Pre-Budget Submission 2024-2025

Removing Barriers to Primary Maternity Care and Maximising Health Outcomes For Women, Babies and Families

Foreword

The Australian College of Midwives (ACM) welcomes the opportunity to provide this pre-budget submission ahead of the 2024-2025 Federal Budget. ACM is the peak professional body representing midwives in Australia. ACM is focused on ensuring best outcomes for women, babies and their families, by supporting the midwifery profession, ensuring access for women and families and enabling midwives to work to full scope of practice. Investing in midwives and midwifery led care improves health outcomes, reduces the long-term burden of chronic disease on the healthcare system and closes the gap for First Nations people [1,2,3,4].

Evidence shows midwifery continuity of care with a known midwife is the best practice model of care for women, their families and babies. It improves health outcomes for women (including mental health), reduces preterm birth and still birth, reduces medical intervention, and increases workforce retention[4,5,6,7,8]. It is the best start to life. If provided in the primary care setting it has been shown that total cost of care is significantly less than for standard care[9].

The Government has demonstrated its commitment to ensuring utilisation of the full scope of our health workforce. However, as per ACM's Scope of Practice Submission[10] there is still some way to go to ensure the full benefit of the midwifery workforce is actualised. This submission focuses on enabling the midwifery workforce to work to full scope with equitable and sustainable access to workforce development and funding to increase access to midwifery continuity of care to improve outcomes for Australian woman and babies.

Australian College of Midwives: Priorities for 2024/2025

1. **Build Midwifery Capacity**
2. **Increasing access to midwifery continuity of care for women and families**
3. **Facilitating multidisciplinary care**

ACM looks forward to working in partnership with the Federal Government other key stakeholders to actualise the premise of Strengthening Medicare to ensure midwives can work to full scope in all settings and provide continuity of care. This will ensure a healthy future for all women, babies and their families.

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Priority 1: Build Midwifery Capacity

ACM recommends the Federal Government

1. **Support midwifery education by:**
   a. **Funding clinical placement costs including meals, parking, travel, and accommodation.**
   b. **Enabling HELP debt removal for midwives.**
   c. **Funding for expanded sexual and reproductive health education for midwives.**
2. **Fund development of a Transition to Practice Program: Mentoring recent graduates to build knowledge, skills, and confidence.**
3. **Equity of funding for midwifery in all existing and future Commonwealth health practitioner incentive programs.**
4. **Supporting Midwifery Digital Health Strategy: funding for interoperability and upload access.**

Recommendation 1: Support midwifery education

a. Fund clinical placement costs including meals, parking, travel, and accommodation costs via a cost-of-living stipend.

Australian Universities[11] and government calculators[12] range very modest living expenses for a single person at between $24 505 and $57 668 per annum. Students of midwifery must complete mandatory clinical placements to fulfill the requirements of their course This means that students are frequently unable to work in paid employment whilst completing the placements as a requirement of their course.

Clinical placements may be some distance from the student's usual place of residence, or involve regional, rural and remote temporary relocation. The nature of shift work, being on-call and working around the clock, access to expensive onsite parking and utilising public transport outside of business hours can be restrictive and a safety concern. There are additional clinical items and mandatory vaccination costs that contribute to the unaffordability of healthcare courses.

Most midwifery students will be required to work to support themselves and often their families throughout their education. This 'placement poverty'[13,14] can act as a disincentive to undertaking and completing their midwifery studies and has an increased impact on some student cohorts, including First Nations students of midwifery and those requiring relocation from rural and remote areas to undertake further study.

Over and above the cost-of-living stipend, midwifery must also be included in existing placement programs such as Rural Health Multidisciplinary Training Program which currently provides placements in rural regional and remote areas for medical, nursing and allied health only.

b. Enabling HELP debt removal for midwives

HELP debt removal for midwives, unlike for GPs and Nurse Practitioners, was not introduced in November 2022. This is an inequity which requires resolution. ACM recommends that midwives HELP debt costs be funded similarly through this or an equivalent program to remove HELP debt at a minimum for those undertaking employment in regional, rural, and remote Australia.

c. Funding expanded sexual and reproductive health education for midwives.

Further to the Senate Inquiry into Universal Access to Reproductive healthcare, ACM seeks funding to provide training for sexual and reproductive healthcare education post-registration. A key feature of midwifery care is the provision of education to women and their families in and around the perinatal period. A core component of this education involves counselling on sexual and reproductive health (SRH). Ensuring women are informed and have access to evidence-based knowledge around SRH is a fundamental human right and an important step in enabling women to control their health outcomes.

A study by Bradfield et al (2022)[15,16] and James et al (2023)[17] identified midwives require comprehensive SRH education post-registration to confidently ensure they can provide this education in all settings and to overcome existing legislative, funding and training barriers to service provision.

ACM seeks funding for midwifery sexual and reproductive health education programs via online and face to face education for all midwives including SRH literacy education, preconception counselling, abortion counselling and additional education for endorsed midwives to insert and remove Long Acting Reversible Contraceptives and sexual and reproductive health services within scope.

ACM seeks $400 000 over two years to facilitate the development, implementation, and evaluation of this program.

Recommendation 2: Fund development of a Transition to Practice Program: Mentoring recent graduates to build knowledge skills and confidence.

ACM seeks funding for the development of a graduate mentoring program, online, face to face and hybrid modes to work with the graduate midwife during the consolidation of their first year of practice to build confidence, clinical skills and networked support. Similar to the Australian Government funded evidence-based framework Transition to Practice Program facilitated by Australian Primary Health Care Nurses Association (APNA) and the Midwifery First Year of Practice (MFYP) program in New Zealand which has been found to increase retention in the recently graduated cohort.

ACM would phase this program to build capacity, initially prioritising graduates working in rural and remote areas and continuity of care models to eventually including all graduate midwives and those undergoing re-entry to practice.

ACM seeks an initial $500,000 over two years to facilitate the development and actualisation of this program.

Recommendation 3: Equity of funding for midwifery in all existing and future Commonwealth health practitioner incentive and support programs

Midwifery is conspicuous by its absence from existing Commonwealth incentives, however we are pleased to note that midwifery was added to eligible professions recently in MYEFO for the Workforce Incentive Program. In view of the focus on midwifery as one of the key health workforces in primary care via the Strengthening Medicare Taskforce report, and the Unleashing the Potential of our Health Workforce: Scope of Practice Review, ACM recommends that midwifery is introduced to all existing and future

incentive programs, to ensure that supports afforded to GPs, nurse and allied health in particular, are extended to midwives. These include, but are not limited to:

- Practice Incentive Program (PIP)
- Health Workforce Scholarship Program (Currently only for GPs, nurses, and allied health)
- Rural Health Multidisciplinary Training Program (Currently only for Medical, nursing, dental and allied health)
- Rural Bulk Billing Incentive Payments

Recommendation 4: Integrate Midwifery into Existing Digital Health Infrastructure

The premise of digital integration is to support safe and quality care however a substantial proportion of the workforce, including midwifery and thus women and their families are prevented from genuine engagement in My Health Record. Despite the benefits of access to real-time health information via the My Health Record (MHR) and midwives' role as experts in primary maternity care, midwives are not able to:

- Contribute critical health information to the MHR via upload – for both mother and baby dyad.
- Access suitable clinical information systems that are interoperable with MHR
- Access the information required to inform practice at the point of care.
- Participate in the efficient and timely sharing of consistent data to support mother and baby, practice, and community-level planning.
- Readily participate in real-time multi-disciplinary team meetings, nor contribute to them via connected and interoperable IT systems.

ACM recommends that the Government invest in digital health integration for midwifery to ensure midwives can work to full scope in all setting; including:

1. Invest in modernising MHR to enable midwives to contribute critical health information via automated reports.
2. Adequately fund integration between MHR and midwifery clinical information systems.
3. Fund development of education packages to support midwives to rapidly integrate digital reforms.
4. Incentivise midwives to rapidly adopt digital health and new digital technologies.

Priority 2: Increasing access to midwifery continuity of care for women and families.

As identified in the 'Woman-centred care: Strategic Directions for Australian Maternity Services' strategic direction 12, improved access to the midwifery Continuity of Care (MCoC) model is identified as ***the best practice model for improved choice and outcomes for women, babies and their families***. In Australia's Primary Health Care 10-year plan 2022-2032 this is further confirmed: '***Reinforce and support best practice models of midwifery-led care (including continuity of care) for the multidisciplinary team in primary care and maternity services'***.

Nationally less than 10% of women can *access* a known primary midwife throughout the childbearing continuum[18]. This number marginally increases to 17.5% of women being *offered* a known midwife according to AIHW[19]. Improved outcomes for women and babies can be achieved through the expansion of MCoC models nationally and by reducing structural barriers for MCoC to operate in the primary care space through funding equity within the MBS and broader funding reforms, funding the expansion of Birthing on Country (BOC) models, and developing the first 2,000 days strategy including in rural and remote areas.

ACM recommends that the Federal Government:

5. Fund Medicare Benefits Schedule (MBS) items for midwifery and actualises bundled funding mechanism within 1-3 years as per NHRA Report.

- **a. Implement remaining Medicare items already endorsed by the MBS Taskforce.**
- **b. Expansion of Medicare item numbers for midwives for primary sexual and reproductive health including recommendations from the Senate inquiry.**
- **c. Review and reform maternity funding longer term: bundling of antenatal, intrapartum, and postpartum care.**

6. Fund primary maternity care strategies e.g. expansion of Birthing on Country MoC.

7. Review the current insurance products available and funds an affordable midwifery professional indemnity insurance (PII) product for endorsed midwives, midwives and organisations employing midwives for full midwifery scope, including homebirth.

Recommendation 5. Fund Medicare Benefits Schedule (MBS) items for midwifery:
5(a): Government implements the Medicare items already endorsed by the MBS Taskforce.

As per ACM 2023 pre-budget submission, ACM again recommends Government implement and fund MBS changes endorsed by the Taskforce that have not yet been introduced by Government. This also reflects the Senate Inquiry into Reproductive Healthcare **recommendation 14**:

> '*The committee recommends that the Australian Government implements outstanding recommendations made by the Participating Midwife Reference Group to the Medicare Benefits Schedule (MBS) Review Taskforce regarding midwifery services and continuity of care'.*

These are:

- ***Taskforce endorsed outcome 1*** – Include a minimum duration for initial antenatal attendances and align the schedule fee with average attendance duration (60 minute) i.e. Increase time tier for item 82100 (booking visit) to a 60-minute minimum to enable screening for mental health and domestic violence as part of the health history.
- ***Taskforce endorsed outcome 3*** – Introduce a new item for a complex antenatal attendance leading to a hospital admission i.e. an extended visit of over 3 hours for complex care (leading to presentation/admission to hospital)
- ***Taskforce endorsed outcome 10*** – Include mandatory clinical activities and increase the minimum time for a six-week postnatal check i.e. amend item no. 82140 to a 60 minutes minimum as final postnatal visit to allow for birth debrief, mental health assessment and domestic violence screening and contraception as required.

The adjustment of time tiering requires additional consideration of level of funding associated with these items.

ACM again recommends that all MBS items endorsed by the MBS Taskforce are implemented by government.

ACM also recommends that further consideration for recommendations 2 and 9 by the Participating Midwife Reference Group is undertaken to adjust time tiering and fees associated with short, routine and long antenatal and postnatal consultations.

These recommendations also align with Access to universal access to sexual and reproductive health Senate Inquiry recommendation 14 (above).

5 (b) – Expansion of Medicare item numbers for midwives, to provide care across the pre and interconception continuum encompassing primary sexual and reproductive health.

Midwifery scope of practice includes sexual and reproductive health. Current limitations on Medicare items allow midwives to provide rebated care only during the antenatal and postnatal period to six weeks after birth. This creates a barrier for women's access to this care as there is currently no Medicare rebate for preconception counselling, cervical screening, contraception (including LARC), and sexual health services for midwifery except during pregnancy or in the immediate six weeks after birth.

Recent research confirms Australian midwives can fulfil pre and interconception care requirements within scope however both midwives and women are currently restricted by lack of access to Medicare funding in this area[20]. Maximising women's options for care particularly for rural, regional and Aboriginal Community Controlled Health Organisation (ACCHO) settings is paramount.

ACM recommends that recommendations from the 'Inquiry' are adopted by Government and funded in full, including:

- ***Recommendation 5****: The committee recommends that the Australian Government ensures that there is adequate remuneration, through Medicare, for general practitioners, nurses, and midwives to provide contraceptive administration services, including the insertion and removal of long-acting reversible contraceptives.*

- ***Recommendation 10****: The committee recommends that the Australian Government considers and implements a separate Medicare Benefits Schedule item number for contraceptive counselling and advice for all prescribers, including midwives.*

- ***Recommendation 12****: The committee recommends that the Australian, state, and territory governments ensure that maternity care services, including birthing services, in non-metropolitan public hospitals are available and accessible for all pregnant women at the time they require them. This is particularly important for women in rural and regional areas.*

- ***Recommendation 18****: The committee recommends that the Australian Government reviews the existing Medicare arrangements which support medical termination consultations with the aim of ensuring adequate remuneration for practitioners to deliver these services while also ensuring patient privacy.*

5(c)- ACM recommends full implementation of recommendation 13 of NHRA Final Report to develop and implement the alternative funding mechanism of bundled payments for maternity care within 1-3 years.

Further to the ACM Submission, the National Health Reform Agreement Mid-Term Final Report recommends the following:

- ***Recommendation 13****: A structured program of work should be undertaken to develop and implement bundled payments within the NHRA for certain end to end episodes of care (before, during and after a planned hospital admission), with an initial focus on maternity care, and with additional priority areas identified early in the Agreement in consultation with the national bodies and relevant stakeholders. Bundled payments should be implemented across several priority areas within the period of the next Agreement.*

ACM acknowledges this work and further recommends full implementation of recommendation 13 to deliver a national woman-centred approach to maternity care funding to maximise continuity of care and thus improve outcomes for women and babies through the provision of a more integrated care pathway through the continuum of maternity care within the published timeframe.

Recommendation 6: Fund and implement primary maternity care models.

Midwives have a key role across the first 2,000 days in engaging families, providing care across the continuum including birth, and intense postnatal period. Care provided by a midwife during pregnancy, labour and birth and into the first 6 weeks after birth is pivotal in improving outcomes in a range of national core maternity indicators and closing the gap targets such as the number of antenatal visits, low birth weight, preterm birth, stillbirth and neonatal death rates, for birth outcomes. Perinatal mental health and in the initiation and continuation of breastfeeding are further key outcomes. The first 2,000 days provides a rare opportunity to impact the health of the family at a time of peak motivation for health and behaviour change.

Endorsed midwives can fulfill primary/lead care roles in the community setting, with admitting rights for labour and birth care into public hospitals as per the Birthing on Country model using Medicare or blended funding models as discussed in Recommendation 5c. There are also a range of potential funding options including Primary Health Networks (PHN's) commissioning to support integration of endorsed midwives/endorsed midwifery practices into a range of multidisciplinary models within community hubs or GP settings.

Birthing on Country

Funding further development and expansion of Birthing on Country models provide another opportunity to expand primary maternity care. Birthing on Country models provide First Nations women, babies and families the best start to life with access to culturally safe and responsive maternity care provided in a midwifery continuity of care model with wrap around services across the continuum of care. First Nations mothers and babies experience significantly worse outcomes than non-First Nations Australians. Birthing on Country has been demonstrated to increase the number of antenatal visits, reduce rates of preterm birth by half, decrease the incidence of low birthweight babies, increase rates of breastfeeding and decrease removal of children from their families[4,21,22].

The current development of the National Roadmap to Birthing on Country services aligns with the other areas of this pre-budget submission. Enablers for the road map include growing the endorsed midwifery and First Nations midwifery workforce, also a key recommendation of Congress of Aboriginal and Torres Strait Islanders Nursing and Midwifery (CATSINaM's) Genke II report which is supported by ACM as well as funding and incentives for midwives and endorsed midwives in this space.

ACM recommends that government prioritises expansion of primary maternity care models including Birthing on Country via funding expansion and ensuring affordable professional indemnity insurance as per Recommendation 7.

More broadly the models currently being implemented within the ACCHO sector also apply to additional settings including the rural and remote context. The RISE Framework was identified by all stakeholders in the National Rural Maternity Forum held in August 2023 led by the Office of the National Rural Health Commissioner as the number one priority for implementation across all rural and remote areas to preserve services and increase access to care for rural women and families.

ACM recommends the application of the RISE framework model as a pilot scheme for thin markets in rural and remote areas.

Recommendation 7: Review the current insurance products available and fund an affordable midwifery professional indemnity insurance (PII) product for endorsed midwives, midwives and organisations employing midwives for full midwifery scope, including homebirth.

Endorsed midwives working in primary care including Birthing on Country (BoC) are required to hold an additional professional indemnity insurance product. This creates recruitment barriers due to increased cost to the midwife and in particular the cost of Run Off Cover if a midwife wishes to change work setting. Currently this incurs a three-year cost to the midwife, which can total up to $15,000.

Midwifery continuity of care is evidence based best practice. The evidence shows that for best outcomes MCoC includes intrapartum care. This model is practiced in multiple settings; however Birthing on Country is an example of this model. It is a key building block to Closing the Gap (CTG) for health outcomes for First Nations people. BoC already has shown significantly improved health outcomes whereby other CTG targets are stagnant or worsening.

To maintain and grow evidence-based midwifery continuity of care practice including for BoC, an affordable midwifery insurance product, for both individuals and practices, is required. This includes removing the requirement to pay for three years run-off cover for midwives.

ACM's **recommendation 7** is fundamental to ensuring endorsed midwives are able to work to full scope of practice. ACM seeks investment in an updated midwifery professional indemnity scheme which insures individual midwives and also practices appropriately, including through an additional subsidy, indemnity for practices through a high-cost claims scheme or equivalent and access to immediate run-off cover as soon as the midwife ceases practice in primary care.

Priority 3: Facilitating Multidisciplinary Care

ACM recommends that the Federal Government:

8. commit initial funding to ACM of $500,000 over two years to review, update and digitise the current 4th edition of 'National Midwifery Guidelines for Consultation and Referral'.

The Strengthening Medicare Taskforce report has recognised the role of all health care practitioners within the multidisciplinary team. Within the maternity care sector, this relies on clear consultation and referral processes.

The National Midwifery Guidelines for Consultation and Referral are the foundation for the relationship between midwives and obstetricians, General Practitioner (Obstetrics) and other key maternity stakeholders and service providers. The consultation and referral guidelines, developed by ACM and endorsed by The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, are firmly embedded in Maternity Service Clinical Governance, jurisdictional policy and safety and quality guidelines for privately practicing midwives nationally. They are essential for guiding clinical midwifery care and are applicable to all health practitioners across all maternity settings, models and practice contexts.

The Guidelines were last updated in 2020 and are ***due for review***, consultation and a 5th edition developed to remain a current resource as well as digitisation and app development for ease of use in the modern context and interoperability of their use in practice software and readily accessible by all clinicians.

ACM recommends the Australian Government commit initial funding to ACM of $500,000 over two years to review, update and digitise the current 4th edition of 'National Midwifery Guidelines for Consultation and Referral'.

END.

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