ACM: For midwives. With women. For the future.

NSW Special Commission of Inquiry into Healthcare Funding

ACM Submission

Issued November 2023

NSW Special Commission of Inquiry into Healthcare Funding – ACM Submission

The Australian College of Midwives

The Australian College of Midwives (ACM) is the peak professional body for midwives in Australia; and welcomes the opportunity to provide a written submission to the *NSW Special Commission of Inquiry into Healthcare Funding*. ACM represents the professional interests of midwives, supports the midwifery profession to enable midwives to work to full scope of practice (SoP), and is focused on ensuring better health outcomes for women, babies, and their families.

Midwives are primary maternity care providers working directly with women and families, in public and private health care settings across all geographical regions. There are over **33 000**[24] midwives in Australia and 1,089 endorsed midwives[25]. ACM is committed to leadership and growth of the midwifery profession, through strengthening midwifery leadership and enhancing professional opportunities for midwives.

Terms of Reference

This submission will address the subject matter as identified by the *NSW Special Commission of Inquiry into Healthcare Funding* terms of reference.

Background

There are 69 maternity facilities in New South Wales. Of these, 52 maternity services are public (16 in the Sydney metropolitan area, 36 are in rural and regional NSW), and 17 are private providers. Among the 52 public providers, there is capacity to be a privately insured user within these facilities. While this seems like a large number of facilities to service the population of NSW of over 8 million people and 95,758 registered births, there are significant gaps in the availability of maternity services in regional areas[1]. Ultimately, the lack of obstetric oversight due to workforce challenges has led to the closure and/or service reduction of maternity services, requiring women to travel long distances to access antenatal and birth care[2]. This increases the risk of women giving birth on the roadside, delays or inhibits equitable access to services and contributes to the separation of mothers from their families. This impact of this lack of birthing services is significant in priority populations including First Nations, women living with disability and culturally and linguistically diverse community.

Midwives are primary maternity care providers who are highly skilled to provide pregnancy, birth and postnatal care to women and their families. When working to their full scope of practice, midwives comprehensively oversee pregnancy for all women, with clear guidance from the ACM National Midwifery Guidelines for Consultation and Referral[3] where necessary. There is a lack of understanding of the scope of midwifery expertise among government bodies and hospital executives. For example, midwives in rural settings frequently describe frustration about the lack of understanding and respect for midwifery skill and scope of practice, largely because the Directors of Nursing (and Midwifery) in smaller rural hospitals are Nursing trained only. This lack of midwifery representation at an executive level result in discussions and decisions relating to midwifery scope of practice and workforce planning being made by nurses and medical staff.

Acknowledgement

ACM acknowledges the contribution of Dr Vanessa Scarf (ACM NSW Branch Chair) and Jennifer Green, (ACM Advocacy committee member) in the preparation of this submission.

The priority recommendations to the NSW Special Commission of Inquiry into Healthcare Funding are;

1. Midwives are recognised as autonomous practitioners and structures are put in place to allow them to work to their full scope of practice. This includes Endorsed Midwives having prescribing capacity in appropriate public provider settings and midwife-led models of care being implemented in **all** maternity services.

2. NSW Ministry of Health to commit to fully funding all ten goals and associated objectives of the '2023 Blueprint for Action – Maternity Care in NSW' with a completed implementation plan including benchmark targets, actualised within 6-12 months.

3. NSW Ministry of Health to review and/or implement Service Level Agreements with Local Health Districts to ensure the required structural and system level reform in maternity care as per Blueprint objectives is included, funded, and actioned.

A. The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future;

The NSW Health *Blueprint for Action – Maternity Care in NSW* (The Blueprint)[4] contains comprehensive, achievable goals to strengthen maternity services in NSW. The ACM strongly recommend the NSW Ministry of Health to commit to fully funding all ten goals and associated objectives of the '2023 Blueprint for Action – Maternity Care in NSW' with a completed implementation plan including benchmark targets, actualised within 6-12 months.

There is an opportunity to harness the expertise of midwives to provide safe, woman-centred care that is cost-effective and acceptable to women. A recent study conducted in Queensland found a saving of 22% for public MGP caseload care from study entry (<27 weeks gestation) through to 12 months postpartum, compared to other models of care. There was also no significant difference in health outcomes[5]. The cost savings were largely driven by lower inpatient costs for women, which also supports the expansion of midwifery care in community settings such as antenatal clinics, freestanding birth centres, publicly funded homebirth, and postnatal care in the home[6].

Recognising midwives as autonomous practitioners working collaboratively with doctors speaks to the Strengthening Medicare Taskforce recommendation to review barriers and incentives for midwives to work to their full scope of practice[7]. There is an opportunity for State-wide programs to be implemented that enable and empower midwives to work to their full scope of practice, for example enabling endorsed midwives to order medications and diagnostic tests and expanding midwifery led continuity of care models in all areas of NSW for better outcomes and cost saving benefits.

Additionally, the first 2000 days of life are widely acknowledged as a critical opportunity to influence and improve long-term population health and wellbeing[15], with concern mounting for the growing burden of chronic disease such as diabetes and cardiovascular disease[17]. Primary health interventions implemented throughout the maternity continuum are demonstrated to be instrumental in promoting long-term health for women and their families[16]. With this in mind, acknowledging and funding midwives as essential

primary health clinicians is paramount for ensuring safe, effective preventive health strategies across the life-continuum with long-term cost saving potential.

Recommendation: ACM seeks inclusion into the expert advisory group to be established to improve the birthing experiences of mothers, their partners and families across NSW, as committed by Minister for Health, Ryan Park.

B. The existing governance and accountability structure of NSW Health including:

i. the balance between central oversight and locally devolved decision making (including the current operating model of Local Health Districts);

The existing governance and accountability structures in NSW have led to a diversity of interpretation of policies and delivery of services across the state. Local Health Districts (LHDs) and, in some cases individual hospitals, have policies and guidelines that are specific to their facility that do not necessarily reflect current, evidence-based care and interventions. This situation seems to have arisen out of the devolution of governance to LHDs, which then pass clinical and organisational capacity on to individual hospital services in many cases. The ACM frequently receives communication from midwife members of wide variation in policy implementation, with maternity services often ignoring NSW Health recommendations in favour of local practice preferences and workforce structures.

Recommendation: implement state-wide clinical guidelines and a clinical governance framework to implement and monitor adherence and accountability.

ii. the engagement and involvement of local communities in health service development and delivery;

The Blueprint[4] received extensive community and consumer responses. This indicates a clear investment in the improvement of maternity services in NSW. The Blueprint contains 10 clear goals, the ACM recommends the NSW Government use The Blueprint to plan and implement maternity service reform across the state. ACM supports the ongoing inclusion and prioritisation of consumers in the co-design of local maternity services.

iii. how governance structures can support efficient implementation of state-wide reform programs and a balance of system and local level needs and priorities;

Midwives need to be led by midwives. There is a lack of understanding of the scope of midwifery expertise among government bodies and hospital executives. For example, midwives in rural settings frequently describe frustration about the lack of understanding and respect for midwifery skill and scope of practice, largely because the Directors of Nursing (and Midwifery) in many rural hospitals are nursing trained only. This lack of understanding at an executive level result in discussions and decisions relating to midwifery scope of practice and workforce planning being made by nurses and medical staff. Interestingly, many Chief Nurse and Midwife positions across the country are held by nurses who are not midwifery qualified and there is no prerequisite for a midwifery qualification to be appointed to these roles. This disregard for Midwifery expertise often extends to Directors of Nursing and Midwifery and Professors of Nursing and Midwifery at university level, leading to a lack of understanding in the extent of the midwifery scope of practice and how it applies to the workplace and future state of midwifery.

Strategies to support the future of the midwifery workforce are further supported by the Council of Deans of Nursing and Midwifery[19] demanding urgent investment in midwifery leadership to develop an effective and sustainable midwifery workforce. The report highlighted the following key areas:

- commitment to appointing Chief Midwifery Officers throughout every Australian State and Territory;
- adopting midwifery continuity of care as the foundation for all maternity services;
- increasing leadership representation of Aboriginal and Torres Strait Islander and culturally and linguistically diverse midwives; and
- commitment to expand the number of midwifery clinical placements over a 3-year period [19].

iv. the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW;

Privatisation and outsourcing of maternity related health services should be made with caution. Women, their newborn's experience and health outcomes should be placed at the centre of decision making. Findings from research conducted in Queensland comparing women's experiences of care between the public and private hospital maternity sector reported that women receiving private hospital maternity care were less satisfied; largely attributed to the lack of midwifery support in the community or information regarding recommended follow-up after discharge from hospital[18]. This is noteworthy from a public health perspective in terms of promoting breastfeeding, wellbeing including parenting confidence or mental health concerns, and sustaining health engagement throughout the transition to parenthood[15].

There has been a steady increase in the number of endorsed midwives over the last 10 years and, if this trend continues, endorsed midwives could have the capacity to provide care to up to 30% of Australia's birthing population annually. A significant number of these endorsed midwives may work in private practice, and this is an example of positive outsourcing with improved maternal and neonatal outcomes with reduced impact on the public sector midwifery workforce.

v. how governance structures can support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centred care to improve the health of the NSW population;

In addition to point iii., midwives frequently report frustration at the lack of ability to work to their full scope of practice. This is related to lack of recognition of the scope of practice but is also closely linked to workplace culture and staffing. There is a complex interplay between staff satisfaction and workload, and research has found that staff attrition in maternity services often relates to midwives' workplace experiences and negative perceptions of organisational culture[8]. Midwives surveyed in 2016 reported feeling disengaged and unsupported by managers and described an inability to use all their midwifery knowledge in medically dominated environments. This was replicated in the FUCHSIA study and again in ACM's member survey informing the submission to the NSW Select Committee Inquiry into Birth Trauma. The poor workplace culture was attributed to limited resources, time pressures and lack of adequate communication, leaving midwives feeling disempowered about their work[8]. The same survey received responses related to workplace experiences which were related to a positive culture and role models that inspired their practice. Unfortunately, similar sentiments are still felt seven years on, and the impact of the pressure caused by the pandemic has amplified many of these issues.

C. The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventive and community health initiatives and overall optimal health outcomes for all people across NSW;

When midwives are able to work autonomously and to their full scope of practice, women and babies experience better outcomes. Continuity of care models such as midwifery group practice (MGP) is more cost-effective[5,9] and offers better outcomes for women, resulting in significantly higher rates of normal birth compared to standard fragmented hospital care and private obstetric care[10]. NSW offers MGP to 11% of women through the public maternity system, falling well short of demand. This leads to a lack of access and availability and is often prioritised to low-risk women. Queensland offers MGP to 25% of women through hospitals, and [ACT Health Maternity in Focus] sets targets of over 50% by 2028 and 75% access to continuity of care by 2032. MGPs demonstrate cost savings for health services due to reduced intervention and hospital stays and were shown to cost 22% ($5,208) less per pregnancy than other models of maternity care[5].

The Covid-19 pandemic, while creating enormous stress on the health system, facilitated rapid change within maternity care that could and should be retained. For example, the shift away from hospital-based antenatal consultations for most women is achievable and sustainable when organised within community facilities or private practice. Existing community settings such as child and family health centres, GP hubs and other partially used community held assets are perfect for midwife-led antenatal consultations which increase access for women who presently need to travel and wait in busy public hospital outpatient clinics.

Incorporating MGPs into primary health centres and with midwives collaborating with other health practitioners would help to improve communication and continuity of care. By providing community-based, life-course care for women and their families that could be accessed through pregnancy and as their children grow, quality of care would improve. This type of service, staffed by midwives, child and family health practitioners, women's health nurses, mental health clinicians, and nurses working to full scope of practice would improve access for women and families and encourage greater community engagement and support.

D. Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency;

Escalating costs in maternity care can be attributed to rapidly increasing intervention rates, most notably the caesarean section rate of 37.6% according to the 2021 Mother's and Babies' report[11]. Only 28.9% of women went into labour spontaneously, and a further 11.3% of women had their labour medically augmented with an oxytocin drip or artificial rupture of membranes after it began spontaneously[11]. A further 35.5% of women had their labour induced (medically induced contractions). All these interventions can initiate a 'cascade' which leads to the use of epidural anaesthesia, instrumental birth and labour obstruction[12]. It is unsurprising that the 'cascade of intervention' leads to higher costs to the health service[13]. While this study was conducted 20 years ago, it retains relevance today and highlights other research that shows the reduction in intervention rates afforded to midwifery continuity models translates to lower costs to the health service[9,10].

Australia's First Nations women are experiencing significantly worse outcomes compared to their non-Indigenous counterparts. Research conducted in Victoria[14] and Queensland[5] have found exceptionally improved outcomes and high levels of satisfaction for Indigenous women and their families. The women in the MGP models were less likely to experience preterm birth, have a low-birth-weight baby or suffer infant loss. In NSW, the South Coast Women's Health and Wellbeing Aboriginal Corporation Waminda in Nowra is providing culturally safe continuity of care for women which continues into the child's early years. The scale-up of midwife-led services in NSW is the obvious answer to cost saving and improved outcomes while using existing facilities and community settings.

The current fragmented nature of the health system results in multiple clinical handovers and has been highlighted as a barrier to optimal transition from hospital to home in the postnatal period[21]. Clinical handover is widely acknowledged to be a time of high-risk in terms of clinical errors with the potential for adverse outcomes and increased healthcare costs, with the transition of care between hospital and community-based care being particularly vulnerable[20]. There are number of strategies to overcome this including increased investment for midwifery-led continuity of care programs as previously highlighted. Furthermore, there is a current lack of robust postnatal care guidelines implemented throughout practice. A collaborative initiative (Living Evidence for Australian pregnancy and Postnatal care (LEAPP) guidelines) is working to address this with demand for evidence-based postnatal care in alignment with the COAG Woman-Centred Care Strategy published in 2019 calling for 'improved access to appropriate maternity care where they choose from conception until 12 months after birth'[22].

Australian maternity services are largely restricted to hospitals and are often segregated from community, unlike in various European settings. Whilst shared care has evolved between hospitals and GPs, returning to community services is less effective[21]. Collaborative maternity models-of-care are demonstrated to be effective, promoting breastfeeding, reducing smoking, and improving mental health[23]. Such evidence further supports the need to acknowledge the full scope and abilities of midwifery practice to support women throughout the postnatal period through effective primary health care in the community to promote long-term health and being for women and their families.

E. Opportunities to improve NSW Health procurement process and practice, to enhance support for operational decision-making, service planning and delivery of quality and timely health care, including consideration of supply chain disruptions.

Question not answered.

F. The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services, including:

i. the distribution of health workers in NSW;

The ACM NSW Branch Committee have midwife committee members located in rural and regional NSW. They frequently speak of extreme staff shortages and a frustration with the lack of understanding by the health service executives of midwifery scope of practice. Midwives inform us that they are committed to implementing midwifery models of care but are met with resistance, often due to a misguided belief that MGP and other continuity models will result in a waste of workforce resources.

ii. an examination of existing skills shortages;

Rural and remote area midwives require additional support to enhance their scope of practice. This will deliver services to women and families in areas lacking in midwifery and obstetric oversight and resourcing. Remote/virtual modes of communication, e.g. Telehealth, would allow midwives to remain in rural areas that don't have on-site obstetric cover to service the local women. Clear, integrated transfer systems would assist these services to be safe and would mean women can stay in their local area, potentially until the birth, keeping the family disruption to a minimum. These services are imperative for Indigenous women and families who are committed to birthing on Country. By enabling midwives to work to their full scope of practice, including the ability to offer continuity of midwifery models of care, and permitting endorsed midwives to utilise their skills within the public system, utilises the existing midwifery resources at a cost-effective level of function.

iii. evaluating financial and non-financial factors impacting on the retention and attraction of staff;

As discussed in sections above, retention and attraction of staff is a priority. Improvement in workplace culture and the recognition of midwifery scope of practice will contribute to the retention of staff, as well as attracting new midwives to the profession. Truly respectful, collaborative relationships are needed to deliver the respectful maternity care services women and families deserve, and that midwives will feel proud of.

iv. existing employment standards;

The current annualised salary arrangements for midwives working in MGP are outdated and fall behind other States and Territories. The original annualised loading negotiated in 2014 for MGP was 29%. This has not been reviewed since, despite the plan for this to occur in 2019. Other states such as Tasmania and the ACT are paid a substantially higher wage. Midwives working in the MGP model in Tasmania receive a 35% loading whilst the ACT receive a 40% loading. This lack of appropriate renumeration is adding to the workforce attrition as midwives seek permanent employment elsewhere.

vi. the role and scope of workforce accreditation and registration;

Endorsed midwives have completed a postgraduate qualification from an NMBA-approved program of study in prescribing, a minimum of 5,000 hours of clinical practice and applied to the NMBA for an endorsement for scheduled medicines. Endorsed midwives are recognised within the regulatory framework to be able to legally prescribe schedule 2, 3, 4 and 8 medicines and to provide associated services required for midwifery practice in accordance with relevant state and territory legislation[8]. Endorsed midwives have access to Medicare provider numbers which provides the bulk of the funding for the care for women across the continuum of care (refer to infographic in Appendix A). The endorsed midwife pathway is restrictive in its existing format, with little incentive for midwives working in the public sector to gain this qualification unless pursuing a career in private practice.

Each jurisdiction has a different pathway for endorsed midwives to admit to public hospitals. Some have been very successful, some have no pathway, it is limited or at a local level. In QLD there have been over 4,300 Medicare funded births[25] with endorsed midwives, in SA there have been only 20. There is no national approach to facilitate a formal pathway for endorsed midwives to admit to hospitals. Within

jurisdictions midwives apply at each hospital, and each hospital may have different processes or approach to admitting rights. The COAG 19[2] initiative currently allows public health services to bulk bill primary care in rural and remote areas however it is limited to MMM 5-7 and there are multiple limitations including population size. Endorsed midwives working in the public sector would be better able to fulfil their professional scope by using their qualification, including prescribing in all settings and not simply in COAG 19[2] locations.

vi. the skill mix, distribution and scope of practice of the health workforce;

Please refer to the ACM submission into Unleashing the Potential of our Health Workforce Scope of Practice Review.

The State of the World's Midwifery 2021 report has identified four areas of investment that could enable midwives to work to their full scope of practice.

Workforce and Planning: This encompasses investments in well-thought-out strategies that acknowledge the autonomy and professional scope of midwives. It involves directing resources towards underserved areas, particularly in primary healthcare, and creating work environments that promote gender-transformative practices.

Education: The report highlights the need to invest in education, educators, and training programs to ensure that all midwives can practice to their full capacity.

Midwife-Led Improvements in SRMNAH Service Delivery: The report suggests investments in enhancing communication and partnerships, as well as optimising roles for midwives through midwife-led care models.

Midwifery Leadership and Governance: To further enhance the role of midwives, the report recommends creating senior midwife positions, such as a Chief Midwife in each state accompanied by midwives in senior leadership and executive roles and providing opportunities for midwives to actively influence health policy development. Demonstrating clear career progression for early career midwives is seen as a crucial tool for retaining this workforce.

The report concludes that when midwives are fully educated, licensed, and integrated into a multidisciplinary team, midwives can meet about 90% of the needs of SRMNAH interventions but currently midwives only make up just 8% of the global SRMNAH workforce. Boosting that number can be transformative to saving not only money but lives.

Due to midwives not working to their full scope of practice, there is a loss of essential skills and an underutilisation of midwives as lead carers across the full continuum of preconception, pregnancy, labour, birth and postnatal care. The most defined underutilised midwifery skills include prescribing, ultrasound, abortion care, and primary healthcare.

Including abortion care and ultrasound in the midwifery scope of practice could enhance access to care in rural and remote areas. Recent legislative changes in Australia provide an opportunity to reorientate abortion services to be woman-centered, accessible, and integrated into primary maternity care services. The prescribing rights of MS-2 Step now means midwives with an endorsement can prescribe drugs for abortion, but in the public system midwives cannot use their endorsement.

Prescribing is another example of how midwifery scope of practice can be extended. The number of endorsed midwives in Australia has grown significantly. While there were only 157 in 2014, as of June 2023, there were 1089. In NSW, however, there are only 157 endorsed midwives, and many of them are underutilised within the public health system. Allowing midwives to prescribe could potentially reduce errors, decrease waiting times, and enable the medical team to focus on tasks that are beyond the scope of midwives.

Midwifery Group Practice (MGP) is another model that allows midwives to work to their full scope of practice. The benefits are three-fold, including improved outcomes for women and babies, reduced burnout for midwives, and cost savings for the healthcare system. Continuity is now factored into the midwifery curriculum and in a survey of midwifery students 90% said they felt working in MGP would provide them with the most satisfaction. The current demand for midwives to work in MGP exceeds capacity in NSW health, and addressing this issue is recognized as a workforce retention concern.

In The first 2000 days, conception to age 5 framework, strategic objective 2 speaks about working in partnership to promote health, wellbeing, capacity and resilience. Bringing midwifery into the primary health space with other health professionals such as GPs and child and family health nurses improves communication, less women and families would 'fall through the gap' and greater community engagement and support.

Some further recommendations that would enable midwives to work to their full scope would be funding for education. Short term funding or paid scholarships in protected time to extend or reinforce the skills of the midwife, with the long-term goals of introducing skills such as cannulation and suturing into the undergraduate/postgraduate course. This would enable midwives to qualify practicing to their full scope.

There is a need for a comprehensive strategy to enable midwives to practice to their full scope by addressing policy barriers, ensuring appropriate remuneration, and incorporating additional skills into the undergraduate core curriculum. By taking these steps, we can empower midwives to provide comprehensive, woman-centered care, improve healthcare outcomes, and reduce workforce attrition, ultimately benefiting women, families, and the healthcare system.

vii. the use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements;

A locum workforce is unsustainable and not cost-effective, however more importantly it does not provide continuity of care to women or midwives working in the model. The locum workforce is extremely competitive nationally, and ACM recommends incentivisation for permanent recruitment and in particular rural areas.

viii. the relationship between NSW Health agencies and medical practitioners;

Question not answered.

ix. opportunities for an expanded scope of practice for paramedics, community and allied health workers, nurses and/or midwives;

ACM recommends NSW Health align with key national strategies and pieces of work informing scope of practice for midwives. A comprehensive understanding of the scope of practice of a midwife and an endorsed midwife, ensures that midwives across all settings and models of care are able to work to full scope of practice. It is when full scope of practice is supported and understood as the minimum standard, that expanded scope of practice can be realised. Midwives are experts in primary maternity care and as such should always be the lead carer and not substituted with other disciplines, such as paramedics, health workers and nursing stuff routinely providing this care or as a result of the implementation of ratios for example where a midwifery workforce gap may exist.

x. the role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system;

This has been addressed in the previous sections above. In brief: realising midwives' scope of practice; supporting the expansion and utilisation of endorsed midwives; supporting midwives/endorsed midwives in hospitals, GP clinics, community centres and private practice to provide women with more options for expert maternity, sexual and reproductive and child, family and maternal health care. ACM recommends prioritising and expanding access to Midwifery lead care.

xi. opportunities and quality of care outcomes in maintaining direct employment arrangements with health workers;

Midwifery lead continuity of care models are well supported by evidence and research to improve outcomes for women and babies, and to be more cost-effective for the health service. A locum workforce does not contribute to continuity or stability and sustainability of a workforce. Please refer to vii above.

G. Current education and training programs for specialist clinicians and their sustainability to meet future needs, including:

i. placements;

Midwifery student numbers are solely restricted by the number of clinical placements maternity hospitals can provide. A more creative approach to student placement and recognition of the midwifery mentors and preceptors is needed to allow more midwives to be educated to fill the workforce shortage. This does not address skill-mix, however, and retention approaches that reward midwives for staying in the workforce are needed. Please refer to the Council of Deans – Future of the Midwifery workforce paper available here:

Further, the implementation and expansion of Midwifery Clinical Chair positions in alignment with medical appointments demonstrating meaningful collaboration across both the university and health service will support maternity care provision in NSW.

ii. the way training is offered and overseen (including for internationally trained specialists);

There is opportunity to re-attract midwives into practice. The re-entry into clinical practice is cumbersome and requires both a theory and clinical placement element. NSW could attract midwives back into the profession by making this pathway attractive and accessible through innovative recruitment.

iii. how colleges support and respond to escalating community demand for services;

Maternity consumers are requesting access to continuity of midwifery lead models of care. Demand for these models of care outweigh supply. ACM recommends review of the submission to the NSW select committee into Birth Trauma.

iv. the engagement between medical colleges and local health districts and speciality health networks;

Question not answered.

v. how barriers to workforce expansion can be addressed to increase the supply, accessibility, and affordability of specialist clinical services in healthcare workers in NSW;

Question not answered.

H. New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation; and

Meaningful acknowledgement of midwifery as primary health care providers from a funding perspective would facilitate opportunities to acknowledge and appropriately fund antenatal and postnatal care. Midwifery care is an essential component of primary health care and includes education and health promotion. Access to midwifery models of care improves health literacy and will have lasting effects on the reduction in the burden of chronic disease, improved health engagement and a primary and preventative approach to service delivery.

Please refer to the ACM submission to the National Health Reform Agreement (NHRA) Addendum 2020-2025. Maternity care funding is fragmented, spanning the MBS (for primary care by general practitioners (GPs) and general practitioner with obstetrics (GPO's), endorsed midwives and specialist obstetricians), public hospital funding and private health. This means that the overarching funding model is inefficient, costly and non-integrated. A key driver for the need to reform funding is the lack of funding integration between primary care and the acute care sectors. There is an urgent need for change given current models of funding have a negative impact on women having choice and access to best practice and timely care; in particular barriers to midwifery continuity of care (MCoC) by a known midwife - established as best practice in the Woman-Centred Care, Strategic directions for Australian Maternity Services (2019).

Importantly the current models do not allow health professionals to work to full scope, are more costly and outcomes are poorer. Furthermore, in the existing model, all funding for maternity is deemed to be 'acute care' within the IHPACA. However, this is incongruous as the majority of women who birth in each setting do not fit this descriptor given pregnancy and birth is a normal physiological process and most women are healthy.

Recommendations:

1. Introduce bundled funding for maternity care to provide best health outcomes, with choice of care, at lowest cost through a new IHACPA modelling project, to include all-risk models of care and care for women with complexity.

2. Introduce a specific funding stream for integrated primary care and admitted acute care for Birthing on Country models for First Nations families and models for admitted care from an endorsed midwife (particularly in rural areas).

3. Seek long-term funding and/or incentives/innovative models of care funding to facilitate long-term embedding of best practice models e.g., rural MGP networked with the multidisciplinary team to address variability and under-servicing.

4. Review existing provision within the Health Insurance Act and support the amendment of Section 19.2(b) to encompass primary maternity care, and specifically for all eligible midwives to provide seamless care.

Prioritise integrated funding models, via system-wide change or via innovative models of care funding:

   a. specific to the whole maternity system; and/or
   b. specific to midwifery continuity of care models; and/or
   c. specific to ACCHO led Birthing on Country models.

Conclusion

The role of the midwife working to full scope of practice in all settings, and in primary care will improve outcomes for women, reduce cost to Government, and take pressure off the overburdened primary care system, in particular the decline in medical practitioners, GP obstetricians and General ruralists.

Midwifery is an autonomous profession which is undervalued and underutilised. ACM welcomes this consultation and is committed to ensuring that midwives in NSW and Nationally can use their skills and expanded scope to provide women and families with the person-centred care that they have the right to expect and that they deserve. ACM looks forward to ongoing engagement and would welcome representation on the expert advisory group for the implementation of the NSW Blueprint into Action.

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Consent to publish and provide further information.

ACM consents to this submission being published in its entirety, including names is available to provide further expert opinion and advice if required.

Appendix A

WHAT IS AN ENDORSED MIDWIFE?

An Endorsed Midwife is a Midwife with a postgraduate qualification for an Endorsement for Scheduled Medicines and can provide autonomous care.

Endorsed midwives therefore do not require a GP referral to work with women.

Endorsed midwives can provide direct referral to other health care professionals, prescribe some medications and order diagnostic interventions.

MEDICARE (MBS) PROVIDER

PRESCRIBING RIGHTS WITH PBS ACCESS

REFERS TO OTHER HEALTHCARE PROFESSIONALS IF NEEDED

WOMEN DO NOT REQUIRE GP REFERRAL

ADMITTING RIGHTS TO HOSPITAL

ORDER MBS REBATED BLOOD TESTS AND SCANS

SCOPE TO PROVIDE:

- Sexual and Reproductive Health
- Maternal, Child and Family Health

acm Australian College of Midwives

References

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