Australian Government
Australian Institute of Health and Welfare

Maternity models of care in Australia

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About

Maternity care is delivered in different ways and these are referred to as ‘models of care’. At a service level, a maternity model of care describes how and where care is provided, the carers involved and the continuity of carer within them. A model of care can be tailored to meet the needs of a specific group of women and may vary by location and service. Many maternity services provide more than one model to meet the needs of their communities.

In 2025, around 1,100 models of care were reported as being in use across 248 maternity services in Australia. This report explores the key characteristics of these models to provide insights into how maternity care is delivered.

Cat. no: PER 118

Key findings

- The most common model category is public hospital maternity care (42% of models)
- Over three-quarters (77%) of models provide residential postnatal visits
- Nearly half of maternity services (46%) have a midwifery continuity of carer model, an increase from 42% in 2024
- The number of services with a model designed for First Nations women increased from 36% in 2024 to 38% in 2025

Maternity models of care

What is a 'model of care'?

Each maternity model of care describes how a group of women are cared for during pregnancy, birth and the postnatal period at a maternity service. This includes the carers involved and the role they play during the maternity period, as well as aspects of how and where care is provided. A model of care can be designed to support women with specific pregnancy and birthing needs and in response to the context in which the maternity service operates. For example, the number and types of models of care available will differ between large urban hospitals and smaller rural settings, and between public and private maternity services.

Each individual model of care can be grouped into one of the following 11 categories:

- combined care
- general practitioner obstetrician care
- midwifery group practice caseload care
- private midwifery care
- private obstetrician specialist care
- private obstetrician and privately practicing midwife joint care
- public hospital high risk maternity care
- public hospital maternity care
- remote area maternity care
- shared care
- team midwifery care.

Why do we classify them?

Around 300,000 babies are born in Australia each year. While women have some choice around the health providers and care they receive during the maternity period, this may depend on where they live and their individual circumstances. The maternity period is a time of interaction with the health care system. Women may access maternity care through the public health system or privately or use a combination of both, and care may involve midwives, obstetricians, general practitioners (GPs) and other health care providers (Healthdirect 2022). Sometimes a woman will see the same provider throughout the maternity period – known as continuity of care – and sometimes they will see different providers, for example, have some appointments with a GP and others with a midwife.

Maternity services are provided by state and territory health departments and private providers, often with funding and subsidies provided by the Commonwealth Government, and may vary both within and between jurisdictions (Rolfe et al. 2017). The models of care available to women will depend on their specific geographic location, the nature of their local maternity service and factors such as workforce availability, individual resources, and whether there are complexities surrounding the pregnancy, for example the level of obstetric input required (COAG 2019).

Most maternity models of care in Australia include care in either a public or private hospital setting. A maternity service will provide one or more models of care and some of these may be designed to support specific groups of women.

In 2009, a review of maternity services in Australia recommended some changes to improve choices for women and increase the variety of care options available to them (DoHA 2009).

In 2019, all Australian governments agreed the *Woman-centred care: Strategic directions for Australian maternity services* and to the principle that women should have access to continuity of care with the care provider(s) of their choice – including midwifery continuity of care (COAG 2019).

To monitor the variety of care options available to and used by women requires the collection of this information in a standardised way. Reporting on models of care and the model categories they sit under helps to answer important questions about maternity care, such as which models of care are available to women across Australia, whether these provide continuity of care and how maternity care is changing over time.

These data are also designed to support the collection and reporting of model of care information via the National Perinatal Data Collection (NPDC). This report focuses on describing and monitoring changes at a system level in the models of care being developed and implemented over time. Linking NPDC data with model of care information is vital for understanding how different care models relate to pregnancy and birth outcomes over time.

What is the Maternity Care Classification System?

The Maternity Care Classification System (MaCCS) is a standardised nomenclature for maternity models of care. It is used to identify, describe, and report on the range of maternity models of care available to women in Australia. Funded by the Commonwealth Department of Health, Disability and Ageing, the MaCCS was developed by the National Perinatal Epidemiology and Statistics Unit at the University of New South Wales and the Australian Institute of Health and Welfare (AIHW), as part of the *National Maternity Data Development Project* (AIHW 2014a, 2016a, 2018). This involved consultation with a range of stakeholders across the country (AIHW 2014b, 2016b).

The MaCCS underpins the AIHW's maternity models of care data collection and the Maternity Model of Care Data Set (MoC DS). The MoC DS contains information about the models of care available at maternity services across Australia. Collecting service-level data using the MaCCS has also facilitated the inclusion of model of care data elements into the NPDC. Two model of care data elements were added to the specifications for this collection in July 2020.

The AIHW would like to thank and acknowledge the maternity services and jurisdictions that contribute to the MoC DS. While this release reports on the characteristics of the models themselves, the AIHW also reports on the women utilising different models of care using data from the NPDC in jurisdictions where perinatal models of care data are available (currently Victoria, Queensland and Western Australia). This will expand as more

jurisdictions implement the model of care data items in their perinatal data collections. See Australia's mothers and babies: Maternity models of care.

References

AIHW (Australian Institute of Health and Welfare) (2014a) *Foundations for enhanced maternity data collection and reporting in Australia: National Maternity Data Development Project Stage 1*, Cat. No. PER 60. Canberra: AIHW, Australian Government.

AIHW (2014b) *Nomenclature for models of maternity care: a consultation report*, Cat. No. PER 64. AIHW, Australian Government.

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AIHW (2016b) *Maternity Care Classification System: Maternity Model of Care Data Set Specification national pilot report November 2014*, Cat. No. PER 74. AIHW, Australian Government.

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Council of Australian Government (COAG) Health Council (2019) *Woman-centred care: Strategic directions for Australian maternity services*, Department of Health, Australian Government.

Department of Health and Ageing (DoHA) (2009) *Improving maternity services in Australia: the report of the Maternity Services Review*, DoHA, Australian Government.

Healthdirect (2022) *Maternity care in Australia*, healthdirect website, accessed 31 July 2023.

Rolfe MI, Donoghue DA, Longman JM, Pilcher J, Kildea S, Kruske S, Kornelsen J, Grzybowski S, Barclay L and Morgan GG (2017) 'The distribution of maternity services across rural and remote Australia: does it reflect population need?', BMC Health Services Research, 17:163, doi:10.1186/s12913-017-2084-8.

How many models of care are there?

Models of care are classified at the maternity service level and each model gets a unique model of care number.

Models of care are unique to a maternity service, however, the models available in different locations may be similar to each other with respect to their key characteristics. Every model can be grouped into one of 11 model categories making it possible to report on the range of models of care available to women using common terminology. See Major model category definitions.

About the data in this report

Some jurisdictions have a small number of services and models of care which are used as the denominators in this report. This should be considered when interpreting this data. Also, having a particular model of care at a maternity service may not mean this model is available to all women who want to access it. Some models may be subject to resourcing-driven caps and inclusion criteria.

Maternity models of care – at a glance

In 2025, around 1,100 maternity models of care were reported as being in use across 248 maternity services providing intrapartum care. In these services:

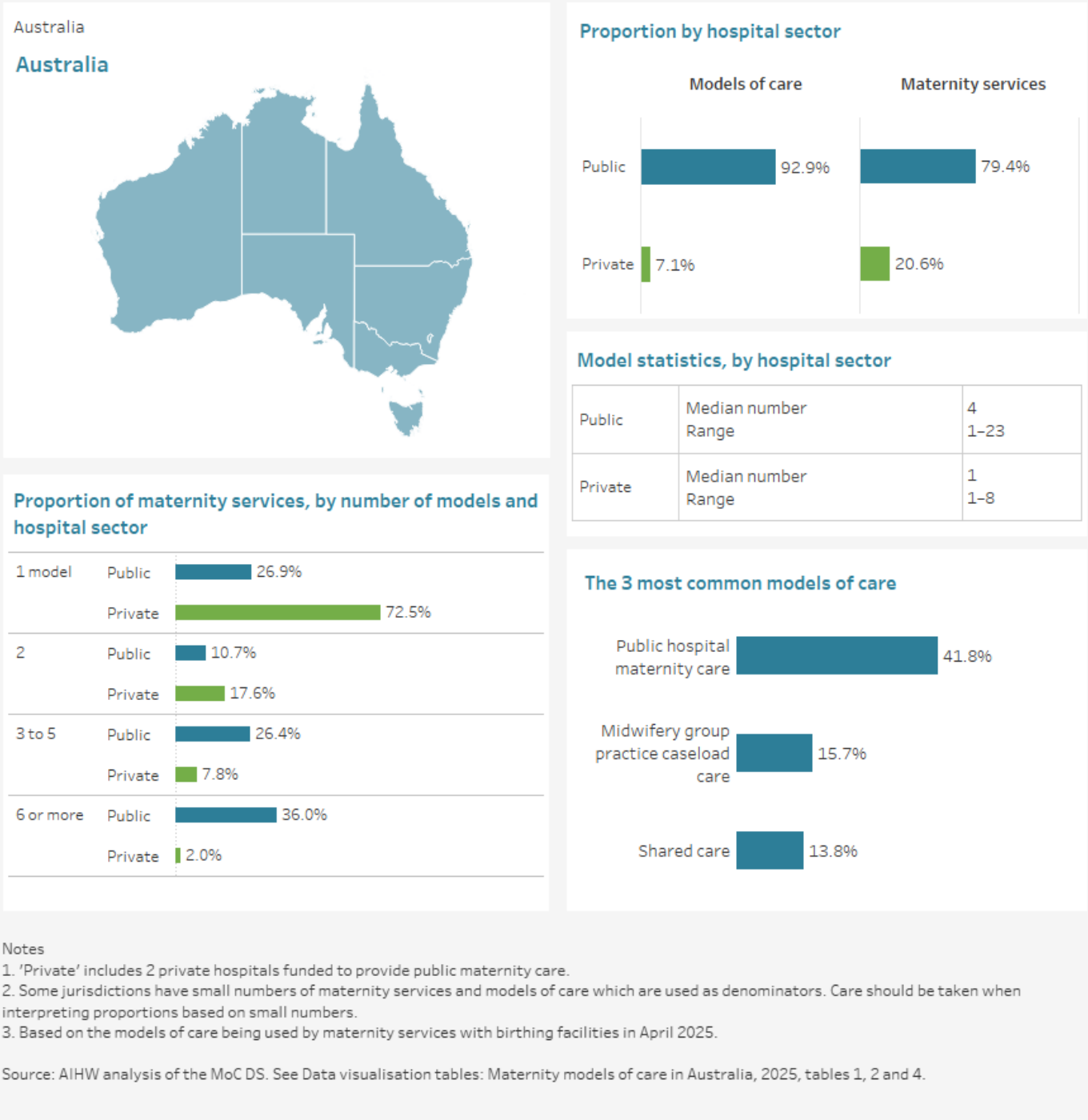
- over one-third (36%) have one model of care
- 12% have 2 models of care
- 23% have between 3 and 5 models
- 29% have 6 or more models of care.

This was similar to the distribution of models of care reported in 2024.

The median number of models across all maternity services was 3, the same as 2024. Public maternity services tend to have more models of care per service than private services, with a median of 4 models per service, compared with 1 in private services.

The interactive map below (Figure 1) summarises the models of care in use in Australia. Select a jurisdiction (state or territory) from the map or the dropdown menu to see its summary information.

Figure 1: Maternity models of care, by jurisdiction, Australia, 2025



Notes
1. 'Private' includes 2 private hospitals funded to provide public maternity care.
2. Some jurisdictions have small numbers of maternity services and models of care which are used as denominators. Care should be taken when interpreting proportions based on small numbers.
3. Based on the models of care being used by maternity services with birthing facilities in April 2025.

Source: AIHW analysis of the MoC DS. See Data visualisation tables: Maternity models of care in Australia, 2025, tables 1, 2 and 4.

Common models of care

The most common model category is *public hospital maternity care* with around 460 models (42%) falling into this category; over half (57%) of all maternity services have at least one model of care in this category. This was similar to 2024 (42% of models at 56% of services). Models of care in this category typically have no continuity of carer (54% of these models) or some continuity of carer (either antenatal, antenatal/postnatal, antenatal/intrapartum or intrapartum/postnatal) (44% of these models).

The next most common model category is *midwifery group practice caseload care,* with around 170 models (16%) falling into this category. This type of model provides midwifery continuity of carer through the whole maternity period; just under half of maternity services (46%) have this model of care in place.

Other common maternity models of care include:

- *shared care* accounting for 14% of models and available at 51% of service in 2025. This was similar to 2024 (151 models in 2024 and 152 models in 2025).
- *private obstetrician specialist care* accounting for 8.7% of models and available at 37% of maternity services. The number of these models dropped from 102 in 2024 to 96 in 2025.

Continuity of carer

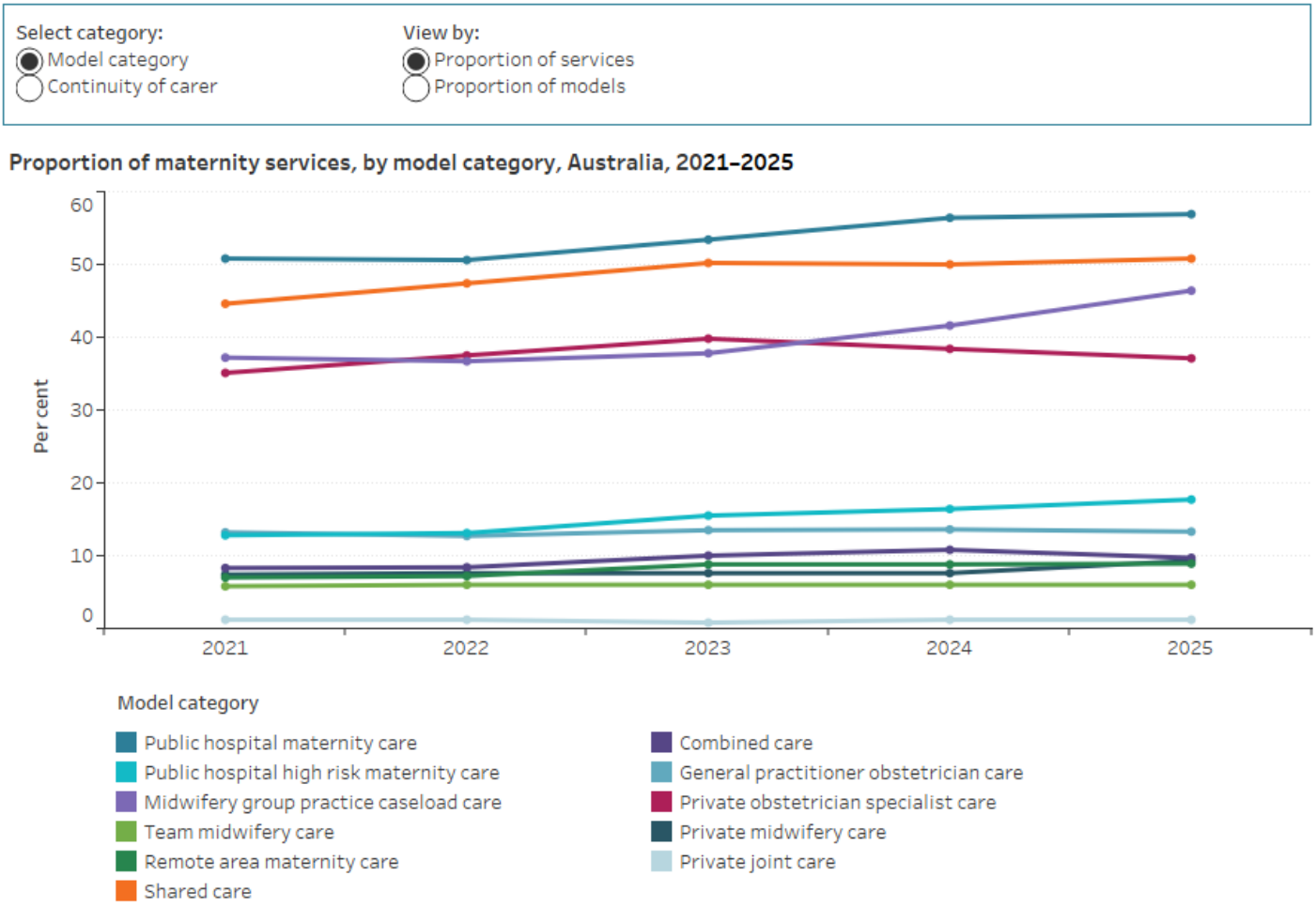
Around 29% of models have continuity of carer from the same named carer for the whole maternity period, compared with 28% in 2024. This reflects *midwifery group practice caseload care* (16%) and other models of care (13%), usually *private obstetrician specialist care*. Just over one-third of models (35%) have no continuity of carer in any stage of the maternity period (compared with 36% in 2024), while a similar proportion (37%) have continuity of carer

for some part of the maternity period (compared with 35% in 2024).

Around three-quarters of maternity services (77%) have at least one model of care with continuity of carer for the whole maternity period (compared with 74% in 2024). Midwifery continuity of carer is available at 46% of maternity services, an increase from 42% in 2024. Around 7% of services (17) have no models of care with any continuity of carer, a decrease from 9.6% (24 services) in 2024.

The data visualisation below (Figure 2) summarises two model of care characteristics, the model category and the extent of continuity of carer.

Figure 2: Maternity models of care and maternity services, by model category and continuity of carer, Australia, 2021–2025



Notes
1. A maternity service may have more than one model of care and be counted in more than one model category.
2. Care should be taken when interpreting changes over time as there have been improvements in coverage and data quality in some maternity services and the number of services in scope for reporting may change.
3. Based on the models of care being used by maternity services with birthing facilities when the collection was finalised in each year.

Source: AIHW analysis of the Maternity Model of Care Data Set. See Data visualisation tables: Maternity models of care in Australia, 2025, table 4.

What do maternity models of care look like?

Around 1,100 models of care were reported as being in use across Australia in 2025. Most maternity services with birthing facilities (99%) had models of care included in the 2025 Maternity Model of Care Data Set (MoC DS), an increase from 98% of services in 2024.

There were 2 maternity services with models of care included for the first time because they now offer birthing services, and 5 services no longer in scope for reporting because they do not currently have birthing services. While the total number of services with classified models of care was similar at around 250, the number of models reported increased by 40, from 1,062 in 2024 to 1,102 in 2025. Most of this increase was due to more models of care being classified by maternity services in New South Wales (11), Queensland (9) and Western Australia (11), and most of these were new models implemented since the last collection.

The key characteristics of these models of care can be explored in the following sections.

Major model category

42% of models are classified as *public hospital maternity care*, followed by *midwifery group practice caseload care* (16%) and *shared care* (14%)

Maternity carers

49% of models have a *midwife – public* as the designated (lead) maternity carer, compared with 47% in 2024

Continuity of carer

16% of models have *midwifery continuity of carer* through the whole maternity period, compared with 15% in 2024

Target groups

64% of models are designed for specific groups of women

Antenatal and postnatal care

77% of models provide access to postnatal visits in a residential setting

Labour and birth settings

3% of models have the home as a planned setting for birth

Model category

Each individual model of care is grouped into one of 11 different model categories based on its specific characteristics. These describe the intent of the model of care, although not all women in a model of care will necessarily follow the same journey or receive the same care pathway. See Major model category definitions.

The most common model category in 2025 was *public hospital maternity care* (42% of models of care). This was followed by *midwifery group practice caseload care* (16% of models), *shared care* (14% of models), and *private obstetrician specialist care* (8.7% of models). The proportion of services providing these different models of care in 2025 were generally similar to 2024, however, the proportion providing *midwifery group practice caseload care* increased from 42% of services in 2024 to 46% in 2025 (from 104 to 115 services).

Public hospital high risk maternity care made up around 6.4% of models, an increase from 5.6% in 2024. Other, less common models include *general practitioner obstetrician care* (3.4%), *combined care* (2.5%), *private midwifery care* (2.1%) and *team midwifery care* (1.6%).

In 2025, *public hospital maternity care* was the most common model category in all states and territories, except the Northern Territory where *remote area maternity care* (28% of models) and *shared care* (24% of models) are more common. Queensland and South Australia have relatively high proportions of models classified as *midwifery group practice caseload care* (26% and 20%, respectively).

Around two-thirds of services in Queensland (69%) and the Australian Capital Territory (67%) had a model classified as *midwifery group practice caseload care*, compared with 46% of services overall. Victoria had a higher proportion of services with a model classified as *private obstetrician specialist care* (54%, compared with 37% overall).

The data visualisation below (Figure 3) shows maternity models of care by model category for both maternity services and models of care. Select the drop-down menu to filter by jurisdiction (state or territory) and use the buttons to view the data table and trend data.

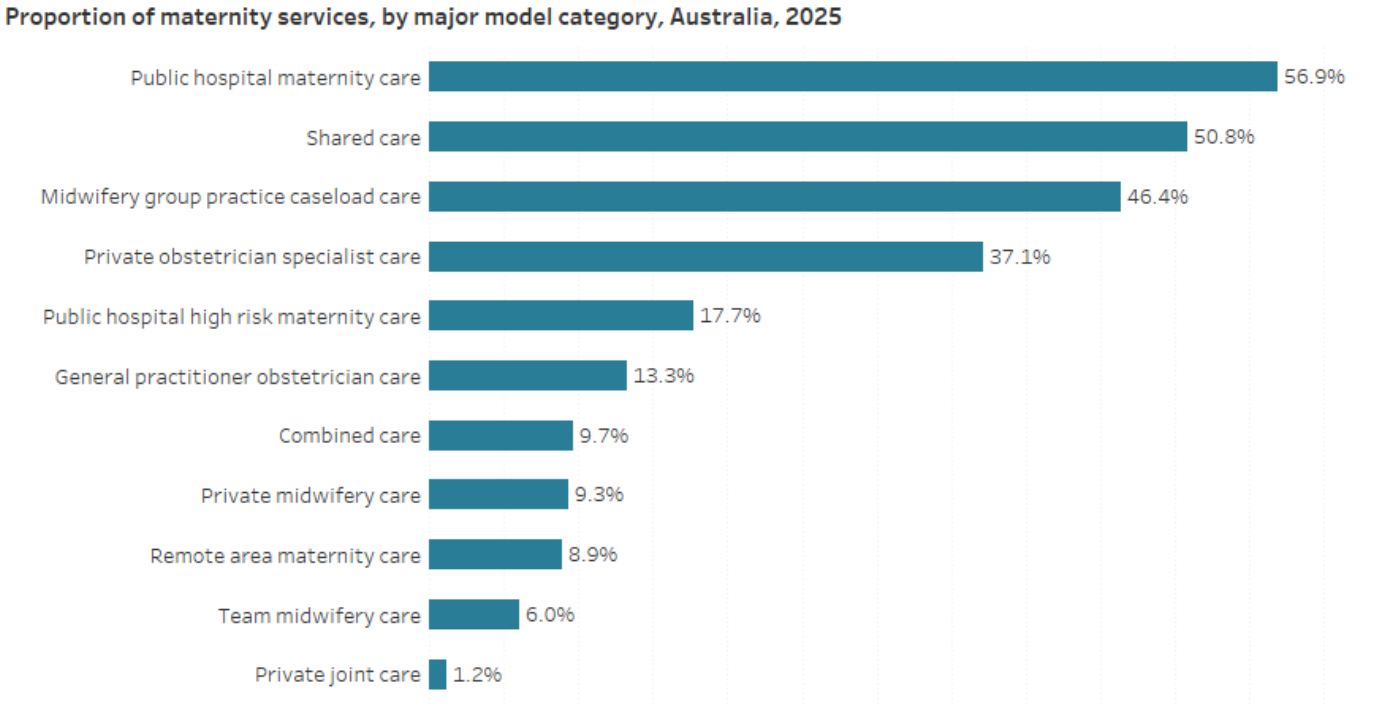
Figure 3: Maternity models of care, by major model category, Australia, 2021–2025

Select jurisdiction:
Australia

View proportion of:
(●) Services
( ) Models

Trend data

Data table



Notes
1. Some model categories are not represented in some jurisdictions as health system structures and care frameworks may differ. There may also be a small number of models that are not included if they have not yet been classified by maternity services or are state-wide models that do not sit under a specific service.
2. A maternity service may have more than one model of care and be counted in more than one model category, therefore the sum of services may exceed the total.
3. Some jurisdictions have a small number of maternity services which are used as denominators. Care should be taken when interpreting proportions based on small numbers.
4. Based on the models of care being used by maternity services with birthing facilities in April 2025.

Source: AIHW analysis of the Maternity Model of Care Data Set. See Data visualisation tables: Maternity models of care in Australia, 2025, table 4.

Models of care may differ within the same model category

There may still be differences between models of care with the same model category. *Public hospital maternity care* is the model category with the most variation (Donnolley et al. 2017). It broadly describes a model of care where antenatal care is provided by midwives and/or doctors in onsite or outreach clinics. Intrapartum (labour and birth) and postnatal care is provided in hospital by midwives in collaboration with doctors as needed. This category is used to describe models that cover a range of clinics, including those led by midwives that support low risk women, to those led by public specialist obstetricians for women with obstetric complexities such as gestational diabetes, multiple pregnancy, or next birth after caesarean section. In 2025, around three-quarters (75%) of models classified as *public hospital maternity care* were designed for a specific group of women, compared with 64% of models overall.

In contrast, models classified as *midwifery group practice caseload care* (also known as midwifery continuity of carer) have less variation. This category describes models where antenatal, intrapartum, and postnatal care are provided within a publicly funded caseload model by a known primary midwife, with secondary backup midwives providing cover and assistance, and collaboration with doctors and other health professionals as needed. Antenatal care and postnatal care are usually provided in the hospital, community, or home with intrapartum care in a hospital, birth centre or home. This model category, by definition, has a public midwife as the designated carer and continuity of carer for the whole maternity period. It is also more likely to be designed for women with low risk pregnancy (32%, compared with 18% overall in 2025) and to provide residential postnatal care (100%, compared with 77% overall in 2025).

A *shared care* model category describes models of care where antenatal care is provided by a community service provider (doctor and/or midwife) in collaboration with hospital medical and/or midwifery staff, under an agreed schedule of care. Intrapartum and early postnatal care usually takes place in the hospital, by hospital midwives and doctors, often in conjunction with the community doctor or midwife (particularly in rural settings). In 2025, over half (55%) of models of care in this category were designed for a specific group of women, compared with 64% overall, and 26% were designed for low risk pregnancy.

Private obstetrician specialist care describes models of care where antenatal care is provided by a private specialist obstetrician (as the lead carer) in their private rooms or at a hospital. Intrapartum care is provided in either a public or private hospital by the private specialist obstetrician in collaboration with hospital midwives. Postnatal care is usually provided in the hospital by the private specialist obstetrician and hospital midwives, and care by

midwives may continue in the home. Most (84%) models in this category provide continuity of carer across the whole maternity period. These models are not usually designed for specific groups of women; only 8.3% had a target group 2025.

References

Donnolley NR, Chambers GM, Butler-Henderson KA, Chapman MG & Sullivan EA (2017) 'More than a name: Heterogeneity in characteristics of models of maternity care reported from the Australian Maternity Care Classification System validation study', *Women and Birth* 30(4): 332–341, doi:10.1016/j.wombi.2017.01.005

Maternity carers

Designated (lead) carers

The *designated* or *lead* maternity carer is the health professional coordinating the care for women during the antenatal, intrapartum, and postnatal periods.

In 2025, just under half of all models of care (49%) have a *midwife – public* (midwives employed in the public health system) as the designated carer, compared with 47% in 2024. This is an essential component of models classified as *midwifery group practice caseload care* (100%) and is also found in nearly two-thirds of models classified as *public hospital maternity care* (65%).

The next most common designated carer is a *specialist obstetrician – public* (15% in both 2024 and 2025), followed by a *shared care* arrangement (14% of models in both 2024 and 2025) and a *specialist obstetrician – private* (10% in 2025 and 11% in 2024). Having a *shared care* arrangement means the model of care does not have a single designated carer and the carer may change at different times or be shared.

A designated carer of *midwife – public* is more common in models of care in New South Wales and Queensland (60% and 52%, respectively, compared with 49% overall). Two-thirds of maternity services (66%) have a model of care with a *midwife – public* as a designated carer. Victoria had a higher proportion of models of care with a *specialist obstetrician – private* as the designated carer (17%, compared with 9.9% overall). Over half (56%) of maternity services in Victoria have a model of care with a *specialist obstetrician – private* as the designated carer, compared with 40% of services overall.

The data visualisation below (Figure 4) shows maternity models of care by type of designated carer for both maternity services and models of care. Select the drop-down menu to filter by jurisdiction (state or territory) and use the buttons to view the data table and trend data.

Figure 4: Maternity models of care, by type of designated carer, Australia, 2021–2025

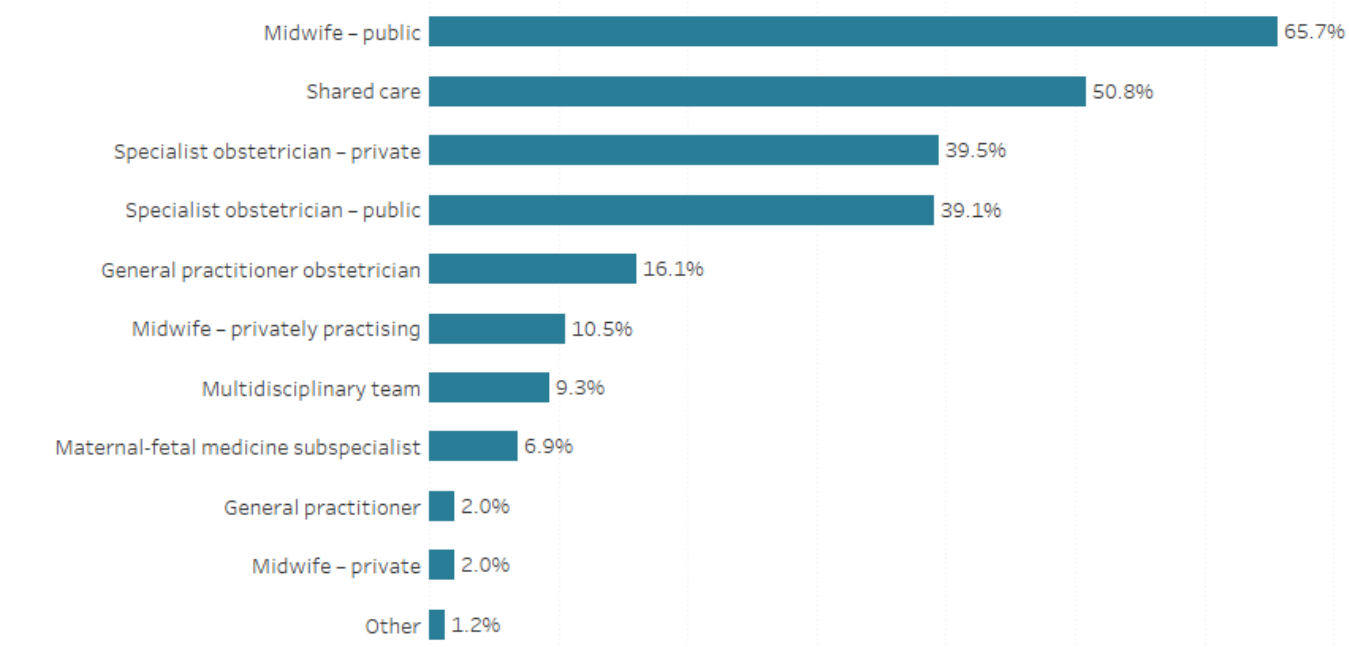
Select jurisdiction:
Australia

View proportion of:
(•) Services
( ) Models

Trend data

Data table

Proportion of maternity services, by designated carer, Australia, 2025



Notes
1. A designated or lead carer is the health professional coordinating the care for women during the antenatal, intrapartum and postpartum periods.
2. 'Midwife – privately practicing' refers to privately practising midwives working in a private or public healthcare setting. 'Midwife-private' refers to midwives employed in the private health system. 'Other' includes Aboriginal maternal infant care practitioner and other not specified carers.
3. A maternity service may have more than one model of care and be counted in more than one designated carer category, therefore the sum of services may exceed the total.
4. Some jurisdictions have a small number of maternity services which are used as denominators. Care should be taken when interpreting proportions based on small numbers.
5. Based on the models of care being used by maternity services with birthing facilities in April 2025.

Source: AIHW analysis of the Maternity Model of Care Data Set. See Data visualisation tables: Maternity models of care in Australia, 2025, table 5.

Collaborative carers

Collaborative maternity carers are other health professionals that work in partnership with the lead carer to provide maternity care. In 2025 most models of care (94%) have at least one collaborative carer, in addition to the lead or designated carer. Around half (47%) of all models have one collaborative carer, and this was higher in models classified as:

- *private obstetrician specialist care* (85%)
- *general practitioner (GP) obstetrician care* (81%)
- *team midwifery care* (72%)
- *remote area maternity care* (70%).

Just over one-quarter of models (28%) have 2 collaborative carers, and this was higher in models classified as *combined care* (61%), *public hospital high risk maternity care* (49%), and *shared care* (40%).

Common collaborative carers include *specialist obstetrician – public* (47% of models)*, midwife – public* (43%) and *GP obstetrician* (16%). All models of care with a designated carer of *specialist obstetrician – public* have a *midwife – public* as a collaborative carer, while two-thirds (68%) of models with a *midwife – public* as a designated carer have a *specialist obstetrician – public* as a collaborative carer.

In models with a designated carer of *shared care,* most (92%) have a *midwife – public* as a collaborative carer, while around half have a *specialist obstetrician – public* (53%), *GP* (53%), or *GP obstetrician* (40%) as a collaborative carer.

Continuity of carer

The *extent of continuity of carer* is a measure of the one-to-one care provided by the same named caregiver. In 2025, over one-third of models (35%, or 381 models) had no continuity of carer in any stage of the maternity period, so care is given by different providers. This was similar to 2024 (36%, or 385 models). A similar proportion (37%) have continuity of carer for some part of the maternity period, for example the antenatal period only (20%), or the antenatal and postpartum periods (15%).

Around 317 models (29%) in 2025 have continuity of carer for the whole maternity period, meaning a single named carer provides or coordinates care for the antenatal, intrapartum, and postpartum periods. This is 15 more models than reported in 2024 (28%, or 302 models). Continuity of carer for the whole maternity period reflects models classified as *midwifery group practice caseload care* (16%) – also known as midwifery continuity of carer and other models of care (13%), usually those classified as *private obstetrician specialist care*. The number of models providing midwifery continuity of carer increased from 154 in 2024 to 173 in 2025, while those providing whole duration continuity of carer from other care providers changed from 148 models in 2024 to144 models in 2025.

The proportion of models with continuity of carer through the whole maternity period was higher in Queensland (39%) which may be related to the higher number of models classified as *midwifery group practice caseload care.*

Around three-quarters (77%) of maternity services have at least one model of care with continuity of carer for the whole maternity period – this was higher in private maternity services (94%) than public services (72%). Fifty-seven per cent of services (142 services) have a model of care with no continuity of carer, compared with 62% (155 services) in 2024. A midwifery continuity of carer model was available at 46% of maternity services overall and is higher for services in Queensland (69%) and the Australian Capital Territory (67%).

The data visualisation below (Figure 5) shows maternity models of care by the extent of their continuity of carer for both maternity services and models of care. Select the drop-down menu to filter by jurisdiction (state or territory) and use the buttons to view the data table and trend data.

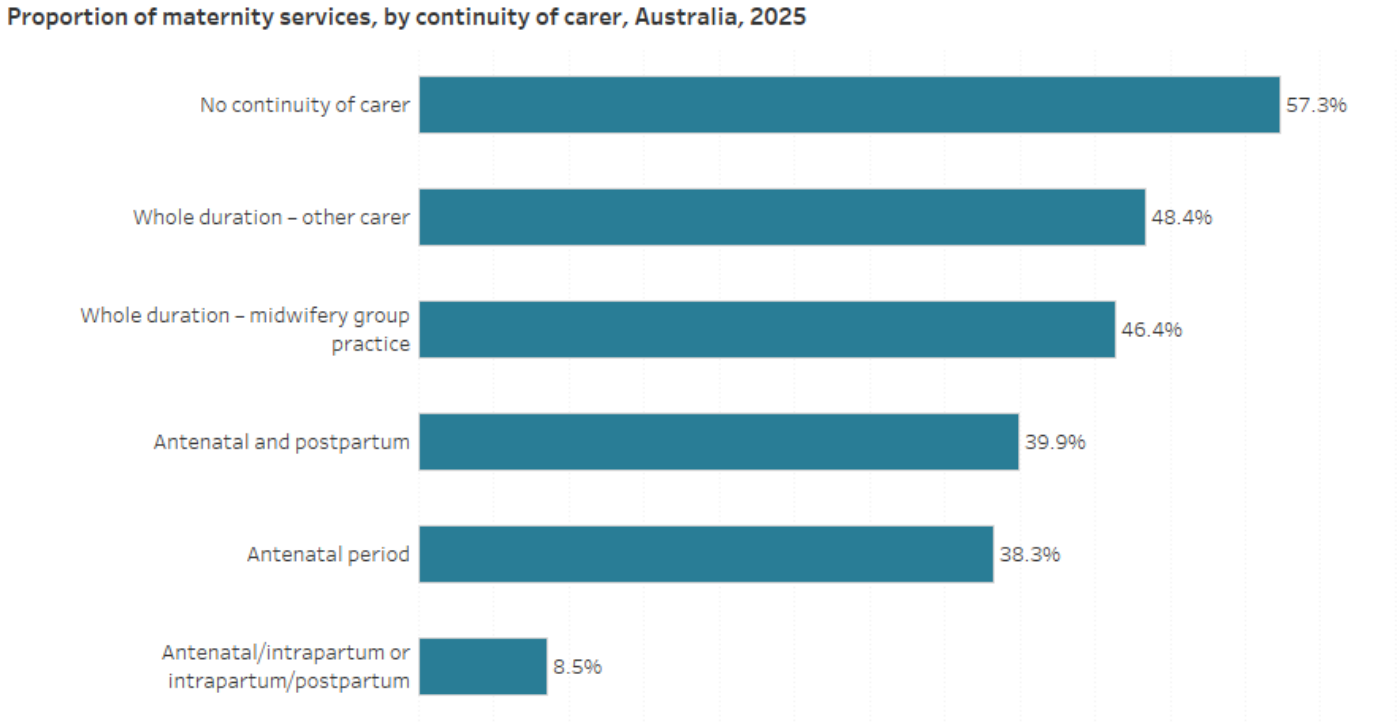
Figure 5: Maternity models of care, by continuity of carer, Australia, 2021–2025

Select jurisdiction:
Australia

View proportion of:
(•) Services
( ) Models

Trend data

Data table



Notes
1. The extent of continuity of carer is a measure of the one-to-one care provided by the same named carer across the antenatal, intrapartum and postpartum periods.
2. A maternity service may have more than one model of care and be counted in more than one continuity of care category, therefore the sum of services may exceed the total.
3. Some jurisdictions have a small number of maternity services. Care should be taken when interpreting proportions based on small numbers.
4. Based on the models of care being used by maternity services with birthing facilities in April 2025.

Source: AIHW analysis of the Maternity Model of Care Data Set. See Data visualisation tables: Maternity models of care in Australia, 2025, table 6.

Continuity of carer varies by model category and designated carer

The extent of continuity of carer varies by model category. Models classified as *midwifery group practice caseload care*, by definition, have continuity of carer for the whole maternity period. Models classified as *private midwifery care*, and *private obstetrician specialist care* also have a high level of continuity of carer for the whole maternity period (100% and 84% of models in these categories, respectively in 2025). In contrast, models classified as *team midwifery care*, by definition, have no continuity of carer across any stage of the maternity period. Models classified as *public hospital maternity care* and *public hospital high risk maternity care* are more likely to have no continuity of carer (54% and 55% of models in these categories, respectively).

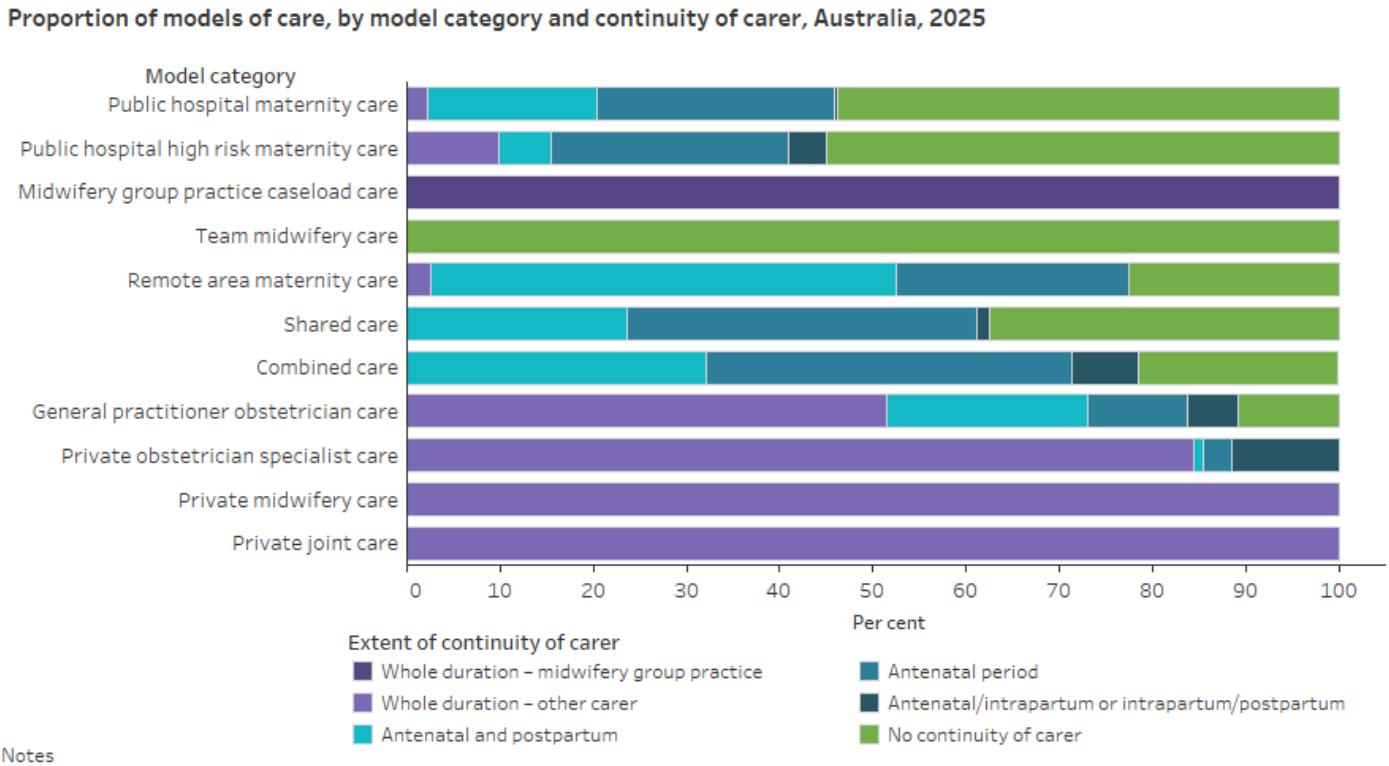
The extent of continuity of carer also varies by the health profession of the designated carer. Models of care with a designated carer of *midwife – privately practising* or *specialist obstetrician – private* are more likely to have continuity of carer for the whole maternity period (89% and 76% of these models, respectively in 2025). In contrast, three-quarters (76%) of models of care with a designated carer of *specialist obstetrician – public* have no continuity of carer at any stage of the maternity period.

Continuity models of care with different professional groups as the designated carer are likely to use different approaches and practices in the care they provide. For example, all midwifery continuity of carer models offer a postnatal visit in a residential setting, compared with 36% of *private obstetrician specialist care* models of care.

The data visualisation below (Figure 6) shows the extent of continuity of carer by major model category and designated carer. Change the display by selecting either major model category or designated carer.

Figure 6: Continuity of carer, by model category and designated carer, Australia, 2025

View by:
(●) Model category
( ) Designated carer



Notes
1. The extent of continuity of carer is a measure of the one-to-one care provided by the same named carer across the antenatal, intrapartum and postpartum periods.
2. Some categories have small numbers of models of care which are used as denominators. Care should be taken when interpreting proportions based on small numbers.
3. Based on the models of care being used by maternity services with birthing facilities in April 2025.

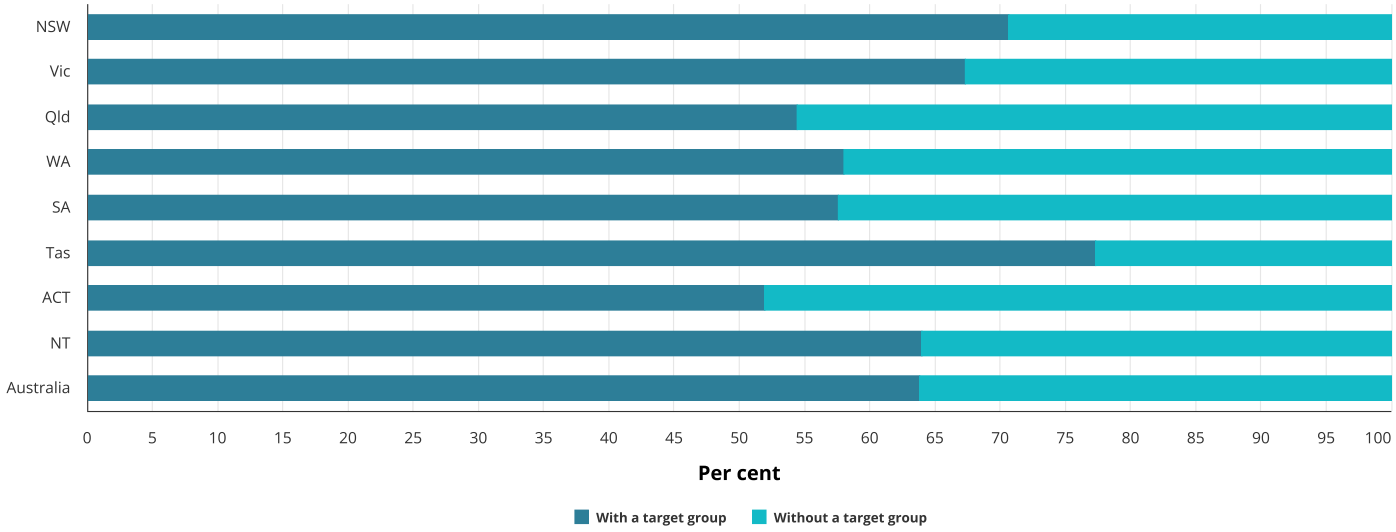
Source: AIHW analysis of the Maternity Model of Care Data Set. See Data tables: Maternity models of care in Australia, 2025, table 9.

Models designed for specific groups of women

Some models of care are designed for specific groups of women with similar characteristics. This may be based on geographical area, risk status, obstetric or medical conditions or social or cultural characteristics. A model of care may support more than one group of women.

In 2025, nearly two-thirds (64%) of models were designed for groups of women who share a common characteristic or set of characteristics, while 36% were not specifically designed for any group of women (Figure 7). This was similar to 2024.

Figure 7: Models of care designed for a specific group of women, by jurisdiction, Australia, 2025



Notes

1. Some models of care are designed to support a specific group of women, while others are available to all women.
2. Based on the models of care being used by maternity services with birthing facilities in April 2025.

Source: AIHW analysis of the Maternity Model of Care Data Set.

The broad groups of *low risk or normal pregnancy* and *all excluding high risk pregnancy* were reported in 18% and 11% of models of care, respectively. *Aboriginal or Torres Strait Islander identification* is a target group in 11% of models and this was higher in the Northern Territory (32%). There were 8 more models in 2025 with this target group, an increase from 117 models in 2024 to 125 in 2025.

Over one-third of maternity services across Australia (38%) have a model of care designed for First Nations women, an increase from 36% in 2024.

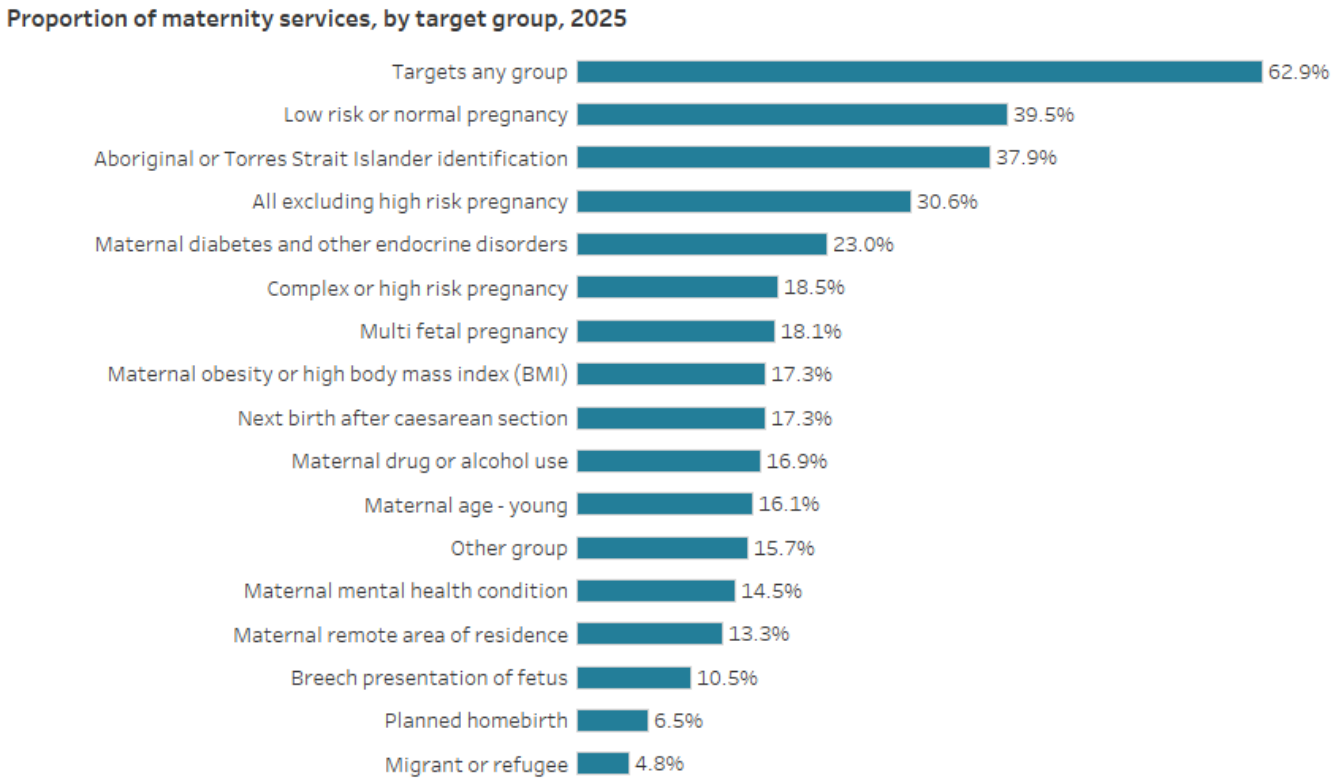
Complex or high-risk pregnancy is a target group in 6.8% of models and 19% of services have a model of care that supports women having this type of pregnancy.

The data visualisation below (Figure 8) shows maternity models of care by their target group category for all maternity services and models of care. Use the button to view trend data.

Figure 8: Maternity models of care, by target group category, Australia, 2021–2025

View by:
- (●) Proportion of services
- ( ) Proportion of models

Trend data



Notes
1. Some models of care are designed to support groups of women with similar characteristics. A model may be designed for more than one group of women and be counted in more than one target group category.
2. A maternity service may have more than one model of care and be counted in more than one target group category.
3. 'Other group' includes models designed for other cultural groups, social groups and vulnerable groups not already specified, or other maternity groups.
4. Based on the models of care being used by maternity services with birthing facilities in April 2025.

Source: AIHW analysis of the Maternity Model of Care Data Set. See Data visualisation tables: Maternity models of care in Australia, 2025, table 7.

Maternity care for First Nations people

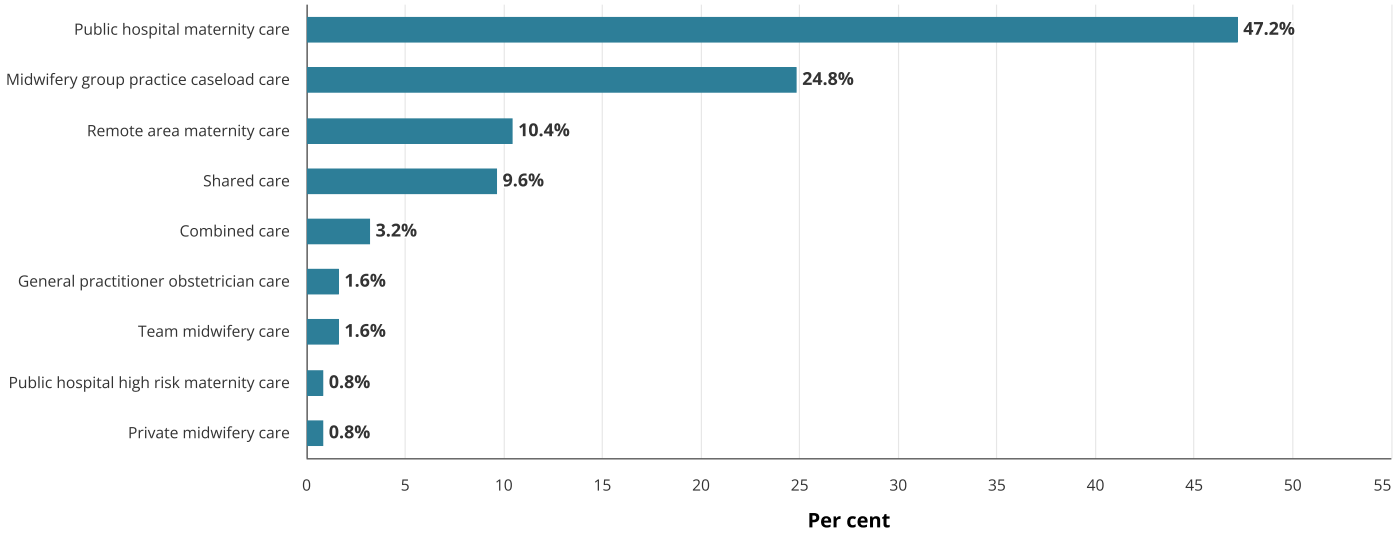
One of the strategic directions outlined in *Woman-centred care: strategic directions for Australian maternity services* is the development and implementation of culturally safe, evidence-based models of care in partnership with Aboriginal and Torres Strait Islander (First Nations) peoples and communities (COAG 2019).

These models of care are focused on improving maternal health outcomes for First Nations mothers and babies and contribute to progress made against outcome 2 under the *National Agreement on Closing the Gap* – that First Nations babies are born healthy and strong, and the associated Target that 91% of babies born in 2031 are a healthy birthweight (NIAA 2020).

Culturally safe maternity services are important for improving a broad range of health and wellbeing outcomes and experiences for First Nations mothers and babies (Kildea et al. 2016). Midwifery continuity of care and having the same named maternity carer for all, or part of the maternity period is an important part of culturally safe care for First Nations women (Hickey et al. 2018; McCalman 2024). In Australia, models of care that provide continuity of midwifery care for the whole maternity period have been shown to improve outcomes and increase childbirth satisfaction for women (McLachlan et al. 2012). In 2025:

- Around 125 (11%) models of care across 94 maternity services were designed for those who identify as First Nations, an increase from 117 models in 2024.
- Most of these models (76%) were designed for First Nations women only, while 24% were designed for more than one group of women, for example, they also support women living in remote areas.
- Around 75 (6.8%) models across 64 maternity services have an *Aboriginal healthcare practitioner* or *Aboriginal maternal infant care practitioner* as a collaborative carer, which means they have a recognised and planned role for all women using this model of care.
- Around 58 (5.3%) models across 45 maternity services offer antenatal care at an Aboriginal Community Controlled Health Service, providing holistic, comprehensive, and culturally appropriate health care to the local First Nations community.
- Nearly half of models designed for First Nations women (47%) were classified as *public hospital maternity care* and one-quarter (25%) were *midwifery group practice caseload care* (Figure 9). This compares to 42% and 16% of models overall.
- Around one-quarter (26%) of models designed for First Nations women have continuity of carer for the whole maternity period, compared with 29% of models overall. A higher proportion of models designed for First Nations women have continuity of carer for some part of the maternity period (62%, compared with 37% of models overall), and a smaller proportion have no continuity of carer (12%, compared with 35% of models overall).

Figure 9: Models of care designed for First Nations women, by model category, Australia, 2025



Notes

1. Includes models of care that are designed for women who identify as Aboriginal or Torres Strait Islander (First Nations) women. Models of care not specifically designed for this group of women may also be used by First Nations women.
2. Based on the models of care being used by maternity services with birthing facilities in April 2025

Source: AIHW analysis of the Maternity Model of Care Data Set.

Birthing on Country models of care

Birthing on Country increases access to culturally safe care for First Nations women. It has been described as a metaphor for the best start in life for First Nations babies and their families and aims to improve outcomes for First Nations mothers and babies (Kildea et al. 2013). Birthing on Country models have the same clinical requirements as standard maternity care. A key feature of Birthing on Country models is embedded First Nations governance, as models are developed in partnership with First Nations people and communities. The Molly Wardaguga Research Institute within Charles Darwin University have developed a Birthing on Country implementation framework in partnership with key Aboriginal and Torres Strait Islander stakeholders. This framework identifies factors for enabling Birthing on Country models to be developed including:

- continuity of midwifery care

- a First Nations maternity, health, allied health, and community support workforce
- culturally safe and competent maternity health professionals who are supported to work to their full scope of practice
- cultural strengthening and wellbeing programs and services
- First Nations governance and control (Kildea et al. 2019).

Research suggests women pregnant with an Aboriginal or Torres Strait Islander baby receiving a Birthing on Country model of care are more likely to attend five or more antenatal visits, less likely to have an infant born preterm and more likely to exclusively breastfeed on discharge from hospital compared with those in standard public hospital maternity care models (Kildea et al. 2021).

Box 1: Examples of Birthing on Country and First Nations designed models of care

Baggarrook Yurrongi caseload midwifery is a program developed through partnership between La Trobe University and the Victorian Aboriginal Controlled Health Organisation. Three tertiary hospitals in Melbourne offer continuity of midwifery care across the whole maternity period for women having a First Nations baby. Women may also enter a shared care arrangement between the hospital midwives and the Victorian Aboriginal Health Service or Koori maternity service. For more information, see Woman's Journey: Baggarrook Yurrongi, Nurragh Manma Buliana.

Birthing in our Community (BiOC) is a model of care developed through a partnership between the Institute for Urban Indigenous Health, the Brisbane Aboriginal and Torres Strait Islander Community Health Service and the Mater Health Service in Brisbane. It is a midwifery group practice model tailored to the preferences of Aboriginal and Torres Strait Islander families, and provides whole maternity period continuity of carer supported by a First Nations family support worker, allied health professionals, and a women's health doctor. It is overseen by an Indigenous governed steering committee and provides First Nations student midwife cadetships and placement opportunities. There are 5 BiOC hubs across Queensland, partnering with Logan Hospital, Mater Mothers Hospital and Redland Hospital for birthing. For more information, see Birthing in our Community – Institute for Urban Indigenous Health.

Boordjari Yorgas Midwifery Group Practice (BYMGP) is a model of care by Armadale Health Service in Western Australia. BYMGP began in 2007, as a part of a community initiative to build strong, trusting relationships between midwives and women having Aboriginal babies. Midwifery continuity of carer is provided in collaboration with GP obstetricians, or specialist obstetricians in the Perth east metropolitan area. For more information, see Armadale Health Service - Boodjari Yorgas Midwifery Group Practice.

Minga Gudjaga is the child and maternal health program coordinated by Waminda, an Aboriginal Community Controlled Health Organisation in the South Coast region of NSW. In May 2024, Waminda launched their Birthing on Country Midwifery Practice (BoCMP). Waminda midwives provide full continuity of care to women through the antenatal period at their Minga Gudjaga Gunyah clinic in Nowra, during labour and birth as visiting endorsed midwives at Shoalhaven Hospital and in the home during the postnatal period. The team also provide sexual and reproductive health services and child and family health services. For more information, see Waminda Minga Gugjaga child and health program.

Tharawal Aboriginal Midwifery Group Practice at Campbelltown Hospital is a model of care that practices birthing on country principles in the South-Western Sydney area. It is coordinated by Aboriginal midwives with the Tharawal Aboriginal Medical Service and offers continuity of care for the whole duration of the maternity period for First Nations women and their babies. For more information, see South Western Sydney Local Health District Aboriginal health plan to 2027.

The **Galiwin'ku Djäkamirr Program** by the Charles Darwin University Molly Wardaguga Research Centre, seeks to regain control of childbirth for First Nations women in the island town of Galiwin'ku by combining evidence-based Western medical maternity care with cultural caring practices. The program aims to train a local workforce as Yolŋu djäkamirr (cultural birth companions) by embedding Yolŋu knowledge into the certificate IV Doula course (Ireland et al. 2022). The Yolnu Djakamirr support local women during pregnancy and travel off Country with them to give birth. For more information, see Caring for Mum on Country.

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Other maternity care characteristics

Antenatal and postnatal care

In 2025, most maternity models of care (97%) provide antenatal and postnatal care in individual sessions. Some (2.7%) provide this care through a combination of individual and group sessions. These group sessions include both education and clinical care.

Over three-quarters (77%) of models provide women with access to postnatal visits in a residential setting, such as the woman's home. This may be provided by the designated carer or as part of a domiciliary or early discharge midwifery home visiting program. It does not refer to a universal home visit by a maternal and child health nurse. All models classified as *midwifery group practice caseload care* and *private midwifery care* offer postnatal visits in a residential setting, compared with 81% of models classified as *public hospital maternity care*, and 36% of models classified as *private obstetrician specialist care*.

Labour and birth settings

A model of care may have one or more planned settings for birth. Nearly all (97%) maternity models of care offer birthing within a hospital birth suite or labour/delivery ward as a planned setting for birth. A small number of models (38 or 3.4%) have the home as a planned setting for birth; 4 more models were recorded with home as a planned setting for birth in 2025, compared with 2024 (34 models or 3.2%).

Around 77 models of care (7.0%) have a birth centre (either stand alone or in a hospital) as a planned setting for birth; 10 more of these models were recorded in 2025 compared with 2024 (67 models or 6.3%). Only a small number of these centres exist. A birth centre is an alternative setting to the conventional hospital setting for labour and birth. A common feature in a birth centre is a homely space physically separate from the main hospital, midwife-led care with a philosophy towards normality and avoidance of interventions.

Around 7.9% of models of care in 2025 have *routine relocation* of women prior to labour for intrapartum care and birth as part of the model. This was similar to 2024. Women cared for in these models require relocation from their communities to another location prior to labour for intrapartum care and birth. Routine relocation usually applies to models where women reside in a rural or remote community with no access to a birth facility. Women in these models are routinely relocated to a larger town or city some weeks prior to birth. Routine relocation as a characteristic of a model of care is higher in the Northern Territory (28%), Western Australia (14%) and Queensland (13%).

Australian Government
Australian Institute of Health and Welfare

Technical notes

Terminology

First Nations terminology

'First Nations people' is used to refer to Aboriginal and/or Torres Strait Islander people in this report. However, the AIHW acknowledges First Nations peoples comprise hundreds of groups with distinct languages, histories, and cultural traditions and therefore the preferred terminology for the use of either Aboriginal, Aboriginal and/or Torres Strait Islander, First Nations people or other terminology may vary across jurisdictions.

Sex and gender terminology

This report uses the terms 'woman' and 'women' to mean 'female' as this is consistent with terminology used in Australia's mothers and babies and the National Core Maternity Indicators, which refer to data collected in the National Perinatal Data Collection and are based on sex. Information on gender is not recorded in this data collection.

It is acknowledged that this report includes references to people who do not identify as women or mothers, and that individual parents and families may use different words to those used in this report. This may include women, transgender men, intersex people, non-binary and gender diverse people.

Abbreviations

Table 1: Abbreviations

Abbreviation	In full
AIHW	Australian Institute of Health and Welfare
COAG	Council of Australian Governments
DCT	Data Collection Tool
MaCCS	Maternity Care Classification System
MoC DS	Model of Care Data Set
NPDC	National Perinatal Data Collection

Data quality and availability

In this section

- About the maternity model of care data set
- A note about coverage
- Capturing models of care in the National Perinatal Data Collection
- National Perinatal Data Collection model of care data elements
- Data collection documentation

About the maternity model of care data set

The scope of the MoC DS is all models of maternity care available to pregnant and birthing women in Australia. The elements in the data set describe the different characteristics of models of maternity care around 3 domains:

- the women a model is designed for
- the carers working within the model
- how and where care is commonly provided.

Information about each of the data elements in the MoC DS are listed under Data collection documentation and on METEOR.

Data in this report

The scope of this report are the models of care available at maternity services providing intrapartum care at 30 April 2025. Models of care provided by antenatal and postnatal only maternity services are included where they are attached to a birthing service. A small number of models of care (around 2% in 2025) are available at more than one maternity service and for the purposes of reporting are counted at each service where they are available.

Reporting time trend data

To show time trends the AIHW used a snapshot of models that were reported to be in use by maternity services providing birthing care in each year.

For example, 2024 data are based on the snapshot of the data taken on 30 April 2024.

Care should be taken when interpreting changes over time, particularly for data reported for 2021 to 2023, because there have been improvements in coverage and data quality in some maternity services and the number of services in scope for the MoC DS may change each year.

How are data collected?

The Australian Institute of Health and Welfare (AIHW) developed the Maternity Care Classification System (MaCCS) data collection tool (DCT) to collect information on the models of care available at each maternity service. A registered user for each service uses the DCT to classify their models of care, by answering a series of questions on each model of care they offer. This ensures they are classified in a standardised way. The questions used to classify each model of care are in Data collection documentation.

The DCT has a user guide to help registered users enter their models of care information accurately, and inbuilt validation and tool tips to reduce reporting errors. The AIHW also maintains a helpdesk to support services to classify their models of care. To ensure information is kept up to date, the AIHW asks maternity services to review and update their models of care annually and validates new and updated models when they are submitted. Validation queries are followed up with maternity services. Any models of care with significant data quality queries still attached to them after follow up are excluded from reporting. In this report, one model of care was excluded from national reporting.

The information submitted to the DCT forms the basis of the MoC DS. Summary information about each model of care submitted to the DCT is available for each maternity service at MaCCS. This includes the model ID number, model name and the major model category it falls under.

A note about coverage

A characteristic of the MoC DS is that the number of maternity services in scope and submitting data for the collection may change each year. While for the most part it is the same services contributing to the collection, the number of services may change due to changes at the local level, for example, new maternity services are introduced, or services may no longer provide antenatal or birthing services.

Another characteristic of the collection is that the services submitting valid data may change over time. Models of care with significant quality issues at the cut-off date for each collection are excluded from national analyses.

Most (99%) maternity services with birth facilities had at least one ‘active’, or ‘in use’ model of care, classified in the MaCCS DCT on 30 April 2025. Coverage rates are high (92% or above in all jurisdictions), however there are still some differences by jurisdiction and type of service (Table 2). A national baseline for all maternity models of care is not yet available because:

- classifying models of care for the MoC DS is voluntary
- services may not have classified and submitted all of their available models of care
- there is a gap in the collection of some information about models of care within the model category of private midwifery care as data are generally collected at the maternity service level. Some of these models will reflect generic information at the jurisdictional level and differences between these models at a local level may not be being captured. While the number of models of care in this category is likely to be small and some hospitals have entered these models of care on behalf of private midwives, this category may include models of care with poorer specificity compared with other model categories.

Table 2: Maternity service engagement with the MaCCS DCT, by jurisdiction, 2025

Jurisdiction	Services – public (no.)	Services – private (no.)	Total (no.)	Services with at least one active model – public (%)	Services with at least one active model – private (%)	Total with at least one active model (%)
NSW	65	14	79	100.0	92.9	98.7
Vic	40	14	54	100.0	100.0	100.0
Qld	39	13	52	100.0	100.0	100.0
WA	24	5	29	100.0	100.0	100.0
SA	21	3	24	95.2	66.7	91.7
Tas	3	2	5	100.0	100.0	100.0
ACT	2	1	3	100.0	100.0	100.0
NT	4	1	5	100.0	100.0	100.0
Total	**198**	**53**	**251**	**99.5**	**96.2**	**98.8**

Notes

1. Includes maternity services with birth facilities. In 2025, 248 out of 251 maternity services (99%) had at least one active model of care recorded in the MaCCS DCT.
2. 'Services private' includes 2 services that are also funded to provide public maternity care.
3. 'Active' models are those that have been classified and submitted to the MaCCS DCT and are in use at a maternity service on 30 April 2025.

Source: MaCCS DCT, 2025.

How can we improve the collection?

The completeness and quality of the MoC DS will continue to improve as familiarity with the MaCCS DCT grows, with further engagement by maternity services and maternity service providers and with the inclusion of the two model of care data elements into the National Perinatal Data Collection (NPDC). The AIHW will continue to improve the accuracy and completeness of the models of care information and to incorporate these data elements into other maternal and perinatal health reporting.

Capturing models of care in the National Perinatal Data Collection

Collecting models of care at the service level also facilitates the inclusion of model of care data elements into the NPDC. The 2 model of care data elements in the NPDC are *primary maternity model of care* and *maternity model of care at the onset of labour or non-labour caesarean section*. The model of care at the onset of labour or non-labour caesarean section may be similar or different from the primary model of care a woman received through her pregnancy. The MaCCS DCT allocates a unique model ID number to each model of care entered to it. Model ID numbers can then be used to populate the two model of care data elements in each woman's perinatal data record and to link NPDC data with other information in the MoC DS. Analyses based on the number of women that use a particular model of care will be possible once these model of care data elements are routinely collected in the NPDC.

NPDC model of care data elements

Primary maternity model of care

Definition

The maternity model of care a female received for the majority of pregnancy care, as represented by a numeric identifier.

Guide for use

This value is populated using the Maternity Care Classification System (MaCCS) and is the value of the unique model of care code.

The model of care a female received for the majority of pregnancy care, as determined by the number of antenatal visits within that model of care.

Collection methods

To be collected once, after the birth.

Maternity model of care at the onset of labour or non-labour caesarean section

Definition

The model of maternity care a female is under at the onset of labour or at the time of non-labour caesarean section, as represented by a numeric identifier.

Guide for use

This value is populated using the Maternity Care Classification System (MaCCS) and is the value of the unique model of care code.

Collection methods

To be collected once, after the birth.

Source: METEOR.

Data collection documentation

Data quality statement

Maternity model of care NBPDS 2024–25: Maternity Care Classification System, 2025; Quality Statement

Model of Care (MoC) National Best Practice Data Set (NBPDS) data elements

MoC NBPDS data elements [PDF 31KB]

Maternity Care Classification System (MaCCS) Data Collection Tool (DCT) questions

MaCCS DCT questions [PDF 90KB]

Glossary

Aboriginal and/or Torres Strait Islander
A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander. See also First Nations people

antenatal
The period covering conception up to the time of birth. Synonymous with prenatal.

antenatal care
An episode of care between a pregnant woman and a midwife or doctor to assess and improve the wellbeing of the mother and baby throughout pregnancy. It does not include care where the sole purpose is to confirm the pregnancy. Also known as an antenatal visit.

birth centre
Is commonly known as an alternative setting to the conventional hospital setting for labour and birth. These can either be within a hospital or separate to the hospital, that is, freestanding. A common feature in a birth centre is a homely space, midwife-led care with a philosophy of normality and avoidance of interventions. Only a small number of maternity services around the country have a birth centre by this definition.

Birthing on Country models of care
These are maternity services that are designed by, and delivered for, First Nations people and encompass some or all of the following elements:
- are community-based and governed
- allow for incorporation of traditional practice
- involve a connection with land and country
- incorporate a holistic definition of health
- value Indigenous and non-Indigenous ways of knowing and learning
- include risk assessment and service delivery
- are culturally responsive (Kildea et al. 2019).

collaborative maternity carer(s)
The health professional(s) who collaborate with the *designated* or *lead* maternity carer to provide care for women during the antenatal, intrapartum or postnatal stages of maternity care, based on the women's identified needs and individual circumstances. Collaborative carers have a planned role with each woman in the model of care, however, may not necessarily provide direct clinical care to them.

complex or high-risk pregnancy
A target group within the Maternity Care Classification System (MaCCS). This is selected if the model is provided in a public hospital by multidisciplinary specialists for complex maternal, medical and fetal conditions and limited obstetric conditions. It is not used for conditions that require obstetric input such as high body mass index or gestational diabetes.

continuity of carer
Continuity of carer means care is provided, or led, over the full length of a maternity period (the antenatal, intrapartum, or postpartum period) by the same named carer. Other caregivers may be involved in the provision of care, either as a backup to the named carer or to collaborate in the provision of care, however, the named carer continues to coordinate and provide ongoing care throughout. The MaCCS looks at the extent of continuity of carer across the continuum of maternity care (the antenatal, intrapartum, and postpartum periods) within each model of care. There are 6 categories to describe the extent of continuity of carer within a model ranging from no continuity of carer across any stage of the maternity period to continuity of carer across the whole duration of maternity period – antenatal, intrapartum, and postpartum.

designated maternity carer
The health professional who coordinates the care for a woman during the antenatal, intrapartum or postnatal stages of maternity care, based on the woman's identified needs and individual circumstances. May also be known as the maternity care co-ordinator, primary or lead carer or named carer within a model. In some cases, this may not be an individual but a multi-disciplinary team or shared care arrangement. The designated maternity carer may not always be the most senior clinician involved in the care of women in the model. Possible values for this data element include:
- midwife – public
- midwife – privately practising
- specialist obstetrician – public
- specialist obstetrician – private
- general practitioner obstetrician
- maternal-fetal medicine subspecialist
- shared care
- multidisciplinary team
- general practitioner
- midwife – private
- Aboriginal maternal infant care practitioner
- nurse
- other.

First Nations people
People of Aboriginal or Torres Strait Islander descent who identify as an Aboriginal or Torres Strait Islander.

group antenatal/ postnatal sessions
Some models of care offer antenatal and/or postnatal care in groups sessions such as the CenteringPregnancy® model. Group sessions consist of 2 or more women and must include both education and clinical care in a group setting. This does not refer to ‘parenting’ classes or ‘antenatal education’ classes.

hospital (excluding birth centre)

Is a setting for birth that describes areas used for birthing in a hospital (other than a birth centre). These areas may be known by a variety of names such as birth suite, delivery suite, labour ward, labour and delivery.

intrapartum

Is the period from the commencement of labour and including the birth.

major model category

This is the overarching descriptor of a maternity model of care based on its characteristics. It describes the intent of a model of care. Although there is variation between different models of care, each can be grouped into one of 11 different categories based on their specific characteristics. These 11 categories are:

- public hospital maternity care
- public hospital high risk maternity care
- midwifery group practice caseload care
- shared care
- general practitioner obstetrician care
- combined care
- private obstetrician (specialist) care
- private midwifery care
- remote area maternity care
- team midwifery care
- private obstetrician and privately practising midwife joint care.

For a description of these see Major model category definitions.

midwifery caseload

A type of maternity care where women have a primary midwife assigned to them throughout pregnancy, labour and birth and the postnatal period. Each midwife cares for an agreed number (caseload) of women per year. Caseload midwives usually work on a 24-hour on-call basis (this may be organised within a group) and may be employed on an annualised salary. This is also known as a midwifery continuity of carer model of care and may be a private or public arrangement. Midwifery caseload may be managed within a midwifery group practice model where a small number of midwives join together in a group with each midwife having their own caseload and providing backup for the other midwives in the group practice. A key aspect of caseload midwifery practice that differentiates it from *team midwifery* models is that women have a named midwife, caseload midwives have a self-managed workload that is outside of a traditional roster structure and provides a high level of continuity of carer across the continuum of maternity care.

perinatal

Pertaining to, or occurring in, the period shortly before or after birth (usually up to 28 days after).

postnatal/ postpartum

Pertaining to the period immediately after the birth and lasts for 6 weeks. The terms postpartum and postnatal are often used interchangeably (including in this report), however, ‘postpartum’ refers to the woman and ‘postnatal’ refers to the baby.

prenatal

See antenatal

routine relocation

This is where the intention of the model of care is that all women cared for in the model require relocation from their communities to another location prior to labour for intrapartum care and birth. Routine relocation often applies to models where women reside in a rural or remote community where there is no access to an appropriate birth facility and are routinely relocated to a larger town or city some weeks prior to birth. This is not used if the model only requires the transfer of some women with increased risk factors due to complexities of pregnancy.

target group

Some models of care are targeted at specific groups of women with similar characteristics. These may be based on geographical area, risk status, obstetric or medical condition or social/ cultural characteristics. Having a target group does not necessarily mean the model is restricted to only those women (although the model is specifically targeted at them) and other women may also access the model of care. Some models are targeted at more than one group of women so multiple values for this data element may be selected. In the MaCCS the possible values for this data element include:

- low risk or normal pregnancy
- all excluding high risk pregnancy
- complex or high risk pregnancy
- Aboriginal or Torres Strait Islander identification
- migrant or refugee
- maternal age – young
- maternal remote area of residence
- next birth after caesarean section
- planned homebirth
- maternal diabetes and other endocrine disorders
- maternal obesity or high body mass index
- maternal drug or alcohol use
- maternal mental health condition
- breech presentation of fetus
- multi fetal pregnancy
- other specific cultural groups not already specified
- other social groups not already specified
- other vulnerable groups not already specified
- other maternity target group.

See also

Model category definitions

The major model category is the overarching category or group that a maternity model of care belongs to. While there may be differences between models of care, each one can be grouped into one of 11 categories based on its specific characteristics. While the major model category describes the overall intent of a maternity model of care it does not necessarily mean that all women in a model of care will follow the same journey or receive the same care pathway as the model was designed for.

The 4 most common model categories

Most maternity models of care in Australia fall into one of the following 4 model categories:

Public hospital maternity care

- Antenatal care is provided in hospital outpatient clinics (either onsite or outreach) by midwives and/or doctors. Care may also be provided by a multidisciplinary team.
- This is the broadest model category and includes a range of models of care from those led by midwives that target low risk women to those led by obstetricians that target women with obstetric risk factors such as diabetes.
- Intrapartum and postnatal care is provided in hospital by midwives and doctors in collaboration.
- Postnatal care may continue in the home or community by hospital midwives.

Shared care

- Antenatal care is provided by a community maternity service provider (doctor and/or midwife) in collaboration with hospital medical and/or midwifery staff under an established agreement.
- Can occur both in the community and in hospital outpatient clinics.
- Usually includes an agreed schedule of antenatal care between the two providers.
- Intrapartum and early postnatal care usually takes place in the hospital, by hospital midwives and doctors, often in conjunction with the community doctor or midwife (particularly in rural settings).

Midwifery group practice caseload care

- Antenatal, intrapartum and postnatal care is provided within a publicly funded caseload model by a known primary midwife with secondary backup midwives providing cover and assistance, in collaboration with doctors in the event of identified risk factors.
- Antenatal care and postnatal care is usually provided in the hospital, community or home with intrapartum care in a hospital, birth centre or home.
- This category provides continuity of carer across the whole maternity period.

Private obstetrician specialist care

- Antenatal care is provided by a private specialist obstetrician.
- Intrapartum care is provided in either a private or public hospital by the private specialist obstetrician in collaboration with hospital midwives.
- Postnatal care is usually provided in the hospital by the private specialist obstetrician and hospital midwives and care by midwives may continue in the home, hotel or hostel.
- Most models in this category provide continuity of carer across the whole maternity period.

Other model categories

Maternity models of care that fall into the following model categories are also available at some maternity services, however these are less common:

Public hospital high risk maternity care

- Antenatal care is provided to women with medical high risk/complex pregnancies by public hospital maternity care providers (specialist obstetricians and/or maternal-fetal medicine subspecialists in collaboration with midwives).
- Intrapartum and postnatal care is provided by hospital doctors and midwives.
- Postnatal care may continue in the home or community by hospital midwives.
- This category is *not* used for obstetric-led clinics (models of care) such as those designed for women with diabetes or with risk factors such as high body mass index. Models requiring obstetric input but not multi-disciplinary specialised care are classified as *public hospital maternity care*.

Remote area maternity care

- Antenatal and postnatal care is provided in remote communities by a remote area midwife (or nurse) or group of midwives, sometimes in collaboration with a remote area nurse and/or doctor.
- Antenatal care may also be provided via telehealth or fly-in-fly-out clinicians in an outreach setting.
- Intrapartum and early postnatal care is provided in a regional or metropolitan hospital (often involving temporary relocation prior to labour) by hospital midwives and doctors.

General practitioner (GP) obstetrician care

- Antenatal care is provided by a GP obstetrician.
- Intrapartum care is provided in either a private or public hospital by the GP obstetrician in collaboration with the hospital midwives.
- Postnatal care is usually provided in the hospital by the GP obstetrician and hospital midwives.

Combined care

- Antenatal care is provided by a private maternity service provider (doctor and/or midwife) in the community.
- Intrapartum and early postnatal care is provided in a public hospital, by hospital midwives and doctors.
- Postnatal care may continue in the home or community by hospital midwives.

- Usually exists without a shared care agreement, so there is no agreed schedule of visits between providers and the private provider does not provide any care in hospital.

Private midwifery care

- Antenatal, intrapartum and postnatal care is provided by a privately practising midwife or group of midwives in collaboration with doctors in the event of identified risk factors.
- Antenatal, intrapartum and postnatal care could be provided in a range of locations including the home.
- This category is used when the designated maternity carer is a privately practising midwife but is not used if the model of care is shared care between a private midwife and a hospital as part of a formal arrangement.

Team midwifery care

- Antenatal, intrapartum and postnatal care is provided by a small team of rostered midwives in collaboration with doctors in the event of identified risk factors.
- Intrapartum care is usually provided in the hospital or birth centre.
- Postnatal care may continue in the home or community by the team midwives.

Private obstetrician and privately practising midwife joint care

- Antenatal, intrapartum and postnatal care is provided by a privately practising obstetrician and midwife from the same collaborative private practice.
- Intrapartum care is usually provided in either a private or public hospital by the privately practising midwife and/or private obstetrician in collaboration with hospital midwifery staff.
- Postnatal care is provided in hospital and may continue in the home.

Notes

Data quality statement

Maternity model of care NBPDS 2024–25: Maternity Care Classification System, 2025; Quality Statement

Data

For previous reports' data tables, see Archived content.

Data tables: Maternity models of care in Australia, 2025

Data

XLSX 157kB

Data visualisation tables: Maternity models of care in Australia, 2025

Data

XLSX 187kB

Related material

Resources

Maternity models of care

Resource

This report looks at the models of care available to women across Australia in 2023 and the continuity of care within these. It also uses Queensland perinatal data as a case study to explore, for the first time, the models of care women giving birth in Queensland use, including outcomes by model of care.

Mothers & babies

Resource

A newborn baby's health can be a key determinant of their health and wellbeing throughout life. Factors such as physical health, social wellbeing and exposure to harmful behaviours can influence health outcomes for both mothers and babies.

Australia's mothers and babies

Resource

The health of both mothers and babies can have important ongoing implications. Explore the characteristics and health of mothers and their babies through interactive data visualisations, and in-depth information and trends on the antenatal period, labour and birth, and outcomes for babies at birth. This web report also provides information on stillbirths, neonatal and maternal deaths, including causes, maternal characteristics, timing and investigations. The data in this report are based on data from the National Perinatal Data Collection (NPDC), and from the National Maternal Mortality Data Collection and the National Perinatal Mortality Data Collection.

National Core Maternity Indicators

Resource

This report is an online presentation of the 12 National Core Maternity Indicators currently reported. The indicators provide the most recent data available and assist in the assessment, monitoring and evaluation of patient care.

Aboriginal and Torres Strait Islander mothers and babies

Resource

Explore the characteristics and health of Aboriginal and Torres Strait Islander mothers and their babies through interactive data visualisations, and in-depth information and trends on the antenatal period, labour and birth, and outcomes for babies at birth.

Related topics

- Mothers & babies
- Women's health

Archived content

Previous years' data tables

The data tables below are previously published data from the Model of Care National Best Practice Data Set (MoC NBDPS) that have now been superseded. Data were correct at the time of release but may have changed since then.

For this report's data tables see Data.

Data tables: Maternity models of care in Australia, 2021

Data | *18 Nov 2021*
XLSX 63kB

Data tables: Maternity models of care in Australia, 2022

Data | *22 Jul 2022*
XLSX 109kB

Data tables: Maternity models of care in Australia, 2023

Data | *11 Oct 2023*
XLSX 92kB

Data tables: Maternity models of care in Australia, 2024

Data | *13 Dec 2024*
XLSX 153kB

Data visualisation tables: Maternity models of care in Australia, 2024

Data | *13 Dec 2024*
XLSX 162kB