Australian College of Midwives

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

Unleashing the Potential of our Health Workforce
(Scope of Practice Review)

ACM Submission #3 – Response to Issues Paper 2

Issued May 2024

Unleashing the Potential of our Health Workforce – (Scope of Practice Review) – 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 submission to the ***Unleashing the Potential of our Health Workforce – Scope of Practice Review – Consultation 3 – Issues Paper 2***. ACM represents the professional interests of midwives and supports the midwifery profession to enable midwives to work to full scope of practice (SoP). ACM is focused on ensuring better health outcomes for women, babies, and their families.

Background

ACM commends Professor Mark Cormack and the Scope of Practice Team on the consultation, communication and reporting of the Unleashing the Potential of our Health Workforce – Scope of Practice Review to date. ACM has provided written submissions in Phase 1 and Phase 2. Please refer to both of these submissions in the context of addressing a response to Issues Paper 2, which was released on 16 April 2024.

- ACM initial submission
- Issues Paper 1.

The Strengthening Medicare Taskforce Report[1] affirms that midwives have a fundamental role in the provision of primary maternity care to women, in all contexts. In addition to pre-conception, antenatal, intrapartum, and postnatal care, there is a growing recognition of the role midwives can play in relation to improving universal access to reproductive healthcare in areas such as abortion services, prescribing contraceptives, sexual health screening and treatment, and, maternal, child and family health inclusive of the first 2,000 days.

Endorsed midwives hold an endorsement for scheduled medicines qualification, following a postgraduate course of study in prescribing. The autonomous role of the Endorsed Midwife enables the prescribing of medications, ordering of diagnostic screening/testing and pathology related to pregnancy. With the recent Government announcement of the rollback of collaborative arrangements, Endorsed Midwives do not require a GP referral to work with women and can provide direct referral to other health care professionals if needed. Endorsed Midwives and Nurse Practitioners are educated to provide excellent leadership autonomously and/or whilst working in multi-disciplinary teams (MDT). Midwife led primary healthcare contributes to improved outcomes for women and families and lower cost to the health system. Midwife led models of care do not need to be led by General Practitioners or Medical Officers, and in many cases midwives and Nurse Practitioners are the only health professionals in rural and remote communities. This scope of practice review must therefore recognise midwives as equal players in the healthcare system and as lead carers in an authorising environment which includes access to incentives and continued professional development.

All health professionals working to full SoP in Australia, benefits the consumer, the health professional, and the employer. ACM therefore continues to welcome the *Unleashing the potential of the health workforce: A scope of practice review.*

Survey Questions (Terms of Reference)

This submission will address the subject matter as identified by the *Unleashing the Potential of our Health Workforce* (Scope of Practice Review) survey questions.

Challenges facing midwives – evidence collected in the Scope of Practice review so far:

- Poor recognition of the skills that midwives have
- Midwifery students experience primary care during their training which results in midwives being well placed to work in primary care upon graduation
- Legislation impedes midwives working to their full scope
- Funding and payment arrangements impede midwives working to their full scope

The proposed reforms fall under three themes:

- Workforce design, development and planning
- Legislation and Regulation
- Funding and payment policy

ACM notes that implementation of the proposed reforms must be enabled by investment in culture, leadership and clinical governance mechanisms that support the changes required.

Leadership in primary care

What leadership do you consider important to ensure reforms are successfully implemented?

From the perspective of maternity service provision, primary health care reform and scope of practice review, dedicated midwifery leadership is required to increase access to continuity of midwifery care, lead the workforce and address consumer expectation and demand. Midwifery leaders understand the role, scope and models of midwifery care and collaborate with the multidisciplinary health care team and obstetric, nursing and allied health leadership to ensure improved clinical maternity indicators and outcomes for mothers and babies, and access and equity to quality maternity services are met.

Overall there is a significant opportunity to develop strategic interdisciplinary leadership. For example, every facility that provides a maternity and birthing service, a Director of Midwifery is appointed to work collaboratively alongside a dedicated obstetric lead to ensure maternity service provision is co-led and Patient Reported Experience Measures (PREMS), Patient Reported Outcome Measures (PROMs), clinical indicators and consumer engagement are managed proactively, while the continuity model of care is operationally led by the Midwifery Unit Manager. Clinical indicators should be benchmarked, trended and any outliers interpreted and acted upon (for example, to facilitate proactive addressing of the reduction of current rates of caesarean section and induction of labour rates to improve the national average).

Since the introduction of National Law in 2010, Midwifery has been recognised as a separate profession from Nursing. Despite legislative changes, the required leadership structures to recognise and enact this legislative change have not been supported or enabled. There are 6 key areas (domains) of Midwifery Leadership that need to be enabled in Australia which are categorised by the International Confederation of Midwives:

- **Political strategic leadership**:
  Ensuring that the highest level of midwifery policy and strategic leadership in the Commonwealth and jurisdictions are led by midwives.

- **Operational leadership**:
  Health service leadership of midwives should be undertaken by midwives.
- **Regulatory leadership**:
  At the highest regulatory level, wherever decisions about or for midwives are made, there should be equal midwifery representation.
- **Education leadership**:
  Within the tertiary sector and in post-registration education, midwives should lead the design and delivery of education.
- **Research leadership**:
  Evidenced by midwife researchers resourced with funding equitable to national counterparts lead and undertake research addressing demand and investigator driven priorities.
- **Clinical leadership**:
  A harmonised national industrial pathway of leadership that recognises midwives' clinical expertise up to Consultant level.

ACM advocates that all domains of the profession of midwifery must be led, developed and represented by midwives for midwives. The paucity of midwifery expertise in leadership roles, which is vital to effectively guide, inform, operationalise and support midwifery practice and maternity care needs to be addressed as a matter of urgency.

The ACM recommendation for a priority target is support for the first domain through:

1. The appointment of a Commonwealth Chief Midwife
2. The appointment of a Chief Midwife in each jurisdiction to work with the Commonwealth Chief Midwife to drive strategic maternity care policy direction and operationalise reform across Australia, noting Queensland as the exception as it has this position

Workforce design, development and planning

To design, develop and plan for both a midwifery and maternity workforce that meets the needs of women birthing in Australia, it is important to understand the role and scope of a midwife. A midwife is a person who has successfully completed a midwifery education program based on the ICM Essential Competencies for Midwifery Practice, the Australian Nursing and Midwifery Accreditation Council (ANMAC) Midwife Accreditation Standards 2021 and the framework of the ICM Global Standards for Midwifery Education, recognised in Australia, who has acquired the requisite qualifications to be registered and legally licensed to practice midwifery and use the title 'midwife' as determined by the Nursing and Midwifery Board of Australia (NMBA), and who demonstrates competency in the scope of practice of the midwife. The International Confederation of Midwives (ICM) defines the role of the midwife[2].

"The midwife is recognised as a responsible and accountable professional, who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the women and gender diverse people they serve, but also within families and communities. This work should involve antenatal education and preparation for parenthood and may extend to sexual and reproductive health care, and care for infants and young children. A midwife may practice in any setting including the home, community, hospital, clinic or health unit".

Reform Option 1: National skills and capability framework and matrix

ACM affirms the NMBA does not regulate professional scope. Rather, it provides standards, codes and guidelines which establish the requirements for the professional and safe practice of midwives in Australia. NMBA provides a decision-making framework[3] to assist the midwife with determining if an activity is "within the current, contemporary scope of midwifery practice as envisaged in professional practice standards and legislation".

While there appears to be a lack of clear documentation of professional scope of practice of the Australian Health Practitioner Regulation Agency (AHPRA) regulated professions, the NMBA provides a sound, outcomes-based approach to scope of practice. Clarity around the roles and scope of practice of individual health professions will contribute to interprofessional understanding of the full scope of practice of health professions and individual practitioners within them, however, it should be recognised that there are both similar and differing roles various professions play within the multidisciplinary team and the healthcare (maternity) system at large. For example, both midwives and GP(O)'s do and should provide antenatal care.

The Australian College of Midwives is concerned that introducing a skills and capability framework specific to primary healthcare and entry-to-practice level creates unnecessary complexity. There may be confusion or nuances when a health professional works across primary, secondary and tertiary care settings and rurality and geographical location, and an individual's training and experience will implicate clinical and scope of practice. Therefore, defining scope for primary healthcare, without defining scope for the broader healthcare system would create confusion.

The complexities of defining scope of a profession must be addressed, without creating any unintended consequences or additional regulation, if this option for reform is to be successful. The challenge and risk identified – *Overlapping scopes of practice* creates concern over professional boundaries and with an existing health workforce crisis where culture and leadership is either/both suboptimal, absent or inadequately represented, a skills and capability matrix may not be effective.

ACM asserts every pregnant woman in Australia should have access to a (known) midwife during the antenatal, labour and birth and postnatal period. Pregnancy care should be provided by midwives. There is increasing scope creep in nursing to provide midwifery specific care, without the equivalent training and education which creates further risk as described in case description: use of the skills and capability framework – issues paper 2, page 35. *Regional and remote communities unable to attract specific health professionals could use the framework to identify roles that may be performed by equally qualified professionals from another discipline.* The substitution of nursing personnel for a midwifery role, for example on a postnatal ward is not a patient centred approach. It unfortunately, if not addressed, permits health services to 'settle' for sub-optimal care provision which can then become the norm[4].

Reform Option 2: Develop primary health care capability

ACM supports the embedding of primary healthcare into the entry-to-practice curricula across all health professions. Midwifery courses already prioritise and focus on primary maternity care principles and evidence-based continuity of midwifery models of care. Currently, there is a requirement for a midwife to undertake 5 000 clinical hours of practice and complete and NMBA approved course of study on postgraduate prescribing to be eligible to apply for endorsement for scheduled medicines (Endorsed Midwife). The embedding of this prescribing syllabus for midwives into the undergraduate curriculum will enable entry to practice midwives to work to full scope of practice upon graduation. An NMBA review of this regulation is currently in train. The removal of this barrier to scope would also serve as a workforce

attraction and retention strategy if regulation and undergraduate curricula accreditation standards could be fast tracked when there is clear evidence (or lack of evidence) coupled with protection of public safety to support the change. Numbers of endorsed midwives are expected to significantly increase in primary healthcare.

An increased number of clinical placements in primary healthcare settings are essential in maternity care given the increasingly significant role it plays within the health system as a whole and with the increasing complexity of geographic remoteness on both families accessing care and health professionals living and working in community. Barriers to clinical primary care placements such as affordable accommodation, childcare, insurance issues need to be addressed.

Reform Option 3: Early career and ongoing professional development includes multi-professional learning and practice

ACM recommends the introduction of inter-professional learning in the undergraduate and new to practice environments to build positive workplace culture. For example, Medical officers' exposure to normal birth physiology in practice, and shared and mutually beneficial mentorship program (midwife/doctor) across professions that is not based on power imbalance.

Workforce surveys consistently report barriers to accessing professional development, education and upskilling opportunities, especially in rural and remote areas. This is often due to an inability to backfill rosters, geographical distances and costs involved in travelling to attend professional development;

Recommendation:

Support for professional development of midwives and primary healthcare professionals in rural Australia must be an implementation priority.

- **Transition to practice program**. There is currently no transition to practice program in Australia for Midwives. ACM was unsuccessful in gaining funding in the recent 2024/25 Federal Budget 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 by 85%.
- **Culturally responsive and respectful maternity care training** The COAG Woman-centred care Strategic directions for Australian maternity services identifies the values and principles of respectful maternity care which is aligned to the Respectful maternity charter: the universal rights of childbearing women[5]. The recent NSW Select Committee on Birth Trauma inquiry report, released on 29 May 2024 made at least 8 recommendations for education and training for healthcare practitioners; (Refer to Recommendation 13, 15, 17, 21, 22, 28, 33 and 34 of the report). These recommendations included training and funding to support training specific to trauma informed care and practice, consent, respecting women's birth choices, declining recommended care, gender bias, respect and dignity, culturally safe care, and education and training for healthcare practitioners on the unique health and support needs of First Nations people, culturally and linguistically diverse communities, refugees, LGBTQIA+ individuals, young parents, individuals from rural and regional communities, individuals with pre-existing conditions and disability, and fathers and non-birthing parents
- **MDT governance and emergency training** With a focus in interprofessional training and collaboration and multidisciplinary care in issues paper 2, ACM supports joint and co-led multidisciplinary training that also works to strengthen workplace culture. An example of shared

emergency training is the RANZCOG OGET program. The Obstetrics and Gynaecology Education and Training (OGET) project is currently a 12-month Australian Government funded pilot to develop and deliver upskilling and educational training for a range of medical professions who play a role in the provision of maternity and maternity related services. The pilot is being delivered via four hubs providing on site and outreach training to rural and remote areas of Australia. ACM has been a stakeholder in the development of the training programs.

To what extent do you believe the combined options for reform will address the main policy issues relating to education and training and employment practices you have observed in primary health care scope of practice?

- To a great extent
- **Somewhat**
- **A little**
- Not at all

The themes as identified in issues paper 2 are relevant and appropriate, however the combined options for reform as presented in issues paper 2 are complex and will require considerable consultation, investment and change management principles for effective and timely enactment. Parity of representation is required in a primary healthcare system that requires recognition of the scope and contribution of all members of the multidisciplinary healthcare team. ACM recognises this policy window opportunity to remove hierarchical barriers to ensure a move towards better healthcare for all Australians. Currently midwifery representation is absent or underrepresented on several decision making and stakeholder groups. For example, there is no midwifery representation on the Medical Services Advisory Committee (MSAC) and the Pharmaceutical Benefits Advisory Committee (PBAC) despite providing leadership in the national non-medical prescribing sector. The recent removal of legislative and regulatory barriers to the prescribing of MS -2Step (mifepristone and misoprostol for medical abortion), is an example of where there was a lack of understanding and representation required to provide midwifery context for decision makers, resulting in unnecessary delays, omissions and confusion that can be related to midwifery scope of practice.

The proposed development of a competency standard and skills matrix is expected to enhance skill recognition and utilisation by defining competencies for all Health Care Professionals (HCPs). This would complement a skills-based workforce and seek to increase understanding between disciplines, however success for the reform is dependent upon buy-in from all stakeholders and recognise the shift required from existing medical domination of same.

In both birthing on country models of midwifery care and rural maternity, the RISE framework prioritises co-design with consumers. All primary care reform principles should place the consumers at the centre of care[6]. The Office of the National Rural Health Commissioner is currently undergoing a refresh of the National Consensus Framework for Rural Maternity Services, which will encompass the RISE framework principles and demonstrates collaboration from a multidisciplinary approach that prioritises patient and health professionals in optimising equity and access to primary health care service delivery.

Recommendation

ACM requests adequate midwifery representation at every stage where midwifery is regulated in Australia. Adequate representation includes >50% representation when the impact is directly on midwifery/midwives and equal representation when multidisciplinary impacts.

Priority Recommendation

Regarding the establishment of the *independent body (5.1 issues paper 2)* proposed to be tasked with identifying and implementing emerging best practice evidence into primary health care workforce models on an ongoing basis, ACM

a) requests transparency in recruitment to this body, and equitable midwifery representation.
b) recommends further stakeholder engagement regarding if the independent body should be wholly independent or sit under AHPRA to provide adequate professional clinical, operational, policy and strategic representation from the profession.
c) Recommends at a minimum a similar implementation approach to the MBS taskforce – whereby a participating midwives reference group was consulted as subject matter experts.

Midwifery does not have an existing workforce strategy. The National Nursing Workforce strategy is in train, however midwifery is out of scope and the Midwifery Futures: The Australian Midwifery Workforce Project provides a workforce analysis, however does not include scope for a National Midwifery Strategy. Understanding the midwifery workforce demographic and distribution is crucial to workforce planning and sustainability. There is a known ageing workforce and a suspected part time and maldistributed workforce, however the current distribution of the dual registered midwife/Registered Nurse cohort is unknown. While there are 25 455 General Nurse/Midwife on the register, it is unknown how many are working in clinical practice, where they are distributed (MMM1-7) and if they are working in the capacity of a nurse, midwife or both. Comparably there is a National Medical Workforce Strategy and a commitment to a National Allied Health Workforce Strategy which is currently open for consultation. The Council of Deans of Nursing and Midwifery provide a position paper on the future of the midwifery workforce in Australia identifying six causal factors that will impact the sustainability of the profession if not addressed at a strategic level, with one factor a lack of professional recognition of specialised knowledge, skills and scope of practice by one's own and other professions, fuelling intention to leave and workforce attrition.

Priority Recommendation

a) Prioritisation and funding of a designated National Midwifery workforce strategy equivalent to the terms of reference of the National Nursing Workforce Strategy.
b) Progression of the National Maternity Strategy as per recommendation 18 of the Kruk report.

How should the National Skills and Capability Framework and matrix be implemented to ensure it is well-utilised?

The Nursing and Midwifery Board of Australia (NMBA) and the Australian Health Practitioner Regulation Agency (AHPRA) have successfully ensured the national regulation of midwives and nurses since the implementation of the National Registration and Accreditation Scheme (NRAS), and it is appropriate to continue this. The Australian Commission on Safety and Quality in Health Care through National Safety and Quality Health Standards may also be well positioned to oversee the implementation of the National Skills and Capability Framework and matrix (NSCF/M). Consideration needs to be given to the ongoing review and evaluation of the NSCF/M and there is an opportunity to implement this as a living matrix/framework – like clinical guideline development such as LEAPP.

Focusing on entry to practice scope may fail to recognise health care professionals ongoing development and expertise and become an unintended consequence and barrier to healthcare professionals working to full scope. The concept should be recognised as a minimum expected standard or a 'floor' not a 'ceiling' approach and factor in both the endorsed midwife pathway and rurality as metropolitan primary health care is vastly different to rural, regional and remote primary health care. There is a risk of the NSCF/M

failing to meet what is the intended purpose and effective and appropriate implementation and ongoing oversight is critical to its success (see priority recommendation above).

If a National Skills and Capability Framework and matrix (NSCF/M) was to be implemented, the following considerations for implementation would be required and considerable further consultation.

- Programs
  - Undergraduate and postgraduate programs
  - Ongoing midwifery education standards post registration
  - Workplace orientation programs
  - Transition to professional practice
  - Interprofessional education
  - Re-entry into practice
  - Internationally qualified healthcare professionals
- Government consultation
  - Federal, State and territory including funding
- Industry consultation (Local health districts, Local area health services)
  - Peak professional body consultation
  - Clinician consultation
  - Australian Nursing & Midwifery Accreditation Council
  - Universities and educational institutions
- Consumer education
  - (e.g. models of care, parenting education)
- Further considerations
  - Workforce planning and modelling
  - Critical thinking and decision making
  - Australian Qualifications Framework
  - Digital health and data
  - Scope creep
  - Leadership and culture change requirements to drive positive change/reform is unclear

Recommendation
ACM seeks to be included in ongoing consultation regarding implementation of the *independent body* for the NSCF/M

Who do you see providing the necessary leadership to ensure the National Skills and Capability Framework and Matrix achieves the goal of contributing to health professional scope of practice in primary care?
Scope of practice currently experiences many limitations as identified in issues paper 1 and 2. The Department of Health and Aged Care should provide the overarching leadership for the implementation nationally of the NSCF/M.

As discussed above, leadership is required across all levels of the healthcare system. A well planned, consulted, funded, resourced and documented implementation and evaluation strategy is required.

Recommendation
The Australian College of Midwives seeks ongoing consultation regarding development, implementation and evaluation of a National Skills and Capability Framework and Matrix

Legislation and Regulation

Evidence gathered to date has contributed to three proposed reform options related to legislation and regulation:

- *Risk-based approach to regulating scope of practice to complement protection of title approach*
- *Independent, evidence-based assessment of innovation and change in health workforce models*
- *Harmonised Drugs and Poisons regulation to support a dynamic health system.*

Previous ACM Scope of Practice submissions recognised the following areas under legislation and Regulation. Please refer to these for further information and examples:

- Harmonisation of Medicines and Poisons Acts
- Pharmaceutical Benefits Scheme (PBS): Scope based approach
- Authorising environment by title/profession: review
- National credentialling
- Professional Indemnity Insurance (PII) for Privately Practising Midwives
- National approach to admitting rights
- Expansion of 19(2) exemption
- Employment and industrial matters
- Health Insurance Act
- Medicare Benefits Schedule (MBS)

Reform Option 4: Risk-based approach to regulating scope of practice to complement protection of title approach

ACM reiterates that the existing midwifery workforce works effectively under a standards-based approach to regulation[7].

Recommendation

An agreed approach to evaluation of risk is required to determine a suitable risk-based approach to regulation that meets the requirements of all health care professionals.

Reform Option 5: Independent, evidence-based assessment of innovation and change in health workforce models

> *"The reality is, that even the most qualified and skilled midwife, who encounters a service unprepared or unwilling to facilitate scope fulfilment will be unable to fulfil their professional capacity. The disrespect that midwives encounter in services unwilling to enable professional scope fulfilment has an accumulative effect and is contributing to workforce attrition around the world at unprecedented levels"* [8]

Reform Option 6: Harmonised drugs and poisons regulation to support a dynamic health system

ACM supports the harmonisation of the drugs and poisons act, ensuring that this is benchmarked on the state with the most liberal scope of practice to ensure midwives work autonomously. The impact of the variations within Medicines and Poisons legislation is further impacted by the restrictions within the Pharmaceutical Benefits Scheme (PBS), further limiting the capacity of midwives to work to full SoP. Care should be taken not to introduce unnecessary additional bureaucracy and regulation where it is not intended.

To what extent do you believe the combined options for reform will address the main legislative and regulatory policy issues you have observed in primary health care scope of practice?

- **To a great extent**
- **Somewhat**
- A little
- Not at all

With the number of endorsed midwives increasing, a national approach to legislation, access, governance, and insurance is required to enable endorsed midwives to work to full scope of practice, support the primary health sector and boost the healthcare workforce in particular in rural and remote areas and thin-markets locations, particularly for medical workforce. Recognising and acknowledging any shared or overlapping scope is beneficial to providing quality healthcare and acceptance that within a multidisciplinary team, some roles, tasks, skills and functions can be shared to enable efficient and safe service delivery and a positive experience for the woman and her family (patient), especially in thin-markets where it may be difficult to access GP services or healthcare.

Cultural shift and change is required and at the forefront of valuing and respecting the skills and capabilities (and thus scope of practice) of all health professionals. Respectful maternity care, as outlined in the COAG Woman-centred care Strategic directions for Australian maternity services strategy must underpin all (maternity) health care. Midwives are the experts in providing primary maternity care. The maternity models of care are multidisciplinary in nature and through established and robust consultation and referral, maternity care is optimised.

Healthcare that reflects the patient journey across all settings must underpin healthcare reform. Please refer to the full ACM submission to the Mid-term review of the National Health Reform Agreement Addendum 2020-2025.

Recommendation

ACM supports a comprehensive review of legislative and regulatory mechanisms to identify restrictions and optimise opportunity to improve scope of practice for midwives.

To what extent do these options for reform strike the right balance between maintaining protection of title where appropriate, and introducing risk-based regulatory approaches in specific circumstances?

- To a great extent
- **Somewhat**
- A little
- Not at all

In the main, ACM seeks to maintain the protection of title. Regulating scope of practice through a risk-based approach has the potential to support a broader range of health providers to deliver primary health care, however, will not support better utilisation of multidisciplinary teams unless the current skills and capabilities of midwives for example is recognised and valued. Governance over practice, policy and education for midwives and midwifery must be retained by midwives and the profession and reassurance is sought that oversight by another profession such as medicine does not creep into policy, legislation and decision making.

Enabling the Health Ministers' Meeting (HMM) to give policy direction to AHPRA and the National Boards and policy directions to educational accreditation authorities, risks politicising health education. This

leaves the education system open to manipulation based on political agendas. The focus must instead be on ensuring the intent and outcomes remain about educating health professionals to ensure the safety of the public. The safety of the public must continue to be paramount and to do this accreditation authorities must remain as independent

Recommendation
ACM supports the notion of a national digital passport for credentialing, however, seeks further stakeholder consultation around credentialling and micro-credentialling and the impact and unintended consequences it may have on midwifery and other healthcare professions as it relates to scope of practice before any final recommendations are made through this review process.

Recommendation
ACM recommends the genericising of language, such as 'health practitioner' in legislation to avoid the unintended consequences e.g. for midwifery the non-inclusion in the GST Act as it was legislated before midwifery was a separate profession. This will facilitate equity for non-medicalised professions.

What factors should be considered when implementing the changes to legislation and regulation to ensure they are effective?
Any changes to legislation and regulation must be actualised in all jurisdictions. and lead to innovation and improvement. Legislative and regulatory changes must ensure a same or better approach to the jurisdiction with the highest standard of professional autonomy and a jurisdiction must not be subject to 'going backwards' in order to standardise with other jurisdictions. The complexity of scope-of-practice barriers across jurisdictions and between services limit the provision of care and increase risk to patients, especially in the existing critical workforce climate. Any changes to scope of practice must be appropriate for and translate to the service level. Changes should be coordinated across jurisdictions to protect consumers and practitioners from increased risk resulting from confusion.

Are there specific policy actions related to legislation and regulation you believe should be pursued?
Yes

Coag 19(2) Exemption

NHRA report recommendation 37 (P106) outlines the requirement to expand this initiative. Small rural hospitals, and larger services such as Alice Springs hospital would benefit from this initiative. Recommendation 37: The process for the application and approval of exemptions from Section 19(2) Health Insurance Act 1973 should be reviewed, simplified, and expanded to improve access to bulk-billed primary health care (MBS-eligible GP, nursing, and allied health services) in rural and remote areas and where there are thin and failing markets. This work should:

a) Explore opportunities to include further sites and increase the number of exemptions for areas without access to primary health services (including thin and failing markets) within a reasonable distance.
b) Simplify and streamline approval processes to enable timely establishment of services in areas where there is limited access to primary care.
c) Ensure that doctors providing rural hospital emergency services are appropriately remunerated and patients who attend the ED are not charged out-of-pocket fees.

Recommendation
Adoption of recommendation 37 of NHRA report, noting the requirement for the addition of 'midwifery' which is already within the exemption legislation parameters.

Admitting Rights

Currently admitting rights and visiting access approach for many health practitioners including Endorsed Midwives into public and private hospitals varies significantly jurisdictionally and further at local LHD level. A national approach to admitting rights is required to create equitable access to models of care of choice for women. For midwifery this will encourage midwifery in the primary care space and increase women's access to continuity models of care, with admission to public hospitals for birth. The jurisdictional variance in application of admitting rights is demonstrated by the Medicare funded births numbers which since 2010 in Australia currently ranges from 20 and below per state (SA/NT/ACT) to 4 309 (QLD). Additionally, The recent NSW Select Committee on Birth Trauma inquiry report, Recommendation 27 states 'That the NSW Government review the regulatory framework and funding arrangements for privately practicing midwives, including ensuring these midwives have authority to practise within hospital settings as well as hospital admitting rights across New South Wales. ACM would support an extension of this recommendation with harmonisation of established admitting rights to any Australia public hospital.

Recommendation

A national review and harmonisation of admitting rights to all public hospitals in Australia.

Professional Indemnity Insurance

There remains a barrier to midwifery practices professional indemnity entity insurance. While a permanent solution to the existing PII exemption for privately practising midwives and birthing on country midwifery models of care is in train, private midwifery practices are vulnerable and disincentivised.

Recommendation

ACM recommends a sustainable comprehensive fit for purpose midwifery professional indemnity scheme which provides insurance for individual endorsed midwives and midwifery practices which allows them to work to full scope including homebirth without unnecessary restriction and that facilitates and strengthens the role of endorsed midwives in primary healthcare.

Industrial Review

Recommendation

A review of the way health professions are industrially represented in Australia could see a more considered and consistent approach to career pathways, remuneration, conditions and incentives.

Funding Models

Recommendation

ACM recommends that the funding and insurance models are reviewed and updated by Government to allow endorsed midwives to provide care to women as admitted public patients also. This would ensure midwives can work to full scope in all settings and increase options for best practice care as women have financially viable access to choice of care.

Funding and payment policy

Two options for reform have been developed relating to the theme of funding and payment policy:

- *Funding and payment models incentivise multidisciplinary care teams working to full scope of practice*
- *Direct referral pathways supported by technology.*

Reform option 7: Funding and payment models to incentivise multidisciplinary care teams to work to full scope of practice

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 that 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. Importantly the current models do not allow health professionals to work to full scope, are more costly and outcomes are poorer. Currently, 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.

Despite midwives' role in primary care, to date midwives are poorly recognised within the Government's workforce incentives programs. Midwives were a recent inclusion in the Workforce Incentive Program (WIP) – Practice Stream, however midwives remain absent from the after-hours system. Midwives therefore have no access to MBS or After-Hours Practice Incentives Program incentives (and no access to the Practice Incentive Program (PIP) whatsoever). Further if midwives were prioritised access, there is a barrier of the RACGP standards for General Practice accreditation which limits the role of midwives and other non-medical professions. This barrier to access to after-hours funding is inconsistent with the fundamental role of the midwife and primary health care provision, when providing twenty-four-hour caseload continuity of midwifery care, whether in person or via telehealth. The 'right providers' for maternity care are disincentivised or restricted from providing that care

The recent NSW Select Committee on Birth Trauma inquiry report, Recommendation 32 states 'That the NSW Government undertake a comprehensive review of the funding of maternity care and make appropriate representations to the Australian Government following the outcome of that review'.

Reform option 8: Direct referral pathways supported by technology

Endorsed midwives do not require a GP referral to provide care to women. However currently MyMedicare eligibility remains limited to GP practices, and the accreditation process is costly and requires a GP to be engaged within the practice. The RACGP interpretive guide indicate that services that are not GP-led are excluded from the accreditation definition and it explicitly excludes nurse-led (thus one assumes midwife-led): e.g. page 5 of the below: *'services that are not GP-led; that is, those that do not provide predominantly general practice services as per the description of predominantly within the definition (e.g. nurse-led services).'*This limits the practice of non-medical professions by limiting direct access to MyMedicare, both through technology and professionally. Further work to develop an accreditation option for midwives including prioritisation and funding is required to enable seamless work processes for Endorsed midwives in primary care.

To what extent do you believe the combined options for reform will address the main funding and payment policy issues you have observed in primary health care scope of practice?

- **To a great extent**
- **Somewhat**
- A little
- Not at all

The combined options for reform have the potential to address key funding and payment policy issues by promoting more equitable and sustainable funding models. Existing funding models for primary maternity care are complex, not fit for purpose, and incentivise an interventionist, acute care and activity-based approach to care which results in poorer health outcomes for women and babies. Care provided during pregnancy, birth and the postnatal period crosses the primary, secondary, and tertiary healthcare sectors. Please refer to ACM submission 1 and 2. For example, improving access to Medicare Benefits Scheme (MBS) items for endorsed midwives which was a welcomed announcement in the 2024/25 Federal Budget and adopting bundled funding models for maternity care will enhance equity and access to women's health, maternity, sexual and reproductive health and child, family and maternal health for consumers.

Within Australia, primary healthcare funding comes from all levels of government, non-government organisations, private health insurance and individual reimbursement (fee for service). The introduction of all healthcare professionals working in primary healthcare and having access to more appropriate funding models will not only help address the healthcare workforce issue, but also provide consumers with access to timely quality healthcare often outside of the hospital setting. Increasing funded facilities, such as midwife-led clinics, privately practising endorsed midwives with visiting access to hospitals, midwives in GP clinics, ACCHOs, urgent care clinics, nurse-led clinics, emergency departments and community health or after-hours clinics throughout Australia, prioritising rural, regional and remote areas will ensure women and families receive quality health care while also reducing the burden on the acute hospital sector.

Recommendation
ACM endorses the NHRA recommendation 13 for **bundled funding** for maternity 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.
d) Extend funding to include all neonates requiring care on the maternity ward. This is not limited to neonates admitted to SCN or NICU but includes those who may require treatment on the postnatal ward for any complexity or potential complexity.
e) Develop a funding stream for non-medical practices in primary care providing maternity and women's health services where the practice is integrated with a multidisciplinary team either via an endorsed-midwife or nurse-led practice, a GP practice or public hospital

Recommendation
ACM recommends the progression of a pilot site for bundled maternity funding in one or more jurisdictions within the short-term timeframe recommended by the NHRA report.

What other implementation options should be considered to progress the policy intent of these options for reform?

First 2000 days

The National Health Reform Agreement and other mechanisms provide an active policy setting to prioritise multidisciplinary care in collaboration with the ACCHO sector, states, territories and the Commonwealth. The success of Birthing on Country models can be mapped across the multidisciplinary team and the entire primary health care sector as a first 2,000 days strategy, utilising bundled funding and with the prioritisation of relevant non-medical healthcare professionals leading care.

The Quintuple Aim

Implement and utilise the Quintuple Aim as an external driver of health system performance, and the five-dimensional components including the patient experience, population health, reducing costs, care Team well-being and health equity[9].

Funding must align with digital health transformation needs

The NHRA Report recommendations, including the intergovernmental agreement on National Digital Health must be actualised to progress digital health solutions and importantly data sharing. For midwifery, digital transformation is not as progressive as other professions as data sharing is limited. There is no option to upload as yet to MyHealthRecord for example. Although there is work now in train, governmental lack of investment in midwifery and other non-medical professions to date is a barrier to working to full scope in all settings, and to best practice continuity of midwifery care models being prioritised and implemented[10]. It also minimises women's/families' autonomy to be in control of their and their babies' health data; which may extend to management of co-morbidities requiring the services of a diabetes educator, dietician, physiotherapist, GP, for example.

Recommendation

ACM recommends that the NHRA Report recommendation 40 be actualised to maximise enablement of a digitally enabled healthcare system for all primary health professions: **Recommendation 40**: *A future Agreement should include an explicit commitment to progress digital health as a key enabler to improving the health system, as an additional Schedule. The Schedule should reflect: a) Support and incentivisation for a digitally enabled healthcare system, including integrated funding for evolving models of care. b) The role of the Australian Digital Health Agency (ADHA) in progressing digital health. c) The Intergovernmental Agreement (IGA) on National Digital Health 2023-27 and Connecting Australian Healthcare - National Healthcare Interoperability Plan 2023-28.*

What additional actions relating to leadership and culture should be considered to encourage decision-makers to work together in a cooperative way to achieve the intent of these policy options?

Strong and efficient change management principles with clear implementation plans, targets and research and evaluation strategies are required to effect a positive culture shift within healthcare which promotes a culture of collaboration, innovation, and continuous improvement and readily adopt best practice. Ensuring appropriate and timely funding is essential for successful implementation and flexibility to adapt to changing healthcare landscapes and emerging issues. The need for effective leadership and governance is critical to the reform options proposed throughout Issues Paper 2, however further stakeholder engagement is required to achieve tangible implementation without biasing one profession.

Conclusion

The role of the midwife working to full scope of practice, and all healthcare professionals working in a multi-disciplinary environment, to full scope of practice in all settings, in particular primary care, will improve outcomes for women, patients and reduce cost to Government. ACM welcomes this ongoing consultation, recent budget announcements and is committed to ensuring that midwives 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 in this process and enabling all midwives in Australia to work to their full scope of practice.

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Consent to publish

ACM consents to this submission being published in its entirety, including names.

Consent to provide further information

ACM is available to provide further expert opinion and advice if required.

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