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 #2 – Response to Issues Paper 1

Issued March 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 2***. 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.

Background

ACM provided a written submission to the Unleashing the Potential of our Health Workforce – Scope of Practice Review in Phase 1. Issues Paper 1 was released on 23 January 2024.

ACM's priority areas in submission 1 were:

1. Endorsed Midwifery pathway
2. Funding approaches for maternity including bundled funding models
3. Improved equity and access for women to rural maternity services
4. Maximising access to sexual and reproductive health; and child, family & maternal health
5. Workforce sustainability and growth
6. Improving care across the first 2000 days

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 and additionally, maternal, child and family health. 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.

"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" [2]

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.

Legislation and regulation

Legislation or regulation may authorise or inhibit health professionals in performing a particular activity. Evidence to date revealed inconsistencies in the regulatory approaches across primary health care professions, and barriers relating to inconsistent State and Territory legislation and the practice of named professions in specific pieces of legislation or regulation. Greater harmonisation of legislation and a more risk-based approach to regulation are among the potential policy solutions for further exploration.

Questions

What do you believe are the key legislative and regulatory reforms which have the potential to most significantly impact health professionals' ability to work to full scope of practice? (For example, harmonisation of specific legislation between jurisdictions, or regulating health professionals differently.)

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. Key legislative and regulatory reforms as identified by ACM are listed below.

1. **Harmonisation of Medicines and Poisons Acts**
   Medicines and Poisons Acts differ between jurisdictions; this limits scope. ***Example:*** Endorsed midwives in Queensland can prescribe any drug required within their SoP, yet endorsed midwives in Victoria have a specific and narrow drug formulary which limits their ability to provide evidence-based care, scope-fulfilled care.

2. **Pharmaceutical Benefits Scheme (PBS): Scope based approach**
   The impact of the variations within Medicines and Poisons legislation is exacerbated by restrictions within the Pharmaceutical Benefits Scheme (PBS), further limiting the capacity of health practitioners, including midwives to work to full scope. A review of the Pharmaceutical Benefits Scheme for **PBS** for endorsed midwives and nurse practitioners is in train, however including the ability to prescribe all drugs within scope will have significant positive impact.

   Currently Endorsed midwives can prescribe contraceptives listed on the PBS for Midwives[3]. However, the list under the PBS is very limited and both intrauterine devices (Mirena® and Kyleena®) listed on the Pharmaceutical Benefits Scheme are not available for midwives to prescribe despite national regulation that supports prescribing and credentialing that enables procedural insertion. Further medication examples include: domperidone to improve breast milk supply, acyclovir prescribed for active herpes.

3. **Authorising environment by title/profession: review**
   The authorising environment of utilising title creates a lack of clarity as to the scope of the role itself. Any health professional should be able to work to scope and prescribe to scope within the legislative environment.

   Example: For midwifery within legislation there are multiple naming conventions which create a lack of understanding of the role and thus scope of the 'endorsed midwife' (as they hold the endorsement for prescribing scheduled medicines which facilitates access to MBS etc). The endorsed midwife may also be described as 'participating midwife', (e.g. Health Insurance Act Part 2.10), 'authorised

midwife' or 'eligible midwife'. Below is an example of two naming convention in the same clause in the following legislation: National Health (Collaborative Arrangements for Midwives Instrument 2022:

*'6 **Authorised midwives—specified medical practitioners***
*For the purposes of the definition of **authorised midwife** in subsection 84(1) of the Act (which deals with **eligible midwives** providing midwifery treatment in collaborative arrangements with medical practitioners), a medical practitioner of the kind mentioned in a description of a kind of collaborative arrangement in section 7 is specified in relation to that kind of collaborative arrangement'*

Further to this other titles including 'independent' midwife, or 'Privately Practising Midwife' exist within Government lexicon. If naming convention for the authorising environment persists, consistent naming of the protected title 'endorsed midwife' will minimise misinterpretation of the role. The role of the midwife, continuity of midwifery models of care and midwifery as a standalone profession are largely unrecognised or unknown by the general population in part due to these complex naming conventions.

4. National Credentialling.

In the SoP roundtables the notion of national credentialling was raised frequently. Below is an example of the issues facing midwives in this space. A national approach would facilitate transferability across jurisdictions for the midwifery, maternity care (and other health) workforces.

Case Study example: credentialling issues:

Jenny*, a midwife of 30 years who has had admitting rights to Somewhere hospital since 2011, has been asked to assist the establishment of a Birthing On Country model in another state at Anywhere hospital. She has been able to suture for 20 years, has held waterbirth competency since 2006, can cannulate, has completed an induction of labour package, and regularly completes this skill and has worked in a home birth setting for 12 years. This all indicates Jenny* fulfils the usual and regulated scope of a midwife's practice.

On arrival at Anywhere hospital Jenny* is advised that none of these skills will be recognised and before she commences her credentialing process for admitting women in her care, or for in fact performing these skills as a hospital employee during orientation, she will have to observe 3 episodes of suturing, complete a package, and be observed by a consultant obstetrician in suturing (the consultant registered in 2010) and deemed credentialed. She is not employed by the hospital and as her insurance only covers the admission of private patients, she will have to get a casual contract before she can start this process. This is repeated for waterbirth, induction, cannulation and she will also have to complete all emergency skills packages on site as these are also not recognised. The various training courses are only available every three months so the ability to complete them has no timeline. Jenny receives no remuneration for completing these, so all online learning and skills competency recertification is in her own time and without pay.

* Actual story; names have been altered.

Currently midwives are registered after an undergraduate or postgraduate degree and undertake practice to consolidate a variety of skills which fall within scope. A standard to allow the ability to practice to full scope across Australia and the completion and competence of a variety of skills recognised nationally is required, however ACM recommend caution with requiring credentialling of core skills such as intravenous cannulation.

ACM supports a national approach and application to credentialling for all healthcare practitioners, such as a national digital competency passport which will promote transferability across jurisdictions and eliminates the need for healthcare practitioners to redefine and demonstrate clinical skills when they move across hospitals and/or jurisdictions. This is particularly problematic for the non-medical workforce.

5. **Professional Indemnity Insurance (PII) for Privately Practising Midwives: A case study in limiting scope of practice and women's choice.**

PII for privately practising endorsed midwives who are primary maternity care providers is underwritten by Government and is provided by one sole insurer MIGA, via Government contract. PII insurance is a regulation requirement. It includes intrapartum care for planned hospital birth, however it has a number of clauses which restrict scope, for example, it does not include intrapartum care for birth outside of the hospital setting (i.e. planned homebirth [4]). Midwives are afforded an exemption from the requirement to hold PII for homebirth in the National Law (section 284). This means the midwife who attends homebirth is not insured and therefore both the midwife and the family receiving care are under financial risk. This also creates the situation by which Medicare funding is unable to be extended to homebirth (due directly to a lack of insurance) and the women who choose homebirth are required to pay (noting publicly funded homebirth is available in some states) which makes it unaffordable for some, restricts choice of model of care and notably restricts endorsed midwives from working to full scope of practice.

The current National Law exemption and thus the Government contracted insurance product are limiting scope of practice for privately practising midwives as they are unable to be insured for homebirth. It also limits women's choice of care.

Endorsed midwives in private practice provide continuity across the perinatal period. The current funding model and legislation for admission into public hospitals requires women being cared for by endorsed midwives to be admitted as private patients (regardless of whether they have private health insurance or not). This is a result of the professional indemnity insurance that endorsed midwives hold only allowing care of admitted private patients and because the funding model only provides access to the MBS i.e., the woman must be admitted as a private patient for the midwife to be paid. Where women are admitted as private patients, they (or their insurer) are then also expected to pay the hospital an additional bed fee for that admission.

Recommendation:

- ACM recommends a fit for purpose midwifery professional indemnity scheme which provides insurance for individual endorsed midwives which allows them to work to full scope including homebirth, 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. (See also ACM SoP submission 1).
- ACM recommends that the funding and insurance models are reviewed and updated by Government to allow endorsed midwives to provide care to their 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.

6. **National approach to 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).

7. **Expand 19(2) Exemption**
The COAG Section 19(2) Exemptions Initiative aims to improve access to bulk-billed primary health care by giving approval for States and Territories to bulk bill the MBS for primary health care at public hospitals and multipurpose services. The initiative recognises that in rural and remote communities, people have limited access to primary health care and many public hospitals and health services have employed medical officers to provide this care. It has limitations in terms of approved locations and population size.

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.

8. **Employment and Industrial Matters**
A review of the way midwifery is industrially represented in Australia could see a more considered and consistent approach to career pathways, remuneration and conditions for midwives. At a jurisdictional level inconsistent awards create barriers for career progression for all midwives. For example midwives who are not also registered nurses are precluded from executive roles e.g., Director of Nursing and Midwifery as well as roles such as Commonwealth and jurisdictional Chief Nursing and Midwifery Officers (Queensland excepted with the recent positive step of separation of the Nursing and Midwifery office and the inaugural roles of Chief Midwife Officer and Chief Nurse Officer). Refer to ACM's position summary on Midwifery Leadership in Australia and The Council of Deans of Nursing and Midwifery - The future of the Midwifery Workforce paper.

There is currently no provision in the Nurses Award (National award) for caseload midwives which creates a barrier for non-jurisdictional development of caseload models of care (e.g. within the ACCHO sector). There is also no consideration of endorsed midwives within any state awards or at a National level thus currently remuneration for endorsed midwives working to full scope varies significantly between and within jurisdictions; this is inequitable. The annualised salary of midwives across Australia is inconsistent, creating competition between jurisdictions and a bidding war that prioritises a locum workforce. In NSW, the annualised salary is currently 29% in ACT it is 40%. Recognition of midwives' competencies should also translate to appropriate remuneration (refer to ANMF application to the Fair Work Commission to increase award wages for nurses and midwives).

On the 7th of March 2024, Queensland parliament passed a bill to amend legislation to count babies in ratios and legislate a midwife to patient ratio. This is an example of where a national approach to safe staffing levels should be prioritised.

9. Health Insurance Act. The predominant focus of the Health Insurance Act is medical in nature. Health Insurance (Section 3C Midwife and Nurse Practitioner Services) Determination 2020 made under subsection 3C(1) of the Health Insurance Act 1973, Part 2 refers to midwifery services including collaborative arrangements, labour and birth, general items including attendance and MBS items. The announcement of the intent by Government to remove the legislative need for collaborative arrangements between midwives and medical practitioners to provide Medicare Benefits Schedule services and prescribe Pharmaceutical Benefits Scheme medications was welcome by ACM, however the lengthy process requires midwives to maintain status quo in practice, which is restrictive to scope. Health Insurance Act changes are required to removal of collaborative arrangements and further reform is recommended to enable appointments to various decision making bodies, for example representation on governance committees, Professional Services Review Scheme and Medicare Participation Review Committee, by midwives and a growing cohort of health professions including Nurse Practitioners and optometrists. The Health Insurance Act limits access to, as one example, pathology and diagnostics which impacts the scope of practice of midwives and Nurse Practitioners.

10. Medicare Benefits Schedule (**MBS**) – impacts scope of practice of a midwife from a regulatory perspective as current MBS funding is restricted to 6 weeks and 6 days postnatal and the 5000 clinical hours for endorsed midwifery qualification is a barrier to scope (see ACM SoP submission 1). For MBS funding implications, please refer to Funding Policy section below.

Implementation of Participating Midwives Reference Group and MBS Taskforce approved recommendations **1** (extend min duration AN attendance to 60/60, **3** (complex AN) **10** (longer postnatal appointment for DV screening and mental health) will remunerate time spent by a midwife with a woman, and also improve preventative healthcare, and maternal and neonatal outcomes, in this critical period within first 2,000 days of life. Extend payments past 6 weeks 6 days will allow for more comprehensive perinatal mental health assessments, as the onset of postnatal depression is usually around three months postnatal, and suicide is one of the leading causes of death in Australia during pregnancy and the first year after birth[5]. Fathers and non-birthing parents are also at increased risk of suicide and depression during the transition to parenthood. Extended access to continuity of midwifery care and implementation of universal access to reproductive healthcare inquiry recommendations will positively influence outcomes, improving the health status of women, babies and communities if extend access to preconception and interconception care is prioritised.

A risk-based approach to regulation names core competencies, skills or knowledge capabilities required to authorise a health professional to perform a particular activity, rather than relying solely on named professions or protected titles. To what extent do you think a risk-based approach is useful to regulate scope of practice?

To a great extent

Somewhat

A little *Rationale: There is **no evidence** that the current approach of relying on midwives' individual commitment to professional standards places the public at risk.*

Not at all

Risk-based approach to regulation

Midwifery works effectively under a standards-based approach to regulation[6]. In 2021/22 there were 125/10 350 (1.25% of the health workforce) midwife notifications to Ahpra. Of these, 67.2% were closed with no further regulatory outcome.

The **perceptions of risk** for a consumer, midwife, medical professional, hospital executives and boards differ according to profession, personal views, local governance, and legislation. There is clinical and corporate risk, expressed across four dimensions of financial, operation, political and legal risk according to Australian Council on Healthcare Standards[7]. Social risk in one maternity study, identified cultural, emotional, and financial risks to women and families. The complexities that a risk-based approach has on woman centred care requires further exploration. Risk is subjective judgements about potential harm[8]. Therefore, a risk-based approach can create inconsistency for example when an obstetric model takes priority in a hospital or health service setting. Women accessing pregnancy and maternity care navigate a system where risk-management strategies can take precedence over individualised care (fragmented hospital-based system versus continuity of midwifery care) and midwives and consumers autonomy through clinical judgement, evidence, and woman-centred care is not prioritised.

A risk-based approach to regulation creates a potential for further restriction for midwives depending on the decision makers. An example of where a risk-based approach was detrimental was the 'collaborative arrangements' legislation for endorsed midwives. The 2022 ACM Collaborative Arrangements submission clearly evidences this historically ineffective risk-based approach to care. Indeed, Collaborative Arrangements often precluded midwives from working to full scope, and there is no evidence that this legislative approach improved patient safety, or outcomes. Collaborative arrangements rather than improve patient safety, have been shown to reduce public access to preferred models of midwifery led care, inhibited private midwifery providers working to scope and stifled health care innovation that could further improve access to underserved populations.

The implementation of 'care bundles' (e.g. the perineal protection bundle) to group evidence-based practice with the intent of reducing variation on practice can have unintended consequences [9]. We are also seeing increasing rates of intervention in obstetrics and the approach to timing of birth, induction of labour, and a 38% caesarean section rate in Australia (vs the World Health Organisation's acceptable CS rate of 10-15%)[30] , for example, may be attributed to tighter parameters exacerbated by risk-based approaches and the impacts of single research findings that are rapidly translated into fragmented systems and practice (e.g. the Term Breech Trial, the ARRIVE trial).

A risk-based approach to maternity care may promote more 'care outside of recommended guidelines[10]' to meet consumer expectation versus reality and with an anecdotal rise in freebirth in Australia[11], more

women are avoiding hospital based fragmented care due to fear, a previous poor birth experience, birth trauma and inability to access their chosen models of care [12].

What do you see as key barriers to health professionals' authority to make referrals across professions

The NMBA midwife standards for practice states the midwife works with the woman and her baby, partner and family as identified and negotiated by the woman herself. The midwife is also responsible for their practice within the broader health system. Where relevant, this involves collaboration, consultation and referral to other services or health practitioners.

The Australian College of Midwives National Midwifery Guidelines for consultation and referral guidelines defines referral as 'the transfer of primary responsibility from the midwife to another qualified health service provider or professional. The midwife recognises that the care required falls outside of their scope of practice. In response, the midwife discusses the indication(s) for referral with the woman, seeks her informed consent and then refers the woman to the most appropriate health professional for ongoing care. Despite the indicated need for referral, the midwife remains a key member of the multidisciplinary team and continues to provide midwifery care to the woman'.

Under current Medicare services for endorsed midwives, midwives can refer women to an obstetrician or paediatrician. The referral is valid for one pregnancy only for a period of 12 months after the first service. This referral covers the total confinement period of the referred pregnancy. A new referral is required if your patient has a subsequent pregnancy in a 12-month period. A midwife does not need to issue a referral to transfer a patient's care during the intra-partum period under items 16527 and 16528. However, signed clinical notes should be recorded approving the transfer of care. Medicare benefits are not payable if you refer your patient for allied health services.

A woman can self-refer to a continuity of midwifery model of care and privately practising midwives without requiring a referral from a GP, health service or obstetrician in order to provide Medicare rebatable antenatal and postnatal care to women. This creates limitations through GP centric and gatekeeper models, in particular if GP refusal to provide referrals occurs and there is increasing complexity with accessing a GP, and bulk-billing GPs in Australia.

The recent inclusion of midwives in the WIP has not as yet encompassed an awareness campaign, therefore the longstanding views that GP practices didn't consider employing midwives due to cost continues and the WIP does not adequately cover the remuneration of the midwife, resulting in a percentage of midwife earnings going to the practice. There is an overall lack of awareness by PHNs, GP's and consumers as to what maternity models of care are available in a geographical area, hospital, or health service. The lack of public awareness and public health campaigns prioritising pregnancy and maternity care impact on a woman's access to models of care of their choice resulting in fragmented referral pathways and processes.

Access to suitable digital software programs is another barrier to referral, which is covered in the technology section of this submission below.

Employer practices and settings

Evidence to date emphasised the inherent challenges in progressing scope of practice reform over a dispersed primary health care sector in which individual employers hold significant influence over health professionals' authority to practice individually and as multidisciplinary care teams. Targeting leadership and culture to promote enabling and authorising environments at the service level emerged as a critical complement to other system-level reform.

What changes at the employer level would you like to see to enable health professionals to work to full scope of practice? (For example, changes to credentialling, practice standards, clinical governance mechanisms or industrial agreements)

1. **National approach to credentialling** – see legislation and regulation section. There are barriers to not maximising the use of the midwifery qualification on length of stay, when an endorsed midwife in the public sector is not able to work to full scope of practice, for example performing midwifery led low risk discharges.

2. **Employment and industrial agreements –** see legislation and regulation section.

3. **Prioritisation by employers for development of midwifery workforces to effectively increase access to best practice continuity of midwifery care models**.
   Midwifery led care, such as through Midwifery Group Practice caseload (MGP) or publicly funded homebirth provides improved birth outcomes and is very popular among consumers. MGPs are inconsistently implemented and accessed across Australia, despite a considerable body of research evidencing this model of care is what women want [31]. Despite it being the gold standard model of care, the number of midwifery group practices in the public sector is low, indeed AIHW indicate this is only 14% of all models of care currently[13]. This can lead to limitations for midwives in working to full scope, which reduces retention rates and limits women's' access to choose their preferred model of care. Many services have a long wait list for MGP models, and a woman must book in as soon as she is aware she is pregnant. This is not practical for the majority of pregnant women in Australia or priority populations (First Nations, adolescent pregnancy, culturally and linguistically diverse and women with a disability, neurodivergence or complex co-morbidities).

   From Royal Hospital for Women Sydney website**: '***Despite Royal Hospital for Women offering the largest number of MGPs in Australia, places are limited for this option and are generally not available if you live outside of the RHW area' To book into MGP or place your name on the waiting list contact the RHW Outpatients Department.*

   From Townsville Hospital: *It is important to contact our team early into your pregnancy (eight-12 weeks gestation) as our wait list fills quickly.*

   There is capacity to *pivot* an existing workforce through a change management process, from a fragmented hospital model of care to continuity of midwifery care as the default model of care, however the employer level approach, lack of leadership and understanding of the operationalisation and governance of continuity models and overall multidisciplinary workplace culture are examples of barriers to national implementation.

4. **Consumer Information and Health Literacy**: Ensure that employer information to the consumer is equitable and provides sufficient information for patients with regards to options for care. In

this context, women, and families are then able to make an informed decision about their choice of care. Recent national research revealed factors that influence GP referral to maternity care are complex and layered and have a direct impact on patient outcomes [14].

As an example, on the Government's website: https://www.pregnancybirthbaby.org.au/planning-for-pregnancy the first piece of information given for planning a baby is: *'If you are thinking about pregnancy, visit your doctor for a preconception consult. They will provide you with expert advice on planning your pregnancy.*

Equitable information with regards to models of care is required to ensure that informed decision making occurs – (Refer to ACM SoP submission 1).

5. **Recognition of Prior Learning(RPL):** Jurisdictional barriers impede the consistency and flexibility of interprofessional qualifications. Themes from AMC accreditation recommendations for improvement for specialist medical programs related to access to training and learning resources also cited improvements in RPL policies were required [15]. This translates to midwifery and across health professions, where there should be clear frameworks to provide evidence of their extended practice through inclusion of recognition of prior learning.

Which particular activities or tasks within health professionals' scope of practice would you particularly like to see increased employer support for?

1. **Harmonise health practitioner pathways, in particular endorsed midwifery**
There is currently an ad-hoc approach nationally to endorsed midwife pathways in the public hospital sector and collaborative primary care sector. Harmonisation of the endorsed midwife pathways to ensure that midwives with scheduled medicines endorsement are able to work to full scope would enable the profession, and minimise for example discharge wait times as the maternity team (and family) would not be required to wait for a medical professional to be available for the discharge sign off process.

2. Recognition of the value **single qualification midwives bring to practice** is required, especially in rural and remote areas to sustain both the nursing and midwifery workforce moving forward. Midwifery vacancies persist in maternity units across Australia, in particular smaller rural units, where midwives are expected to care for general nursing patients if or when maternity activity is low. A recent scoping review identified;

- Single registered midwives' scope of practice concerning general patients is undefined
- Single registered midwives possess transferrable clinical skills applicable to general patients
- Practical, professional, and emotional barriers exist for single-registered midwives (in small maternity units) and
- Future research recommendations include scope of practice and workplace experiences[16].

This is therefore a critical workforce consideration moving forward and should factor into the National Nursing Workforce Strategy and National Maternity Workforce plan.

3. Recognition of the role and scope of midwifery including **Sexual and Reproductive Health and Maternal, Child and Family Health.**

Sexual and Reproductive Health is within midwives' scope of practice, however employer practice does not consistently prioritise the utilisation of midwives' skills in the women's health space. See ACM's submission to the Senate Enquiry into Universal Access to Reproductive Health.

Maternal, Child and Family Health is critical to ensuring the health of families and children in the first 2,000 days. Midwives, who hold appropriate post graduate qualifications, are able to provide MCFH care to women and families. However, to date there have been barriers for single-qualified midwives (i.e. who are not also nurses) to provide this care. These barriers include position descriptions which require a dual qualified nurse/midwife only for example, and LHDs that will not accept single-qualified midwives as a policy setting for MCFH. The NMBA in December 2023 published a fact sheet with regards to the regulatory environment for nurses and midwives in MCFH which found that 'Midwives, working in MCFH that have a postgraduate MCFH qualification are adequately prepared to practice in the MCFH area and should not require any additional regulatory intervention.' And that 'For midwives that do not hold nursing qualifications there is no evidence to suggest any current regulatory risk for the public that warrants changes to the existing regulation in place for MCFH as it is sufficient to protect the public'.

Recommendation:
Increased employer support for midwives working to full scope by ensuring single qualified midwives with appropriate qualifications are able to work in MCFH settings nationally.

What can employers do to ensure multidisciplinary care teams are better supported at the employer level, in terms of specific workplace policies, procedures, or practices?

- Prioritisation of multidisciplinary team training to improve culture and leadership such as the Obstetrics and Gynaecology Education and Training (OGET) Program using a hub and spoke model, where the hubs provide onsite or outreach training to their peripheral hospitals in the form of case-based learning and interactive forums for the maternity team. The QuMid program in Queensland (refer to Technology section below) and the ALICE program and respectful maternity care Better Births with Consent training are all examples of multi-disciplinary approaches to improve professional relationships and communication.

- Jurisdictions often compete for workforce, and there is no seamless onboarding process or ready workforce due to variations in competency and credentialling management for transferable skills. The implementation of a National digital competency passport for key clinical (not core) skills is a consideration which will ensure key skills within the multi-disciplinary team are available.

- Create opportunities for maximising scope which requires additional education and/or training, in particular in rural and remote areas of Australia (for example vacuum assisted births by midwives). All midwives should be encouraged to work to full scope with opportunities to undertake advanced skills training when supported and appropriate as identified in a recent scoping review in Australia highlighting variance in how scope of midwifery practice is determined and regulated globally, with no consensus on extended or advanced scope[2]. Outcomes resulting in under-utilised staff potential, un-met consumer need, and loss of professional skill[16].

- Evidence based practice should underpin safe clinical practice and National Standards. There should be no public and private sector differences to practice – as all standards should apply for all healthcare in Australia.

- Designated training and upskilling opportunities in regional and metropolitan locations for all health professionals providing maternity care in rural and remote Australia, to ensure sustainability through confidence and competence in their local environment with equitable funding, like other professions. Interdisciplinary training will support stronger interdisciplinary relationships and workplace culture.

- Australia has seen multiple maternity services over time and the clinical service capability frameworks (CSCFs) differ across jurisdictions. A National standardised approach to clinical service capability frameworks is required and how to flex up and down within these capabilities based on infrastructure, resources and workforce is a priority (refer to ACM SoP submission 1). The Office of the National Rural Health Commissioner is currently undertaking a refresh of the National Rural Maternity Consensus Framework.

Education and training

Unclear and inconsistent requirements for pre- and post-professional entry learning and qualifications were highlighted through evidence to date, particularly relating to post-professional entry skills, specialities, and endorsements. There are further opportunities for common interprofessional competencies to be developed.

- **What are the key barriers health professionals experience in accessing ongoing education and training or additional skills, authorities or endorsements needed to practice at full scope? You may select multiple responses.**
  Availability of learning institutions✓
  Employer support for learning✓
  Availability of supervision and mentoring✓
  Quality of training✓
  Time burden✓
  Other (provide details)✓

Education

Endorsed Midwife pathways require the removal of the requirement for 5000 clinical hours over 6 years to apply for endorsement as there is no evidence to support this overregulation. The prescribing course for midwives is not available in every state/territory in Australia and scholarships for nurses and midwives are not equivalent to other health professionals. In a paper exploring midwifery prescribing in Australia, prescribing was viewed positively by midwives, however only a small percentage of midwives could translate this into practice. Barriers included

- Prolonged and complicated registration processes,
- restrictive drug formularies, and
- a lack of prescribing roles for public sector midwives were clear barriers.

Supportive professional relationships, quality education and personal motivation and confidence assisted midwives in overcoming these barriers. Mentoring, professional supportive processes, access to quality education and a personal motivator may help midwives to move into prescribing practice to benefit the health needs of women and infants in Australia[3].

There is a lack of interdisciplinary training, including leadership and mentoring, emergency response training, trauma informed and cultural safety training and respectful maternity care encompassing informed consent.

There is currently no transition to practice program in Australia for Midwives (unlike for nursing and other professions), with New Zealand citing an 85% retention rate as a direct result to their transition to practice program. ACM notes funding for this is included in our Pre-Budget Submission. Further, there is a lack of re-entry into practice programs for midwives in Australia, those that are available are expensive, nor are there seamless processes for oversees trained midwives. Visa processes are lengthy and administration heavy for health service recruitment and management staff.

Recognising the role of the single-qualification midwife in rural and remote areas of Australia is critical to sustaining a midwifery workforce into the future. Recognition of prior learning and continued professional development processes are required to maximise access to training, in community, interstate and abroad to maintain a contemporary workforce and provide return on investment of professional development opportunities for midwives in Australia. Leave and roster backfill is required to enable staff to access educational opportunities.

Incentives

Cost of living and placement poverty experienced by students of midwifery make it challenging to sustain and grow a workforce; the recent Universities Accord report recognises this, however no funding is available for this currently. Incentives are both a short- and long-term priority and midwives currently do not have equivalency of incentives that medical practitioners enjoy, however the permanent workforce should also be considered in particular in rural and remote areas of Australia as this may have an unintended consequence on retention if existing midwives in permanent roles are doing more work for less remuneration. ACM has regularly identified the lack of federal and jurisdictional incentive opportunities for midwives compared with other health professions. Further, access to Commonwealth control and administered HELP debt relief, which is provided for nurse practitioners and medical professionals is also required as an opportunity for midwives.

Geography

Geographical location can be a barriers for rural and remote midwives to access ongoing education and training with no incentive funding, unlike medical practitioners, allied health, and nursing to leave community to upskill and as such, there is no clear 'upskilling' pathway for midwives living and working in MMM3-7. Away from base program settings as offered at some universities may provide an innovative approach to managing training programs.

Workforce

A lack of a National Midwifery workforce strategy is a barrier to the profession working to full scope of practice, with no clear workforce modelling and pathways to the midwifery profession via Tafe and health worker pipelines or cadetships. Paid employer models require consideration for both midwives and students of midwifery with mandated access to clinical supervision for nurses and midwives. Supporting the First Nations Midwifery and Maternity Workforce is a national priority.

Culture & Leadership

Culture and leadership are contributing factors to the success or inefficiency of a maternity service. Midwives mentoring junior doctors through normal birth physiology is an opportunity to strengthen

professional relationships from the grass roots level. Multidisciplinary learning and ongoing training are required to support practice.

- **To what extent do you think health professionals' competencies, including additional skills, endorsements, or advanced practice, are recognised in their everyday practice, and are known to consumers?**
  To a great extent
  Somewhat
  A little
  Not at all

How could recognition of health professionals' competencies in their everyday practice (including existing or new additional skills, endorsements, or advanced practice) be improved?
Establishing evidence of midwives working to full scope of practice is important to continue to develop professional capacity and support contemporary practice, regulation, governance, and policy. Being aware of the global landscape for midwifery practice enables practice development, while improving consumer access to equitable care[2].

Medication prescribing into the entry to registration midwifery curriculum so that all midwives are able to prescribe and order diagnostics on registration would enhance midwifery recognition and everyday practice and reduce barriers to obtaining endorsement.

Improvements to consumer facing education around models of care, and a national investment in maternity care across the first 2000 days as a public health initiative will improve professional recognition and contribute to an expansion of continuity of midwifery care in the primary care space.

Funding policy
Evidence to date highlighted opportunities to better enable connected and multidisciplinary care across professions, through alternatives to the existing fee-for-service model (for example, block or bundled funding). See Funding section of this paper.

Funding mechanism categories
- Fee-for-service: payment for each episode of care.
- Block funding: lump sum payment allocated to service provider.
- Bundled funding: single payment for all services related to a specific treatment, condition, or patient parameter, possibly spanning multiple providers in multiple settings.
- Blended funding: combination of funding streams, such as block/bundled plus fee-for-service.
- Capitation: payment based on the number of patients enrolled or registered with the practice.
- Value-based care: Payments which link clinician, hospital, or health system compensation to performance on specific cost, quality, and equity metrics.
- Program grants: lump sum payment allocated to a specific program.
- Salaried workforce: health professionals earn a salary rather than being funded through one of the above funding mechanisms.
- Delegated funding: a term which appeared through consultations, which refers to practices where a named health professional delegates activities related to care to another health professional, but receives payment for that service.

- **Are you aware of specific instances where funding and payment could be provided differently to enhance health professionals' ability to work to full scope of practice? Please provide specific examples**.
- **Which alternative funding and payment type do you believe has the greatest potential to strengthen multidisciplinary care and support full scope of practice in the primary health care system?**
- **How do you believe your selected funding type(s) could work to resolve barriers to health professionals working to full scope of practice?**
- **To what extent do you believe alternative funding policy approaches create risks or unintended consequences?**
- **How do the risks of alternative funding policy approaches compare to the risks of remaining at status quo?**

Maternity services are a key driver of public hospital costs (~300 000 births/year) therefore funding is relatively predictable and reflects a comparatively fixed cost. ***The current funding model is ineffective*** because of the nature of pregnancy, labour and birth and postnatal care intersecting primary care, secondary care, and tertiary care with inadequate funding to support private homebirth for women with low risk factors. Block, bundled and blended funding models will strengthen maternity care funding as long as there is not a set of requirements (such as those in MyMedicare) that privilege medical funding over other health providers.

Bundled Funding: Focus on Maternity Care

As per ACM's original Scope of Practice submission and 2023 NHRA submission, a **bundled funding approach to maternity care** was recommended. The National Health Reform Agreement Report concurs and has since prioritised and endorsed a bundled funding approach to maternity care with its recommendation 13, to be actioned within 1-3 years (short term):

See below maternity case study from the NHRA Report (p. 81) as an example.

Case study: Maternity bundled pricing model

Maternity care is a predictable care pathway which, in Australia, usually leads to a hospital admission for birth care, has clear start (ten weeks gestation) and end points (six weeks postpartum) to the pathway which allows for identification of clinically warranted and unwarranted variation in care. Care is fundamentally multi-disciplinary, encompassing both primary and secondary (acute or urgent) care.

Maternity care is one of the leading causes of hospital admission and is a driver of public hospital costs. While funding is relatively predictable with around 300,000 births annually and reflects a comparatively fixed cost, there are observed variations in outcomes and costs, and therefore the potential to generate system efficiencies and improved outcomes. Further there are access barriers, particularly in rural and remote areas and for First Nations' families, that lend themselves to alternate funding approaches using multidisciplinary care models and expanded scope of practice.

Currently maternity care funding is fragmented, spanning the MBS (for primary care by GPs, general practitioner with obstetrics, endorsed midwives and specialist obstetricians, pathology and imaging), public hospital funding, private health and consumer contributions (out-of-pocket costs). The elements of the overarching funding model are inefficient, costly and not integrated between primary and acute care. The DRG-based funding model is in general linked to a medical event (e.g., birth), and does not fund care as a continuum (e.g., Midwifery caseload care which is focused on keeping healthy pregnant women and their unborn baby well and preventing unnecessary hospital attendance and/or admission). There are many examples of discontinuity of care which adds to cost and impacts on outcomes.

*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 i**nitial 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.*

This submission asserts that funding reform is required to facilitate best practice maternity care, which will prioritise midwifery led continuity of care which evidence shows leads to improved health outcomes on multiple national core maternity indicators, is 22% cheaper than standard fragmented care and allow midwives to work to full scope, thus improving retention rates. Further, midwifery continuity of care is identified as best practice and a key priority in the 'boost multi-disciplinary team based care' section of the Primary Health care 10 year plan: '*Reinforce and support best practice models of midwifery-led care (including continuity of care) for the multidisciplinary team in primary care and maternity services'.*

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.

Benefits and Risks of alternative funding policy
This NHRA report section 5.3.4.3 (P81) also importantly notes the following:

- **Benefit: Quality, efficiency, and improved outcomes:** 'Consideration should be given to implementing bundled payments, through a structured national approach, where doing so would improve the quality of care and outcomes for patients, enable greater efficiency and support better and more integrated patient pathways.'
- **Risk:** 'Considerable development work will be required by the Commonwealth, States and Territories, together with the national bodies and relevant stakeholders, to identify and agree priority areas, develop a work program and pilot arrangements to refine a new payment approach.'

How does bundled funding for maternity care resolve barriers to working to full scope of practice?

It incentivises outcomes not activity. This enables all practitioners in the continuum of maternity care to work to full scope providing best practice high-quality continuity of care which is patient centred.

The current funding model incentivises activity not outcomes. For maternity care this can equal intervention rather than prioritising women's choice of model of care and is a perverse incentive. The focus on activity-based funding can therefore in turn reduce the opportunity for midwives to work to full scope in all settings by disincentivising physiological birth and midwifery continuity of care.

Example: unwarranted variations in caesarean section rates are clear in recent years as per outcomes measured in Health Atlas 2 (2017) and Health Atlas 4 (2021)

> 'Despite a number of data limitations, the estimates suggest that the percentage of caesarean sections performed before 39 weeks without a medical or obstetric indication may be substantial. Action is needed to reduce these rates.' Health Atlas 4 2021

ACMs SoP Phase 1 submission provided an example of diagnosis-related group (DRG) and national weighted activity unit (NWAU) funding for operative birth has been double that of vaginal birth. In the last two decades the caesarean section rate in Australia has also doubled from 17.5% to nearly 38% without significant alteration in morbidity or mortality for either mother or baby[17].

The funding policy shift to bundled funding will facilitate midwives, and the multi-disciplinary team where required, to work in continuity of care caseload models, which in turn will enable them to work to full scope of practice, including for example sexual and reproductive health care and maternal child and family health care. It will facilitate choice 'Ensuring that young women with uncomplicated pregnancies have information and access to services that support their choices for first birth will help ensure the appropriate use of caesarean section [18].

Other benefits include:

It is cost-effective.

- Continuity of care with a known midwife is 22% cheaper than standard fragmented care[19]
- Bundled funding has been demonstrated to provide cost savings in other countries[20]. In New Zealand, for example, this model offers an approach where payment is split into five time periods – first trimester, second trimester, third trimester, labour and birth and post birth care.

It improves quality of care

- Bundled payments incentivise care coordination which increases provider accountability through the provision of higher-quality care. Integrated care has been found to increase patient satisfaction, perceived quality of care and access to services. There is an alignment of financial incentives with desired health outcomes and therefore avoids unnecessary care, intervention and overservicing. This is compared to the fee-for service approach which enablers larger volume of care regardless of the quality of the service.

Continuity of Care has demonstrated improved outcomes for women and babies

- Nationally only 15% of women have access to a known primary midwife throughout the childbearing continuum[13]. Multiple randomised control trials of over 17,000 women demonstrated that midwifery continuity of care improves outcomes, experiences, and satisfaction for woman and babies[21]. Importantly research shows that it reduces preterm birth in the general population by 24%, and by 50% in First Nations babies. It reduces pregnancy loss/neonatal death by 16%, increases workforce retention by supporting midwives to work to their full scope and reduces cost by at least 22% compared with standard public fragmented care, yet has still not resulted in widespread implementation of this model across Australia[19].

- Private midwifery practices with endorsed midwives providing continuity of care have better outcomes than fragmented care[22].

- **Birthing on Country:** For First Nations women, the continuity of midwifery led care Birthing on Country services offers an exemplar of how wrap-around or bundled funding can improve outcomes, in that ACCHO's provide wrap-around care in a midwifery-led caseload model which manages pregnancy, labour and birth, transport (to and from appointments), co-morbidities such as diabetes, sexual and reproductive health advice (including LARC and medical abortion), mental health and domestic violence screening[23,24].

  First Nations babies are twice as likely to be born preterm as non-First Nations babies, which leads to increased morbidity and mortality rates[24] and First Nations mothers are 3-5 times more likely to die in childbirth[25]. In the Birthing in Our Community model, in Brisbane, women are cared for by a midwife working to full scope of practice in a continuity of care relationship alongside a First Nations Family Support Worker. Care in this model has shown a 5.34% to 14.3% reduction in preterm births, along with a saving to the health care system of $4810 per mother-baby pair (in a 2023 study) [24]. Recent research also shows that this model of care significantly reduces the number of newborn removals by child protection services at birth[26].

> "If we are reducing the risk of a baby being born premature, we are reducing the risk of that baby dying in childhood, of experiencing disability and developing chronic disease such as diabetes, cardiovascular disease or kidney disease later in life."
>
> "We have literally closed the gap for some of these families.
>
> **Kristie Watego, General Manager, Family Health and Wellbeing at the Institute for Urban Indigenous Health**

Midwifery continuity of care is a positive indicator for workforce satisfaction
Increasing evidence supports that working in a MCoC model is beneficial for midwives. Midwives working in MCoC models have:

- lower rates of burnout than their peers in non-continuity models and the level of burnout reduced over time while continuing in a continuity model,
- more positive attitudes towards their work and showed improvement over time, particularly in relation to professional satisfaction, support, and client interaction,
- lower scores for anxiety and depression scores,
- higher midwifery empowerment scores, and
- increased work satisfaction[27].

Midwives working in MCoC models report enhanced autonomy, knowledge, skills development, and stronger professional identity. Midwives' professional satisfaction increased over the time they worked in a MCoC model, and midwives valued the flexibility of working hours.

Alternative funding policy approaches compared to the risks of remaining at status quo

Maintaining the status quo is not beneficial for women, families, or midwives.
Bundled maternity funding is a huge opportunity to *'improve the quality of care and outcomes for patients, enable greater efficiency and support better and more integrated patient pathways.*' However, and as is noted in the NHRA report referencing maternity bundled funding, changing these policy settings is a significant challenge. '*Considerable development work will be required by the Commonwealth, States and*

Territories, together with the national bodies and relevant stakeholders, to identify and agree priority areas, develop a work program and pilot arrangements to refine a new payment approach'.

In this instance the risk of remaining at status quo outweighs the risk of change. That said, consideration could be given for a stepped approach to change via existing payment systems whilst the development work is in train, such as

- Bundling of Medicare items into tiered funding maternity model (antenatal, intrapartum, postnatal) for the primary care sector including GP's, obstetricians and endorsed midwives.
- Block funding to jurisdictions for primary midwifery care practices at jurisdictional level such as the new publicly funded Midwifery Birth Centre in Bentley, Western Australia.

No level-playing field. Investment in non-medical practitioners is required for equitable access to working to full scope.

	GP/GPO/Obs	Endorsed Midwife
Access to MyMedicare	Yes	No
Upload to MyHealthRecord	Yes	No
MBS items reflect scope of practice	Yes	No
Practice/ After Hours Incentives	Yes	No
Rural and Remote Training incentives	Yes	No
PII: Insurance	Yes	Limited (& N/A to homebirth)

Whether health funding remains at the status quo or in a new funding reform environment, there is an inequity in actualising midwives to be able to work to full scope of practice. The midwifery profession does not currently have access to the tools to ensure that endorsed midwives, or midwifery practices are able to work in the same context as GP practices in primary care.

In the technology section in this paper, ACM references potential funding barriers for access by non-medical practitioners to MyMedicare. If the bundled funding is to sit with the woman for maternity (via MyMedicare as a vehicle) it is important to note that a barrier for midwives (particularly endorsed midwives) to working to full scope would be lack of direct access for midwifery practices to MyMedicare. Endorsed midwives do not require a GP referral. If funding access were via a GP there would be both funding and process complexity (and could potentially lead to a form of renewed Collaborative Arrangements which is due to be repealed). ACM does not support this approach.

Further, midwives (and allied health professionals) do not currently have ability to upload to MyHealthRecord due to lack of conformant software. This will need to be addressed if midwives are enabled to work to full scope of practice in the multidisciplinary context which is continuity of midwifery care.

Incentives: Noting that incentives are under review, it is important to note that midwives do not have access to any incentives (aside from recent inclusion of midwifery in WIP which is a GP incentive) to fund or grow their practice, or to undertake training etc. Funding equivalency to medical practitioners for midwives, nurses, allied health and other primary care professions and their practices must be accessible and sustainable.

Furthermore the WIP accreditation process and cost, as well as the requirement for at least one full-time or part-time general practitioner (GP) for the Work Incentive Payment (WIP) Practice Stream is prohibitive

and continues to prioritise the medical model, as opposed to equitable non-medical led multi-disciplinary care practices.

Other funding recommendations

1. Professional Indemnity Insurance – see legislation and regulation
2. Expand COAG 19(2) exemption – see legislation and regulation

Technology

Acknowledging technological improvement and innovation as a key policy direction for the broader health system, the evidence indicated significant barriers relating to health information sharing and digital infrastructure, which if resolved could significantly support continuity of care and multidisciplinary care teams.

- **How do you think technology could be used better or differently in primary health care settings to enable health professionals to work to full scope?**

- **If existing digital health infrastructure were to be improved, what specific changes or new functions do you think are most necessary to enable health professionals to work to full scope?**

- **What risks do you foresee in technology-based strategies to strengthen primary health care providers' ability to work to full scope, and how could these be mitigated?**

There is an overall lack of midwifery representation in digital health and informatics. The development and growth of digital health, including My Health Record (MHR), has been underway for many years. The National Digital Health Strategy outlined that: *'Every healthcare provider will have the ability to communicate with other professionals and their patients via secure digital channels by 2022'*. Despite this, many health professions including midwifery do not have access to My Health Record or similar. In the Primary Health Care 10-year plan, it asserts that Government will 'Work with software providers on potential products to better support nursing and midwifery roles in primary health care'. This has not to date eventuated and is a significant barrier for midwives working in primary health settings.

Health information sharing and the development of accessible digital infrastructure, which is accessible to all primary health care professions, is critical to ensuring that the healthcare workforce can all work to full scope. The national digital health strategy 2023 – 2028 (NDHS) and the accompanying roadmap provide a fulsome account of how technology might be used better.

The NDHS Report asserts: *'Healthcare data remains siloed, largely driven by the lack of connected digital infrastructure, with data processing in rural and remote services often highly manual and paper based. This is limiting the ability to view and track the full patient journey across the system, and between services, due to a lack of interoperability, the absence of cohesive standards for electronic health records, and low public trust in data collection and sharing. The inability to access and use accurate and timely data to inform clinical decisions impacts on outcomes and causes inefficiencies.*' This captures the essence of what is needed to be managed differently to enable all practitioners and importantly midwives to work to full scope.

Within the NDHS Report, midwifery is mentioned but once, and allied health and nursing five times each; despite their fundamentally critical roles that are undertaken. Non-medical professions must have equitable access and funding to develop capacity to implement, train, report and utilise new technology.

Currently this is not the case, the below recommendations therefore encompass the three questions above.

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. For example, there is no software solution for midwives to be able to upload to MyHealthRecord (see point 4 below) and there is not a nationally available fit for purpose software for caseload midwifery care - public or private sector.

This Governmental lack of investment in midwifery and other non-medical professions is a barrier to midwives' ability to work to full scope in all settings, and to best practice continuity of midwifery care models being prioritised and implemented[28]. 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.*

Digital health enabling new and evolving funding models to maximise best practice:
Digital Health must have the capacity to be enabled to facilitate innovative, new, and evolving models of funding (see recommendation 40 above). There are recommendations in the NHRA Report which would not be currently supported by existing technology (and policy settings). For example, continuity of midwifery care via a bundled funding model, for which the NHRA Report 14 is recommended. The approach to this is outlined on pages 81 and 82 of the NHRA report along with a case study (refer also to the **Funding** section of this submission).

The increasing costs and evolving requirements for healthcare to be digitally enabled, such as Artificial Intelligence and machine learning to support real time patient care and virtual healthcare provision are not adequately reflected in funding arrangements. Given this is a complex area involving rapid implementation of ICT solutions, the cost data used for pricing may not reflect the ongoing and enduring costs associated with contemporary ICT infrastructure[29].
Recommendation:
ACM recommends the digital enablement of NHRA recommended new and evolving funding models, including maternity bundled funding is actualised concurrently for all health professions to allow equitable access to funding for providers and equitable access to choice of care for consumers.

MyMedicare must be enabled for all primary health care providers to access directly.
Endorsed midwives do not require a GP referral to provide care to women. However currently MyMedicare eligibility is limited to GP practices, and the accreditation process is costly and requires a GP to be engaged within the practice. This limits the practice of non-medical professions by limiting direct access to MyMedicare, both through technology and professionally.

If endorsed midwives are to be enabled to work to full scope (particularly with regards to ensuring future accessibility to direct bundled funding for maternity as per above) then they must be able to access MyMedicare directly (with minimal accreditation restrictions) and not via the GP as gatekeeper, and with the requirement for a GP in the practice. Midwife-led practices working within a multi-disciplinary setting should be enabled, this includes Birthing on Country settings for First Nations women and women carrying a First Nation's baby, where a known midwife is the primary maternity care provider.

From a technology perspective the requirement for a non-medical professional to be required to access, for example, funding via a GP practice is inefficient and from a consumer perspective it will not be enabling as they will have to access their care for their endorsed midwife unnecessarily via a GP. There is no rationale for Midwife (and Nurse Practitioner) practices not to have direct access to MyMedicare (and thus enable futureproofing bundled funding models as per above).

Current MyMedicare eligible providers criteria are listed below; this is not equitable and may limit non-medical professions to work to full scope:

- Eligible providers can be a vocationally registered GP, non-vocationally registered GP, or a GP registrar
- be accredited against the National General Practice Accreditation Scheme - non-accredited practices will have 12 months to register with an accreditation agency and gain accreditation.

Recommendation:
MyMedicare eligibility and accreditation be reviewed to include non-medical practitioners as eligible providers, without a registered GP requirement.

MyHealthRecord: enablement to upload for midwifery and other non-medical professions.
There is currently no midwifery software that is conformant with the capability to upload to MyHealthRecord. There is no current ADHA plan nor funding for midwifery software to be made conformant, to ACM's knowledge. The onus is on the individual, is cost prohibitive and is an emerging space for midwifery. This is an impediment for midwives to work to full scope in the primary health setting, particularly in view of the NHRA recommendation to prioritise maternity bundled funding to enable continuity of midwifery care models. Continuity of midwifery care encompasses both primary and secondary care and electronic records required for both mother and baby.

Midwives will also need to upload pathology results, which is due to be a legislative requirement in the next 12 months. 'Modernising My Health Record' consultation notes that 'By 30 June 2024, diagnostic imaging and pathology providers should be uploading patient results to MyHealthRecord. It is expected that legal obligations to upload results will be in place from December 2024'. Endorsed Midwives currently only have viewing access for MyHealthRecord and limited access and knowledge of the software technology.

For some women, pregnancy is one of their first presentations to access healthcare services, making it an important opportunity for screening for mental health issues, domestic violence, and medical conditions.

Midwives who undertake this screening assessment have no way to record this information where it can be accessed for future reference by other health care professionals, leaving the woman at clinical risk (and required to retell their story multiple times). This is a barrier to safe, quality care, and to consumer control of their own data.

Recommendation:
ADHA prioritise the conformance of midwifery and other health practitioner software to enable uploading to MyHealthRecord.

Telehealth
The NDHS clearly prioritises telehealth as an enabler for connected health and wellbeing services. Telehealth is a significant opportunity for maternity, particularly in thin markets such as rural and regional Australia. It would allow women to have caseload care (if funded accordingly) via the 'hub and spoke' model of telehealth for antenatal and postnatal visits as well as sexual and reproductive health. However, telehealth should not be at the expense of face-to-face care and there is an increasing reliance on telehealth as a direct result of all of health workforce pressures.

- An example of this is **QuMid** model of care in Queensland (QuMid is an innovative state-wide, midwifery focused service advancing clinical practice, support, and collaboration). It is a Queensland Health initiative supported by Retrieval Services Queensland and the Office of the Chief Nursing and Midwifery Officer (OCNMO)). QuMid's purpose and core objectives were informed by the findings from the Rural Maternity Taskforce (RMT) report 2019 which are to:
    - Provide maternity-specific education and opportunities for clinical reflective practice
    - Establish and promote Telehealth Emergency Management Support Unit (TEMSU) midwifery models
    - Commence Retrieval Services Queensland (RSQ)/TEMSU after hours midwifery support
    - Provide midwifery leadership and expertise to assist with complex obstetric retrievals

Data
In terms of data the maternity patient journey is complex and not well-integrated. There is a long lag time for outcome measures due to reporting from jurisdictions and at a local level. The reporting of data varies from jurisdiction to jurisdiction as do the processes for data management within the state. Terminology between hospital software systems may vary: PE may mean 'pulmonary embolism' in one system and 'pre-eclampsia' in another. This can create significant risk.

Whilst every jurisdiction reports on data to AIHW, there are different perinatal data collection processes within each state. Arguably local to each hospital there may also be variation in reporting on models of care and some elements could also be considered subjective – for example whilst Midwifery Group Practice (MGP) is defined as a model of care, the way the midwives work within MGP varies and this may impact elements such as the level of continuity of carer. Reporting of outcomes for women and newborns accessing private practice endorsed midwives in Australia is important. This data is not readily available or easily disaggregated from routinely collected perinatal data at state and national levels.

Federal and jurisdictional confidentiality clauses and the sharing of information is therefore problematic, especially in rural and remote and primary to secondary/tertiary sectors. For example, Aboriginal

Community Controlled Health Organisations fall under federal legislation and local hospital and health services fall under state and territory legislation.

Each jurisdiction has a pregnancy health record (PHR) and mechanism for reporting on newborn progress i.e. a 'baby book'. Projects are underway to standardise and digitise both the PHR and baby book, which aims to improve national consistency of data and an electronic version option, however inconsistencies remain.

Data sharing between care providers is not seamless, for example, the patient journey and intersection between primary, secondary, and tertiary health care providers, public and private sector, GPs, primary health networks, private practice, pathology and radiology services, allied health, pharmacy, alternate therapies, AMS and ACCHOs. Some area health services contain separate facilities with variable electronic and paper medical records systems.

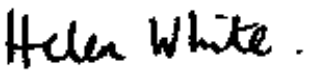
Other technology considerations

- Equipment for patient care and training, especially for rural and remote Australia
- Access to Simulation training and virtual reality
- Improving technology and efficacy (such as developing the Cardiotocography (CTG) machine as a diagnostic tool)
- Secure messaging systems
- Digital referrals
- Electronic scripts
- Realtime data
- Decision support software
- Electronic/digital birth register

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 ongoing consultation 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 and enabling all midwives in Australia to work to their full scope of practice.



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W: https://www.midwives.org.au

References

1. Commonwealth of Australia (2022) Strengthening Medicare Taskforce Report https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_0.pdf
2. Toll, K., Sharp, T., Reynolds, K., & Bradfield, Z. (2024). *Advanced midwifery practice: A scoping review.* Retrieved from https://www.sciencedirect.com/science/article/pii/S1871519223002949
3. Small K, Sidebotham M, Gamble J, Fenwick J. Exploring midwifery prescribing in Australia. Women Birth. 2016 Oct;29(5):436-442. doi: 10.1016/j.wombi.2016.02.001. Epub 2016 Mar 8. PMID: 26964846.
4. Nursing and Midwifery Board. Ahpra. (2022). *Fact sheet: Professional indemnity insurance arrangements*. Retrieved from https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/Fact-sheet-PII.aspx
5. Australian Government. Australian Institute of Health and Welfare. (2023). *Australia's mothers and babies: Maternal deaths.* Retrieved from https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-australia
6. Nursing and Midwifery Board of Australia. (2018). *Midwife standards for practice.* Retrieved from https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/Midwife-standards-for-practice.aspx
7. Barclay, L., Kornelsen, J., Longman, J., Robin, S., & Kruske, S. et al (2016). *Reconceptualising risk: Perceptions of risk in rural and remote maternity service planning.* Retrieved from https://www.sciencedirect.com/science/article/pii/S0266613816300353
8. Thaker, J., Richardson, L., & Holmes, D. (2023). *Australian's perceptions about health risks associated with climate change: Exploring the role of media in a comprehensive climate change risk perception model.* Retrieved from https://www.sciencedirect.com/science/article/pii/S0272494423001123
9. Allen, J., Small, K., & Lee, N. (2022). How a perineal care bundle impacts midwifery practice in Australian maternity hospitals: A critical, reflexive thematic analysis. Retrieved from https://www.sciencedirect.com/science/article/abs/pii/S1871519221000123
10. Queensland Health. Clinical Excellence Queensland.(2020). *Guideline. Partnering with the woman who declines recommended maternity care.* Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0022/736213/maternity-decline-guide.pdf
11. Jackson, M., Schmied, V., & Dahlen, H. (2020). *Birthing outside the system: the motivation behind the choice to freebirth or have a homebirth with risk factors in Australia.* Retrieved from https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-020-02944-6
12. Keedle, H., Keedle, W., & Dahlen, H. (2022). Dehumanized, Violated, and Powerless: An Australian Survey of Women's Experiences of Obstetric Violence in the Past 5 Years. Violence Against Women. doi:https://doi.org/10.1177/10778012221140138
13. Australian Government. Australian Institute of Health and welfare (2023). *Maternity models of care in Australia, 2023.* Retrieved from https://www.aihw.gov.au/reports/mothers-babies/maternity-models-of-care/contents/maternity-models-of-care
14. Thomas, J. Kuliukas, L., Frayne, J., Bradfield, Z. (2022). Factors influencing referral to maternity models of care in Australian General Practice. Journal of Paed and Child Health https://doi.org/10.1111/jpc.15946
15. Australian Medical Council Limited. (2021). *Effecting reforms to Australia's specialist medical training and accreditation system post covid-19 report 5: barriers and enablers of equitable access to learning and training in specialist medical programs in Australia.* Retrieved from https://www.amc.org.au/wp-content/uploads/2021/11/2021-10-AMC-Milestone-5-Report-Barriers-and-Enablers-of-training.pdf
16. Bull, A., Bayes, S., & Geraghty, S. (2023). *Single registered midwives contributing care for general patients: a scoping study.* Retrieved from file:///C:/Users/AlisonWeatherstone/Downloads/AJAN_40(2)_Bull.pdf
17. Australian Government. Australian Institute of Health and Welfare. (2023). *National Core Maternity Indicators.* Retrieved from https://www.aihw.gov.au/reports/mothers-babies/national-core-maternity-indicators/contents/labour-and-birth-indicators/caesarean-section
18. Australian Commission on Safety and Quality in Health Care (2017). *Atlas 2017 – 3. Women's health and maternity*. Retrieved from https://www.safetyandquality.gov.au/our-work/healthcare-variation/atlas-2017/atlas-2017-3-womens-health-and-maternity
19. Callander EJ, Slavin V, Gamble J, Creedy DK, Brittain H. *Cost-effectiveness of public caseload midwifery compared to standard care in an Australian setting: a pragmatic analysis to inform service delivery*. Int J Qual Health Care. 2021 May 28;33(2):mzab084. doi: 10.1093/intqhc/mzab084. PMID: 33988712.
20. Lambooij MS, Veldwijk J, van Gils PF, Suijkerbuijk AWM, Struijs JN. Trading patients' choice in providers for quality of maternity care? A discrete choice experiment amongst pregnant women. PLoS One. 2020 Apr 24;15(4):e0232098. doi: 10.1371/journal.pone.0232098. PMID: 32330182; PMCID: PMC7182251.

21. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5. Accessed 11 March 2024.
22. Gao, Y., Wilkes, L., Tafe, A., Quanchi, A. & Ruthenberg.L. et al (2024). *Clinical outcomes and financial estimates for women attending the largest private midwifery service in Australia compared to national data: a retrospective cohort study.* Retrieved from https://www.sciencedirect.com/science/article/pii/S1871519224000398
23. Kildea, S., Gao, Y., Hickey, S., Nelson, C., Kruske, S &Carson, A. et al. (2021). Effect of a Birthing on Country service redesign on maternal and neonatal health outcomes for First Nations Australians: a prospective, non-randomised, interventional trial. The Lancet Global Health. Retrieved from https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00061-9/fulltext#articleInformation
24. Gao, Y., Roe, Y., Chadha, A., Kruske, S.n Nelson, C. et al (2023). Birthing on country service compared to standard care for First Nations Australians: a cost-effectiveness analysis from a health system perspective. The Lancet Regional Health. Western Pacific, Retrieved from https://www.thelancet.com/journals/lanwpc/article/PIIS2666-6065(23)00040-8/fulltext
25. Australian Government. (2023). *Birthing healthy and strong babies on Country.* Retrieved from https://www.health.gov.au/news/mrff-birthing-healthy-and-strong-babies-on-country#:~:text=First%20Nations%20mothers%20are%203,in%20First%20Nations%20health%20outcomes.
26. O'Dea, B., Roe, Y., Gao, Y., Kruske, S., & Nelson.C.et al (2024). *Breaking the cycle: Effect of a multi-agency maternity service redesign on reducing the over-representation of Aboriginal and Torres Strait Islander newborns in out-of-home care: A prospective, non-randomised, intervention study in urban Australia.* Retrieved from https://www.sciencedirect.com/science/article/pii/S0145213424000395
27. Dawson, K., et al., Comparing caseload and non-caseload midwives' burnout levels and professional attitudes: A national, cross-sectional survey of Australian midwives working in the public maternity system. Midwifery, 2018. 63: p. 60-67.
28. Tracy, S.K., Hartz, D.L., Tracy, M.B., Allen, J., & Forti, A et al. (2013). Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. The Lancet. Retrieved from https://www.thelancet.com/journals/a/article/PIIS0140-6736(13)61406-3/fulltext#seccestitle10
29. Huxtable, R. (2023). *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025.* Final Report. Retrieved from https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf
30. Angolile CM, Max BL, Mushemba J, Mashauri HL. Global increased cesarean section rates and public health implications: A call to action. Health Sci Rep. 2023 May 18;6(5):e1274. doi: 10.1002/hsr2.1274. PMID: 37216058; PMCID: PMC10196217.
31. Cummins, A., Coddington, R., Fox, D., & Symon, A. (2020). Exploring the qualities of midwifery-led continuity of care in Australia (MiLCCA) using the quality maternal and newborn care framework. Women and Birth, 33(2), 125-134.