving profession. The groundwork is already laid with national health goals and initiatives (*Bundesministerium für Gesundheit*, 2017; DHV, 2023a; Desery, 2023), but it is now critical to turn these intentions into concrete action. With the right policies, resources, and cultural shift, supported by comprehensive data, strong national frameworks, a unified midwifery association, and political and public backing, Germany can transition to a more holistic, midwifery-led maternity care system that values midwifery expertise, supports the well-being of midwives, and improves both the quality of care and the satisfaction of women and families during one of the most important times of their lives.

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Eidesstattliche Erklärung

Hiermit versichere ich, Joana Keischgens, [redacted] dass ich die vorliegende Bachelorarbeit mit dem Titel

“From Kiwis to Kinder: How New Zealand’s Lead Maternity Care Model Could Deliver Better Perinatal Care in Germany”

selbstständig und ohne fremde Hilfe, insbesondere ohne entgeltliche Hilfe von Vermittlungs- und Beratungsdiensten sowie ohne die Anwendung von KI-Sprachmodellen wie z.B. ChatGPT, angefertigt und keine anderen als die von mir angegebenen Quellen und Hilfsmittel benutzt habe. Alle wörtlichen oder sinngemäßen Entlehnungen aus anderen Arbeiten sind an den betreffenden Stellen als solche kenntlich gemacht und im entsprechenden Verzeichnis aufgeführt, das gilt insbesondere auch für alle Informationen aus Internetquellen. Ich erkläre zudem, dass ich die an der Medizinischen Fakultät Hamburg geltende „Satzung zur Sicherung guter wissenschaftlicher Praxis und zur Vermeidung wissenschaftlichen Fehlverhaltens an der Universität Hamburg“ in der jeweils gültigen Fassung eingehalten habe.

Des Weiteren versichere ich, dass ich die vorliegende Bachelorarbeit vorher nicht in dieser oder ähnlicher Form in einem anderen Prüfungsverfahren dieser oder einer anderen Fakultät bzw. Hochschule eingereicht habe.

Ich erkläre mich einverstanden, dass meine Bachelorarbeit zum Zweck der Plagiatsprüfung gespeichert und von meiner/-m Erst- und Zweitprüfenden mit einer gängigen Software zur Erkennung von Plagiaten überprüft werden kann.

Ich erkläre mich einverstanden, dass oben genannte Bachelorarbeit oder Teile davon von der Medizinischen Fakultät der Universität Hamburg oder von der HAW Hamburg veröffentlicht werden.

29.11.2024, [redacted]

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