16 September 2022

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Chief Nursing and Midwifery Officer
Australian Government
Department of Health and Ageing
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Via email: CNMO@health.gov.au

Dear Alison,

Thank you for inviting the Australian College of Midwives (ACM) to provide a written submission to the Independent Review of Collaborative Arrangements. ACM sought feedback from its members into the effectiveness and efficacy of collaborative arrangements for midwives with endorsement, herein referred to as PPMs (also known as private midwives, privately practicing midwives, endorsed midwives, eligible midwives). Please find our response below and appendix 1 - survey response charts.

The Australian College of Midwives

The Australian College of Midwives (ACM) is a national not-for-profit membership organisation and the peak professional body for midwives in Australia. ACM was created when independent local and state-based midwifery organisations came together to create a unified voice for the profession of midwifery. Together we work towards building a resilient midwifery workforce for the future by advocating for the profession at all jurisdictions, promoting the benefits of midwifery care to the wider community and ensuring midwives in Australia are supported with industry information, quality education, career development and professional support through all stages of their career.

Subject Matter for Review

ACM was requested to provide views and any supporting evidence on the efficacy and appropriateness of collaborative arrangements' in writing.

ACM Response - Summary

ACM herein provides its views and supporting evidence which recommends amending the relevant legislation to remove the need for mandated collaborative arrangements, namely the National Health (Collaborative arrangements for midwives) Determination 2010, the Health Insurance Amendment Regulations 2010 [No. 1] and associated Medicare Benefits Schedule (MBS) item descriptors.

Full Response

ACM supports item 4.2 of Woman Centred Care – Strategic Directions for Australian Maternity Services (the Strategy) which states "Women have access to continuity of care with the care provider(s) of their choice — including midwifery continuity of care" (p. 16). ACM advocates for the removal of political, structural, and financial barriers to midwifery continuity of care (CoC) to enable women to access midwife-led services and allow midwives to work to their full scope of practice. Removing the barrier of mandatory collaboration increases access to CoC for women. Additionally, ACM supports the rights of midwives to practise to the full extent of their scope and the rights of women to have equity and equality of access to best practice midwifery care; midwifery CoC. Affording pregnant women the opportunity to access

midwifery led CoC across the childbearing continuum, and to be acknowledged as partners in the planning, structuring and implementation in the provision of this care, encompasses and underpins ACM's strategic position.

Present legislation mandates PPMs enter into a collaborative agreement, by way of referral, with either a general practitioner (GP), obstetrician, or health service for women to access MBS rebates for antenatal and/or postnatal care. Reciprocally, there is no legislative requirement in place for health services or medical professionals to collaborate with PPMs. Mandated collaborative arrangement inhibits the nature of true collaboration which is built on: mutual trust, reciprocity, equality, and respect.

The determination for collaborative arrangements was placed during the 2010 National Maternity Services Reform, whereby the recommendation was made that 'eligible' midwives and nurse practitioners have the same requirements, despite working across considerably different scopes and contexts of practice. ACM is concerned that when Government legislation mandates collaboration, it is suggestive of an ongoing priority and support for medical models of childbirth which negates current evidence and World Health Organisation (WHO) recommendations.

Evidence

1. Collaboration is embedded in midwifery regulation

Midwives are competent, collaborative, and safe practitioners and under optimal private practice environments will naturally engage and collaborate appropriately to ensure best outcomes for women in their care and meet the Nursing and Midwifery Board of Australia's (NMBA) Professional Standards including: Standards for Practice (Standard 2) ; Code of Conduct for Midwives (Domain: Practise safely, effectively and collaboratively) and Code of Ethics (Domain I –Midwifery Relationships).

Collaborative working relationships are already embedded in international and Australian midwifery regulatory standards hence negating the need for duplication across different domains. Currently, collaborative arrangements are embedded within insurance requirements, National Law, legislation, regulation, and as a requirement to access the MBS.

Professional and clinical governance documents support midwives to be collaborative partners in a woman's care. In addition to those above, these guiding documents include:

- Nursing and Midwifery Board of Australia - Safety and quality guidelines for privately practicing midwives (NMBA, 2017)
- Australian College of Midwives - National midwifery guidelines for consultation and referral, 4th edn (ACM, 2021) – "Collaboration and cooperation between the woman and all health professionals involved in the provision of maternity care is of major importance and ensures optimal, high quality care. This involves recognition of the expertise of each health care provider involved in the woman's childbearing experience" (p. 15).

Like all registered and regulated health professionals, midwives are obliged to consult and refer appropriately as required. This includes consultation and referral to a wide range of professionals as guided by the National Midwifery Guidelines for Consultation and Referral which are endorsed by a number of collaborating partners including the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

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Mandated collaborative arrangements are unnecessary and undermine midwives as experts in primary maternity care.

2. Midwives support the removal of the mandatory collaborative arrangements

In August 2022, ACM surveyed Australian midwives and invited them to respond to the current collaborative arrangements (see slide deck as appendix 1). The survey was disseminated to all ACM midwife members and released on social media platforms. The survey returned over 220 responses representing ca. 25% of all endorsed midwives in Australia.

Findings show midwives value working collaboratively with other health professionals and health services and would naturally consult, refer and collaborate with other health professionals as it is embedded in the NMBA Professional Standards and Safety and Quality Guidelines.

However findings also showed that:

- 85% of respondents support the removal of legislated, mandatory, one-way collaborative arrangements.
- Over 70% cited the collaborative arrangements mandate as a major barrier to their ability to practise privately or commence private practice.
- Over 50% of survey respondents found the collaborative arrangement requirement challenging or they were unable to engage medical practitioners or health services willing to enter into a collaborative arrangement, particularly in rural or remote settings.

> *"It's a deterrent to even seek to enter into private midwifery practice" – Endorsed Midwife, Western Australia.*
>
> *"I stopped private practice many years ago and moved to New Zealand to work- completely different set up and incredibly supportive of women's choices and midwives as equal partners in maternity care with obstetricians and GPs- midwives are fully autonomous practitioners in NZ" – Endorsed Midwife, South Australia.*

Some midwives stated that the barriers created by collaborative arrangements were the primary reason they exited private practice or are choosing not to enter the industry. Midwifery CoC models ensure best possible outcomes for women and their babies and are supported by a substantial amount of high-level evidence across the world. A systematic review of fifteen randomised controlled trials, including over 17,000 women, demonstrated midwifery CoC saves lives, produces healthier women and babies, improves workforce retention, and is more cost effective than standardised hospital care. These outcomes are particularly profound for First Nations' women in Australia.

Over 50% of survey respondents found the collaborative arrangement requirement challenging or they were unable to engage medical practitioners or health services willing to enter into a collaborative arrangement, particularly in rural or remote settings:

Midwives practising in rural and remote settings are already in smaller numbers than their metropolitan counterparts. The inability to access collaborative arrangements in rural and remote areas has a significant impact for First Nation's women who are 14 times more likely to live in these areas (compared to non-indigenous women). Reduction of an already diminished workforce

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in rural and remote areas undermines the objectives of the Stronger Rural Health Strategy that aims to "improve the health of people in Australia through the supply of a quality health workforce that is distributed across the country according to community need".

> *"Midwives are experts in primary maternity care and have invaluable knowledge, knowledge that is inherently different to the skills and knowledge that doctors have. Subjecting midwives to mandatory collaborative agreements (particularly where doctors are not required to do the same to practice as private obstetricians) belittles the importance, knowledge, and skills of midwives. Collaborative agreements are unnecessary and insulting. Midwives are responsible, ethical, knowledgeable, evidence-based practitioners who excel in providing gold-standard maternity care. Obstetric maternity care is not the gold-standard, continuity midwifery care (i.e., the care that a privately practicing midwife provides) is. The NMBA is more than capable of monitoring and regulating midwifery practice. It is wrong that another profession has any say in the governance and scope of midwives." – Endorsed Midwife, Western Australia.*

3. Lack of monitoring or evaluation

Collaborative arrangements have not been monitored or evaluated since implementation in 2010. Collaborative arrangements were introduced under the premise of reducing fragmented care to improve safety and outcomes for women and babies. Without evaluation or monitoring, it is impossible to determine whether collaborative arrangements have indeed reduced the fragmentation of care or improved safety and outcomes for women and babies. Evidence continues to support the safety of midwifery led CoC and that care provided across the childbirth continuum with a known midwife has better outcomes and is more cost-effective than standardised hospital care.

4. Rural and remote women are disproportionately impacted

The arrangements also present challenges for PPMs working in rural and remote contexts who have reduced access to medical practitioners, have further limited opportunity to fulfill their scope of practice as a collaborative arrangement cannot be sourced. This in turn diminishes a woman's ability to have full choice of the maternity care they desire and is directly antithetical to achieving the National Strategy.

> *"I live in a rural town where all OBs also work as GPs in the communities. The GP practices in town have made a blanket rule to decline all referrals to EPPM [Endorsed Privately Practicing Midwife]. Women have to travel 200kms south or 350km north to doctor shop for a referral." – Endorsed Midwife, Queensland.*

> *"In regional settings they don't actually work productively when there are limited practitioners." – Endorsed Midwife, rural Victoria*

> *"Women have to doctor shop to get a referral. It is hard to get an appointment with doctors as it is without wasting their time to ask for a referral that they are then not understanding why they need to give one or have a political or mis-informed objection to home-birth and won't provide the referral. This happens often." – Endorsed Midwife, rural Victoria*

"Only one GP is willing to provide referrals and if he is fully booked women experience a delay in accessing care and sometimes they must travel a further distance then if safe or feasible" – Endorsed midwife, rural location

"Some GP's decline referrals. Women then have to shop around to find another GP that will refer them. It can be hard and there is always a wait to see a GP in the first place". – Endorsed Midwife, rural New South Wales

"I cannot provide timely midwifery care until the woman is successful in finding a GP who will refer. Women's pregnancy is impacted. Not one woman in my town can get a referral in my town. They have to drive 110km to the nearest city to eventually find a GP who will refer, sometimes the woman needs to visit 3 or more GP before they are successful". – Endorsed Midwife, rural Queensland

"Many GPs refuse to provide a referral so clients have to shop around for a GP to get a referral. When there are few GPs around that makes it more difficult. None of the hospitals have allowed collaborative agreements to be obtained." – Endorsed Midwife, rural New South Wales and Australian Capital Territory

5. Anti-competitive and anti-collaborative behaviour

Survey respondents reported unwillingness and resistance from medical practitioners and health services to collaborate and provide referrals for midwifery-led care. There is no requirement for medical practitioners to comply with the midwife's request for an agreement. This creates a dependency by the midwife on the medical practitioner's decision to participate and jeopardises women's ability to access the model of care of their choice. Around Australia, midwives also report that GPs are refusing to provide referrals to PPMs and survey respondents highlighted health services and groups of GPs colluding to not collaborate.

"I have probably asked upwards of 50 drs to collaborate over the past 3 years! Some of whom I've worked with for decades... reasons given to me being... I'm already collaborating with other EMs (this dr had one in their employment) I'm not in private practice My insurer (MIGA) says they'll have to increase my premiums if I collaborate with you many requests were ignored or went unanswered. I have met with my 2 local public health networks who have refused to collaborate with me but who have had to accept my clients for their planned hospital birth". - Endorsed Midwife, South Australia

"The CA [collaborative arrangement] held with our local hospital caused significant stress and emotional distress, despite many attempts over the three years to improve relationships and explain our role and how it benefits women's experiences of pregnancy and birth if we were all able to collaborate respectfully and professionally. No improvements came of it and so I left that practice and I chose to change my way of meeting CA requirements as an independent Midwife. There was also financial impact, in that our practice was not able to expand into other districts as we wanted to and tried

to, because two large metro hospitals would not have a CA with any private Midwives" – Endorsed Midwife, rural New South Wales

"I feel like it's anti-competitive behaviour and not truly women centred or even based on evidenced based care. Women are usually not informed about all their choices when they present to GP in the beginning of their pregnancies and healthy women are only given the advice to book in with an obstetrician and when they are informed often by their own research, they ask for referrals to private midwives and are either turned away, fear mongered by the GP's own personal beliefs around homebirth. Continuity of Midwifery Care is a safe option for women perhaps there needs to be inservices for GP's to brush up in their education relating to women's choices of maternity care?" – Endorsed Midwife, Queensland

"GPs refusing. There are many in the area that I know simply won't and I direct women elsewhere. This is very common, at least half my women (full case load is 30 per year) have to seek a referral from a 2nd (or 3rd) GP after being refused by their regular or 1st attempt of a GP" – Endorsed Midwife, Queensland

6. Potential liability issues for doctors and healthcare organisations

GPs are being guided by their medical defence organisation that their professional indemnity insurance does not extend to a referral for a woman to a midwife for antenatal and postnatal care. Midwives from the survey have cited that woman have been unable to obtain referrals for antenatal and postnatal midwifery care as their GP refuses to provide the referral for a variety of reasons.

"I'm not insured to refer you to a midwife" "You don't need a collaboration agreement" "Homebirths are unsafe". – Endorsed Midwife – Victoria.

"There have been many times that a request for referral was refused - didn't know what it was - felt that homebirth is dangerous - stated it was illegal to give a referral" – Endorsed Midwife- Queensland.

In these scenarios, women have had to 'doctor shop' until they find a GP willing to provide a referral for midwifery care. Some even travel hundreds of kilometres to find a willing practitioner. These lived experiences of women and midwives demonstrate that the process of referral and collaboration becomes a 'box-ticking' exercise for midwives and does not espouse the nature of a true collaborative relationship. Additionally, when GPs do refer to midwifery care, it is not the practitioner midwives will consult with or refer back to, should a woman's care require escalation; in these instances, the midwife will be discussing care with the woman's back-up maternity hospital.

7. It has decreased women's access to midwifery care

The purpose of creating MBS items for midwifery care was to increase women's access to 'gold standard' CoC. However, this has not borne out in practice and there have been unintended consequences of the mandated collaborative arrangements. Women are bearing the financial burden by way of increased need for travel, time, and cost of finding a GP who will provide a referral. Additionally, this is associated with increased MBS claims for each additional GP appointment women are having while negotiating a referral for midwifery care – hence an unnecessary cost to the Australian Government. In ACM's survey, over 70% of respondents stated that they have had clients visit multiple GPs before they accessed a referral. This cost to women (and MBS) is in direct

opposition to the purpose of the National Maternity Services Reform of 2010. If the purpose of such changes was to increase women's access to midwifery CoC, it has not reached the mark, and may have in fact created a significant barrier for women to access care with a known midwife within their chosen model.

> *"Medicare rebates for women should not be dependent on the ability to establish a collaborative arrangement. Gold standard care is about working with all health providers each individual requires for optimal outcomes. This may be a midwife only, or involve a large multi-disciplinary team. There should be no one-sided arrangements preventing the team working together when required" – Endorsed Midwife, Western Australia*

8. Member feedback

The following are a range of responses from the survey which highlight the significant barriers that women and midwives experience as unintended consequences of mandatory collaborative arrangements.

> *"When a woman doesn't want to see a Dr she has to choose between being financially disadvantaged or working with a practitioner who is not meeting their insurance requirements. This puts the midwife at incredible risk. Women in rural locations do not have anywhere near the options to find supportive GPs" – Endorsed Midwife, South Australia*

> *"I honestly thought getting Medicare for midwives would be like New Zealand but instead we were hogtied from the beginning. I thought it would be midwives working together, with the support of our local hospitals and government to offer women choice over where they have birth and with whom. Instead it ended up as a greedy grab for money led by fear of litigation" - Endorsed Midwife, Queensland*

> *"I commenced in private practice at the beginning of this year, providing antenatal and postnatal care only. To this day I have been unsuccessful in gaining a collaborative agreement. I work in a small-ish rural town. The hospital is very anti-midwife and especially anti private midwives. There is 1 OB who does have a collaborative agreement with the other Midwife in this town. I began approaching him more than 4 months ago but still have not had a definite answer yes/no. His receptionist informs me that he is very time poor and just hasn't had time to respond to my request. This has meant that all of my clients first need to see a GP to obtain a referral before they can see me for care. This is a huge barrier, considering we are primary healthcare providers. Some GP's are hesitant to provide referral even when they know I am not providing homebirth care at the moment. This requirement very much feels like it takes away from our autonomy as Midwives. We have worked very hard to become endorsed and we are more than capable of providing care to women without having GP's or OB's as the gatekeepers to our care. We are the only health professionals that are required to collaborate in this way. Obviously we are well aware of our scope and I have an agreement with the local hospital about how/when to refer women who meet the criteria for consultation and referral. So having this collaborative requirement does not seem to be in the best interest of the women or the Midwives who are affected by it. It begs the question of who this requirement does actually benefit?" – Midwife, Rural New South Wales*

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Summary of ACM's Position

Improving access to high-value maternity care and removing structural barriers to midwifery services are imperative. As such, any review into the effectiveness and efficacy of collaborative arrangements should focus on the provision of affordable, universal, and high-value care for women and, in line with 'Woman-centred care: Strategic Directions for Australian Maternity Services', increase access to midwifery CoC as a priority. Removing non-contemporary and non-evidence-based barriers to midwifery CoC, such as collaborative arrangements, increases equity in access to PPM services.

Additionally, collaborative arrangements should be reviewed in conjunction with all other legislation, regulation, and insurance mandates pertaining to PPMs to ensure that all aspects and intersecting policies are considered, reviewed, and evaluated.

Mandatory one-way collaborative arrangements are ineffective and a barrier to midwives working in private practice, scope of practice fulfilment and importantly it is a barrier to women accessing private midwifery care. Collaborative arrangements also present a significant barrier to Government advancing the Strategy. The Strategy outlines in 2.2 Collaboration among health professionals (p. 13) that 'Women's safety and experience of maternity care is underpinned by respectful communication and collaboration among health professionals'. This is not evident, nor modelled, when collaboration is unilateral.

Current legislation has created an unwieldy and costly system where other professions effectively control the practice of another. This limits the midwifery profession from operating to full scope of practice, undermines public trust in the midwifery profession, reduces women's choice and creates anti-competitive behaviour tantamount to a medical veto in some cases.

ACM is concerned that where GPs, obstetricians and health services are placed as 'gatekeepers' and women are dependent on midwives accessing collaborative arrangements, significant structural barriers to access midwifery care will persist.

The National Midwifery Guidelines for Consultation and Referral, midwives' scope of practice, registration, eligibility (for MBS) and ongoing CPD requirements already encompass and constitute professional standards that should not need repetition in individual collaborative arrangements.

Thus, in conclusion, ACM recommends amending the relevant legislation to remove the need for mandated collaborative arrangements, namely the National Health (Collaborative arrangements for midwives) Determination 2010, the Health Insurance Amendment Regulations 2010 [No. 1] and associated Medicare Benefits Schedule (MBS) item descriptors.

Yours sincerely,

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Attached: ACM member survey results slide deck August 2022