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

Issued October 2023

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

Midwives are primary maternity care providers working directly with women and families, in public and private health care settings across all geographical regions. There are over **33 000**[1] midwives in Australia and 1,089 endorsed midwives[2]. ACM is committed to leadership and growth of the midwifery profession, through strengthening midwifery leadership and enhancing professional opportunities for midwives.

The International Confederation of Midwives (ICM) defines the role of the midwife[3];

> "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."

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. ACM conducted a member survey in September 2023 to inform the responses to this submission, with over 100 responses received (refer **Appendix D**).

Background

The Strengthening Medicare Taskforce Report[4] 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 welcomes the *Unleashing the potential of the health workforce: A scope of practice review*, as while there are significant barriers to midwives currently working to full scope of practice, the onus on person-centred care focused on ensuring all health practitioners can work to full scope within their context of practice is an opportunity to improve health outcomes for all Australians[5].

In Australia, midwives have completed an approved midwifery course through a university and on graduation, register with the National Midwifery Board of Australia (NMBA). The NMBA works in partnership with the Australian Health Practitioner Regulation Agency (AHPRA) to ensure registered health practitioners are suitably trained, qualified and safe to practise. Midwife is a protected title under the Health Practitioner Regulation National Law. Although sometimes confused, Midwifery is a distinct profession and separate from Nursing. Midwifery, therefore, has distinctive education standards, with unique knowledge, skills and standards for practice; and different responsibilities and activities. The NMBA, who regulate the practice of both the professions of nursing and midwifery note: '**while the foundational education of Midwives in Australia captures the full breadth of the scope of the profession at the graduate entry level, the scope of practice of individual practitioners is influenced by the settings in which they practise. As the midwife gains new skills and knowledge, their individual scope of practice changes**'[6]

It is important to understand 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 [7] 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".

Internationally the ICM publishes a list of essential competencies for the midwife[3], where there is recognition of the increased autonomy of the midwifery profession. Midwives are autonomous practitioners who work collaboratively with many other health professionals. A midwife may practise in any setting including the home, community, public and private hospitals, birth centres, clinics or health units including Aboriginal Community Controlled Health Organisations. Regardless of setting, a midwife works in collaboration and partnership with the woman and other health professionals in a dynamic process of facilitating communication, partnership, trust, and pathways to ensure the provision of safe, woman-centred care, promoting normal physiological pregnancy and birth, and care for the newborn and infant[5].

Endorsed Midwives (also known as Participating, Eligible, Independent, Privately Practicing Midwives)
Endorsed midwives have completed a postgraduate qualification from an NMBA-approved program of study in prescribing, a minimum of 5,000 hours of clinical practice and applied to the NMBA for an endorsement for scheduled medicines. Endorsed midwives are recognised within the regulatory framework to be able to legally prescribe schedule 2, 3, 4 and 8 medicines and to provide associated services required for midwifery practice in accordance with relevant state and territory legislation[8]. Endorsed midwives have access to Medicare provider numbers which provides the bulk of the funding for the care for women across the continuum of care (refer to infographic in **Appendix A**).

There is overwhelming evidence that continuity of midwifery care (CoMC) results in outstanding clinical, financial and consumer satisfaction outcomes that benefit families and the community [4]. The Australian Government Woman-centred care *Strategic directions for Australian Maternity Services*[9] outlines three areas to inform shared decision-making between the woman and maternity service providers, including a woman's ***preference*** (choice), ***evidence*** as it applies to the woman, and the ***context of care*** provision. The woman-centred care strategy prioritises *Respectful Maternity Care* and continuity of care to ensure Australian maternity services are equitable, safe, woman-centred, informed and evidence based. However, the strategy lacks an implementation plan or targets to hold maternity care providers accountable for continuous maternity service improvement. CoMC is underpinned by high quality

evidence that support choice, access, and outcomes for consumers. Similarly, there is no nationally established tool or mechanism to benchmark maternity service's achievements against the strategy.

A midwife working in a Continuity of *Midwifery* care model is more likely to work to full SoP where midwives provide comprehensive antenatal, birth and postnatal care to a defined "caseload" of (between 20-40) women per year. Research evidence overwhelmingly asserts CoMC improves outcomes for women and babies (**Figure 1**)[10,11,12] while also providing greater job satisfaction, through alignment with professional philosophy, increased autonomy and flexibility for midwives[13]. Benefits realised by midwives working in CoMC models contribute to higher rates of professional wellbeing and workforce retention than observed in non-CoMC counterparts[14].

First Nations women and babies have the most significant improvement in outcomes when receiving CoMC (refer **Appendix B & C**); reducing preterm birth by up to 50% and babies are more likely to be born at a healthy birth weight and at term[11,12] yet access to CoMC for all women in Australia is sub-optimal. Furthermore, the rising caesarean section rate, currently at 38%[15] in Australia is almost double World Health Organization targets[16] and there is a growing body of evidence that birth trauma is increasing in Australia[17]. The largest survey of Australian women's birth experiences demonstrated 1:10 women reflected they had experienced obstetric violence and 28% of women had experienced birth trauma. Maximising CoMC models will support opportunities for relational based care thereby reducing the risk of intervention and having access to a known midwifery carer is demonstrated to reduce the risk of birth trauma.

What is Continuity of Midwifery Care (CoMC)?

- Known midwife for each woman through antenatal, labour and birth and postnatally.
- Reduces preterm birth in general population by 24%
- Reduces preterm birth in First Nations babies by 50%
- Reduces pregnancy loss/neonatal death by 16%
- Reduces intervention at birth (e.g. induction, forceps, caesarean)
- Increases breastfeeding rates, attendance rate for antenatal visits
- Improves perinatal mental health outcomes

Midwifery CoC provides better health outcomes and is 20% cheaper than standard care[18]

Figure 1 – Continuity of Midwifery Care (CoMC)

There are numerous, largely unrealised benefits to the broader health system when midwives work to full SoP and with improved access to CoMC not limited to but including[19];

- ↓ acute care costs
- ↑ high-value care
- ↑ activity in rural and remote birthing facilities (e.g. operating theatre)
- ↓ occupied bed days
- ↓ inpatient length of stay
- ↓ special care nursery admissions
- ↓ hospital readmissions
- ↓ hospital acquired infections/injury
- ↑ access to maternity care
- ↓ duplication / overservicing / waste / omission
- ↓ carbon footprint
- ↑ quality and coordination of healthcare (↓ fragmentation)

The priority opportunities for ACM to enable midwives working to full SoP include;

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

Risks and challenges

There are no known risks to a midwife working to full scope of practice as this is a highly regulated and safe profession in Australia. The midwifery workforce is declining with data indicating that there are 1,220 less midwives nationally than there were in 2016[20]. There is evidence that work environments are one element impacting midwives leaving the workforce, including the inability of midwives to work to their full scope of practice[21].

The risk to women from CoMC is extremely low. NMBA statistics show that notifications for the midwifery profession overall sits at only 0.4% of the total profession. Notifications for endorsed midwives specifically are comparable to the other professions that are predominantly providing care in private practice i.e. dental 4.1%, medicine 5.7%[22].

Facilitating Best Practice – barriers and enablers

Regulation – endorsement for scheduled medicines/prescribing

Barriers

The endorsed midwife pathway is restrictive in its existing format, with little incentive for midwives working in the public sector to gain this qualification unless pursuing a career in private practice. There is no evidence to indicate that midwives require the 5,000 hours of clinical practice to work to this scope. **Figure 2** below represents a steady increase in the number of endorsed midwives over the last 10 years and, if this trend continues, could have the capacity to provide care to up to 30% of Australia's birthing population annually. The current clinical requirement, however, is a barrier to the growth of endorsed midwives in Australia. These barriers limit the access to CoMC for women; further inhibiting the expansion of midwifery presence in private practice and the primary healthcare sector. This barrier is more significant for maternity care in rural and remote areas where there is an opportunity to upscale midwifery continuity of care in view of the dearth of General Practitioners (GP) and GP obstetricians in these locations. This also applies to the scale up opportunity for Birthing on Country models of care[12].

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total
As at 31 Dec 2014	2	31	1	52	13	3	26	29		157
As at 31 Dec 2015	2	34	2	81	22	3	43	34		221
As at 31 Dec 2016	2	47	3	98	28	9	51	40		278
As at 31 Dec 2017	3	63	3	143	34	10	73	61		390
As at 31 Dec 2018	6	71	5	184	45	12	88	77	1	489
As at 31 Dec 2019	8	85	7	206	48	14	108	101	1	578
As at 31 Dec 2020	8	102	9	242	53	15	127	115	1	672
As at 31 Dec 2021	14	135	9	270	62	18	149	138		795
As at 31 Dec 2022	17	144	11	311	79	21	170	168	47	968
As at 30 Jun 2023	21	157	18	348	87	19	176	189	74	1089

Figure 2 – Midwives with scheduled medicines endorsement[2]

Enablers

A significant enabler and approach to the utilisation of midwives as primary care providers nationally is to reduce the requirement for midwives to complete 5,000 hours of clinical practice to 1,000 hours to be eligible for scheduled medicines endorsement. ACM acknowledges there will be a review to the Endorsed Midwives Standard in 2023/2024 and this question is also within the terms of reference (TOR) of the NMBA's current Midwifery Workforce Review.

Furthermore, ACM asserts that the incorporation of prescribing in the midwifery undergraduate degree would facilitate all midwives to be able to work to full scope in all health settings upon graduation and registration, as is the practice in New Zealand. ACM notes that NMBA has undertaken a consultation for a proposed model of designated nurse prescribing. ACM is heartened that this is supported and notes that the review of the Endorsed Midwife standard should also include midwife prescribing.

Recommendations

1. *All midwives, subject to regulatory change can prescribe scheduled medicines.*
    a. *Clinical Practice hours for the Endorsement for Scheduled Medicines be reduced from 5,000 hours to 1,000 hours.*
    b. *Further to the NMBA review of the endorsed midwife standard, that the endorsement for scheduled medicines modules be incorporated into the undergraduate curriculum.*

Insurance

Barriers

Midwives, alongside all health practitioners, require professional indemnity insurance (PII) to cover all aspects of the care they provide. Midwives are unable to purchase a PII unless they hold an endorsement for scheduled medicines. There is currently only one PII product available for individual midwives under the Midwife Professional Indemnity Scheme (MPIS) which is supported by the Commonwealth Government. This product excludes all intrapartum care outside of hospital from the commencement of labour. The National Law provides an insurance exemption until 2025 for homebirth.

Within the PII product there is a list of services covered and a range of exclusions. In this way the insurer is regulating and restricting the scope of practice of a midwife. A midwife seeking to, for example, provide maternal child health services or sexual and reproductive health services under their own PII must first seek permission of the insurer to do so.

MIGA also provides a healthcare practice policy which provide PII for the employees of organisations holding the policy. This policy has several restrictions and requirements and also excludes provision of intrapartum care outside a hospital.

The insurance framework creates many barriers for midwives to work to full SoP.

1. Midwives who do not hold an endorsement for scheduled medicines cannot participate in the MPIS and therefore cannot access PII.
2. Exclusion of homebirth from PII insurance, and exemption under National Law. Home birth is a safe and reasonable choice for many women, it is within the scope of practice of a midwife under the ICM definition. Access to homebirth, including publicly funded homebirth, is poor in many areas of Australia, leading to rising rates of unattended (free) birth.
3. Policy requirements include that midwives who have purchased PII and have ceased private practice must participate in run-off cover for 21-23 years depending on jurisdiction to cover the care that they provided during their period in private practice.
4. The cost of the Healthcare Practice policy and constraints around the care that can be provided under this policy (e.g. The supervision of non-endorsed midwives).
5. No high cost or exceptional claims cover for organisations that employ midwives providing intrapartum care only for the individual midwives.

The Commonwealth Government has reviewed the availability for insurance for midwives over the last 13 years, and the current solution is deficient. There is a clear market failure in midwifery insurance which requires ***urgent*** government attention to resolve.

Enablers

Provision of one or more insurance products which allows midwives to work to full scope of practice, including early labour care and homebirth, would be a significant enabler for both midwives and women.

Recommendation

2. *An urgent review of midwifery professional indemnity insurance in Australia for endorsed midwives, midwives and organisations employing midwives to enable access to high cost and exceptional claims without limitation of working to full scope, and expanded scope.*

Jurisdictional limitations, credentialling, scope fulfilment and skills development

Barriers

There are jurisdictional and Local Health District (LHD)/ Hospital and Health Service (HHS) and local hospital level variance in what is considered SoP for midwives. Midwives are often required to be 'credentialed' for many areas which are 'normal' or routine SoP for midwives including water immersion in labour, perineal suturing, and cannulation. In addition there are many examples of skills that are considered normal scope in some areas and extended scope in others. An example of this is ultrasound, midwives are able to be credentialed across Victoria for provision of ultrasound services. However, within Queensland, this is not within the scope of practice of an endorsed midwife who has admitting rights to a hospital.

Another example is MS 2 Step (medical abortion); now listed on the PBS for endorsed midwives to prescribe with a removal of the commonwealth requirement for education. However, at a jurisdictional level there is discussion to develop educational and other competency or credentialing requirements for prescribing of MS 2 Step. This is not warranted, reduces accessibility of MS 2 Step for women and is unnecessary over regulation.

The Australian Commission on Safety and Quality in Health Care provides a document[24] to provide practical guidance for managers and clinicians responsible for credentialing, and for 'determining and managing a clinician's scope of clinical practice'.

Enabler

A national passport for all health practitioners - including endorsed midwives would prevent duplication; reducing lengthy and administratively burdensome credentialing and recredentialing processes at every hospital a midwife attends to provide care. This would also support the locum workforce who would not have to redemonstrate their skill set when moving between employment.

Recommendation

3. *Implementation of a national passport for all health practitioners - including endorsed midwives.*

Hospital Admitting Rights

Barriers

Each jurisdiction has a different pathway for endorsed midwives to admit to public hospitals. Some have been very successful, some have no pathway, it is limited or at a local level. In QLD there have been over 4,300 Medicare funded births[25] **(Figure 3)** with endorsed midwives, in SA there have been only 20. There is no national approach to facilitate a formal pathway for endorsed midwives to admit to hospitals. Within jurisdictions midwives apply at each hospital, and each hospital may have different processes or approach to admitting rights.

	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
	Services	Services	Services	Services	Services	Services	Services	Services	Services
Item									
82120	201	457	4,309	20	165	1	4	3	5,160

Figure 3 – Medicare item 82120 processed from July 2010 to June 2023

As can be seen from the Medicare Benefits Schedule (MBS) statistics, this limits options for women for Midwifery continuity of care and thus midwives often are not able to provide care to their full SoP.

Recommendation

4. *The NHRA or similar Commonwealth lever requires jurisdictions to enable admitting rights for endorsed midwives.*

Clinical Services Capability Framework – Jurisdictions

Barriers

The Clinical Services Capability Framework (CSCF) is an overarching maternity and newborn services framework defining the requirements for workforce, infrastructure and equipment relating to the capability of service provision. This framework differs within each jurisdiction and has an impact on the SoP of the maternity workforce, most acutely impacting midwives. Midwives may be working at a particular health service and may be, through no change to their skills or knowledge, suddenly unable to work to full SoP due to moving to work in a new area health service or jurisdiction. CSCF can be found and compared here for Victoria and Queensland.

The Maternity Care Classification System (MaCCS) [26] was developed to classify, record and report data about maternity models of care in Australia. With 11 main models of care, it is unclear how MaCCS as a tool informs best practice and aligns with key government strategic documents to improve health outcomes for maternity consumers. Around 1,000 maternity models of care were reported as being in use across Australia in 2023, which indicate a significant number of hybrid models of care in operation.

Recommendation

5. *A National CSCF to ensure consistency in approach for clinical* services.
6. *Review of the Maternity Care Classification System to ensure*
   a) *Fit for purpose*
   b) *Prioritisation of evidence-based Models of Care such as CoMC.*

Medicines and Poisons Act

Barriers

Medicines and Poisons Acts differ between jurisdictions. 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. 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.

Recommendations

7. ***Prioritisation of*** *National Harmonisation of the Medicines and Poisons Act & Regulations.*

Funding

Barriers

Maternity care funding is fragmented. Funding is distributed via the MBS, public hospital funding, and private health insurance which has been shown to be inefficient and increases costs[19]. Due to the focus on medical acuity and diagnosis it also minimises choice, and is a barrier to best practice CoMC. In the existing funding model, all funding for maternity is deemed to be 'acute care'. However, this is incongruous as the majority of the 300,000 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.

Most maternity care funding is activity based, meaning the more episodes of care provided, the more funding the health service receives. Complex care such as caesarean section and longer than average

postnatal inpatient stays cost more to provide, and therefore attract more funding under activity-based funding models than normal birth. As an example, the Diagnostic Related Group (DRG) for vaginal birth in Queensland in a major city is $4,857 and a caesarean birth in Queensland in a major city is $10,807. Noting this funding model, the Caesarean rate in Australia has doubled over the past three decades from 17.5% to 38% in 2021[15] without evidence to indicate commensurate improvement in outcomes for women or babies.

Australian research demonstrates MCoC models, which allow midwives to work to full scope, deliver cost savings of up to 22% for health services when compared to 'standard', fragmented public service provision. This cost saving is largely due to lower rates of intervention, operative birth, and inpatient stays. In addition to cost savings in direct service-provision, there are broader system-wide, public health and individual benefits derived through MCoC via significantly better perinatal health outcomes including reduced unnecessary intervention, reduced nursery admissions, better perinatal mental health and improved breastfeeding[27]. Funding systems should be adapted to incentivise delivery of best practice, primary care, continuity of carer models that demonstrate improved maternity outcomes for women and their babies as well as prioritising midwives' ability to work to full SoP in the primary care setting.

Enabler

Bundled funding as an alternative mechanism which funds the full episode of care including pregnancy, birth and postnatal care through a bundle payment model. 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. As an alternative to existing mechanisms, ACM notes that this approach warrants consideration as it reduces the risks associated with overservicing and increases the options of high value care for women. This approach would not require new funding but would require a reallocation of existing funding as the number of pregnancies does not significantly change year to year.

In 2017 IHPACA (then IHPA) sought to identify a bundled pricing for maternity care model[28] which was limited only by the lack of a unique patient identifier, which with MyMedicare, is now in existence. Bundled funding is used in other countries, which provide greater access to midwifery continuity of carer (94% of woman choose midwifery continuity of care in New Zealand). The New Zealand maternity care system demonstrates integrated, woman centred CoMC and midwives work autonomously to full SoP across all settings from graduation. In New Zealand, public sector payment covers all the care provided to a woman throughout the pregnancy continuum.

Recommendation

8. *Review of Government funding and consultation to develop a tiered funding model allowing for a bulk/bundled payment model for maternity continuity of care as an alternative to a direct fee for service model.*

National Health Reform Agreement

Barriers

The existing Australian funding model does not have a 'whole of health' fit. Whilst the National Health Reform Agreement addendum seeks to ensure efficiency, sustainability, equity, accessibility, and safety – currently in the maternity context in particular the Addendum does not deliver well. This is a barrier which needs to be addressed to enable midwives and all health practitioners to be able to work to full SoP. Please refer to ACM NHRA Reform Agreement Addendum Review Submission (**Appendix E**).

COAG 19 (2) Exemption

This initiative currently allows public health services to bulk bill primary care in rural and remote areas however it is limited to MMM 5-7 and there are multiple limitations including population size. Endorsed midwives working in the public sector would be better able to fulfil their professional scope by using their qualification, including prescribing in all settings and not simply in COAG 19 (2) locations.

Recommendation

9. *Coag 19(2) exemption as a universal initiative*
10. *Actualise recommendations of ACM NHRA submission*

Medicare Benefits Schedule (MBS)

Barriers

MBS items for midwives are limited to antenatal care to 6 weeks postpartum. Access is also limited to only endorsed midwives. The current items restrict midwives working to full SoP, examples include but are not limited to:

1. Sexual and Reproductive Health (SRH) outside of 6 weeks post-partum. If a woman requires contraception, or SRH counselling outside of 6 weeks postpartum, this is not covered under Medicare.
2. Perinatal mental health; post 6 weeks postpartum there is no MBS item for a visit pertaining to postnatal mental health, despite evidence which indicates that postnatal depression is most prevalent after 6 weeks postpartum.
3. Ultrasound scans: There are limitations on number of scans which can be ordered within each trimester of pregnancy which limits midwives' ability to service the needs of women.
4. Lactation support: No item for ongoing lactation support, despite evidence of benefits of breastfeeding

Recommendation

11. *MBS Items: That Government reviews MBS items to include all items that allow midwives to work to full and expanded scope of practice including but not limited to recommendations from the recent Senate Inquiry into universal access to reproductive healthcare:*
    a. ***recommendation 5*:** The committee recommends that the Australian Government ensures that there is adequate remuneration, through Medicare, for general practitioners, nurses, and midwives to provide contraceptive administration services, including the insertion and removal of long-acting reversible contraceptives.
    b. ***recommendation 10***: The committee recommends that the Australian Government considers and implements a separate Medicare Benefits Schedule item number for contraceptive counselling and advice for all prescribers, including midwives.

12. *The Australian Government implements outstanding recommendations made by the Participating Midwife Reference Group to the Medicare Benefits Schedule (MBS) Review Taskforce regarding midwifery services and continuity of care. (Also recommendation 13 of Senate Inquiry)*

Pharmaceutical Benefits Scheme (PBS)

Barriers

The national regulator NMBA has no defined formulary for midwife prescribing. Rather, endorsed midwives in Australia are regulated to prescribe to scope of sexual and reproductive health and maternity care. Despite this regulation to in-scope prescribing, there are only 18 medicines listed on the PBS for

midwives to prescribe. This limitation results in women accessing some prescriptions from an endorsed midwife being out of pocket. Examples include contraceptives such as LARCs and were addressed as per the Senate Enquiry into Universal Access to Reproductive Healthcare. The report can be viewed here.

There is inequitable access to the PBS subsidy as not all medicines relevant to the scope of an Endorsed Midwife attract a PBS subsidy. This is not the case for like professions such as medical practitioners. This creates an equity issue for access to medication for women who choose midwifery care directly with an endorsed privately practising midwife, as a woman may have to pay full price or have an additional consultation with another practitioner to have a PBS subsidy for certain medications. For example, Acyclovir prescribed for active herpes by an Endorsed Midwife does not attract a PBS subsidy as it would if prescribed for the same condition by a GP. This inequitable access results in further barriers to patient care, overservicing and underservicing, potential patient harm and is limiting for midwifery SoP.

Enabler

ACM does note that this is under review with the Department of Health currently.

Recommendation

13. *Alignment of PBS subsidy access for Endorsed Midwives with other medical practitioners to create equity of cost for women and their families.*

Technology

Barriers

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.

If private practice midwifery were to be integrated into My Health Record, it would create effective multidisciplinary models of care and improve patient experience. A woman with birth trauma for example, should not be required to repeat her experience to multiple providers. The 10-year plan further acknowledges this: ***'People have to tell and retell their stories to each health care provider they see, with an associated burden of time, effort, frustration and in some cases reinforced trauma***.

The premise of digital integration is to support safe and quality care however a substantial proportion of the workforce, including midwifery is prevented from genuine engagement in My Health Record and in there is little to no development of compliant software for secure messaging and other applications for midwifery.

An example of this is the current 'Modernising My Health Record' consultation notes that 'By 30 June 2024, diagnostic imaging and pathology providers should be uploading patient results to My Health Record. It is expected that legal obligations to upload results will be in place from December 2024'. Endorsed Midwives currently only have viewing records for MHR and limited access and knowledge of software technology.

Recommendations

14. *Midwifery to be prioritised, included and supported in the Digital Health Strategy and the interoperability consultation and implementation*
15. *Midwives to have access to upload to MyHealthRecord*
16. *Midwives to be funded to facilitate digital capability within their practices*.

Culture and Leadership

Barriers

Research identifies that midwives SoP is challenged when working within a hospital-based, hierarchical or medically led health service, further complicated by fragmented and policy-driven medical models of care and a lack of midwifery leadership and professional representation in order to prioritise implementation of CoMC. This was attributed to[23]

- the absence of informed executive and strong midwifery leadership;
- lack of knowledge, understanding and implementation of contemporary CoMC;
- inadequate clinical governance;
- poor workforce planning and use of resources;
- interdisciplinary risk perception; and
- a significant lack of community engagement and consultation.

Interdisciplinary communication and workplace culture in maternity is complex, and results in either a highly functioning and supportive environments of collaboration, or can have impacts on trust, clinician roles and expectations and patient safety measures. Policy, process, philosophy and culture contribute to the success of midwifery in primary care. ACM notes below some of the many responses to barriers to SoP in our member survey **(refer appendix D for comprehensive summary)**.

How is an existing service, with existing protocols and leadership required to intentionally change and develop its culture, its collaborative approach or its development of MCoC models in the face of tradition, midwifery leadership vacuum at executive levels, status quo and power imbalance? As articulated by authors in a recent 'Advanced Midwifery Practice, A Scoping Review [5]

> "The reality is that even the most qualified and skilled midwife who encounters a service unprepared or unwilling to facilitate scope fulfillment will be unable to fulfil their professional capacity. The disrespect that midwives encounter in services unwilling to enable professional scope fulfillment has an accumulative effect and is contributing to workforce attrition".

Quotes from midwives in the ACM SoP survey:

'Indifference from medical staff or a medically run executive board who continues to make decisions that limit midwives' ability to use their full scope of practice (such as endorsed midwives unable to prescribe in the hospital setting)'

❖

'Medical powerbase within organisations affects midwives from providing comprehensive care to low risk woman and families'

❖

'Apathy and unwillingness of health services to change the status quo to implement changes when faced with push back from medical staff. GP's/obstetrician gatekeeping'

❖

'Hospital administration and doctors unwilling to accept midwives both as a separate profession to nursing and as skilled practitioners.'

❖

'local hospital culture: power imbalance between midwives and GP O&G's; in rural settings the maternity service is dependent on the presence of a GP O&G therefore the GP can demand whatever they like and the hospital will concede to that request in order to keep the doctor happy and retain their service; lack of vision for maternity services (always in survival mode), lack of desire from the Local health districts'

❖

Enablers

Challenging embedded customs and misogynistic culture in maternity services requires innovative and strong health services as well as midwifery leadership at national, state and health systems level. The Commonwealth, state and territory governments should build and enhance core leadership competencies across the midwifery workforce from pre-registration education to executive levels in partnership with midwifery professional bodies. Furthermore multi-disciplinary work should be undertaken to facilitate collaborative and respectful working in the maternity department.

Structural, embedded midwifery leadership is required to ensure significant and long overdue change for the midwifery workforce is enabled to safely and sustainably progress. When this exists systems have improved. Midwives who work with a dedicated professional midwifery leadership structure receive support, respect, and autonomy. They are enabled to work to full SoP in all areas of maternity, with reduced structural and policy barriers, effectively collaborate with multidisciplinary colleagues, and provide high quality evidence-based care to women. Experience shows they are more likely to be a stable workforce. Senior midwifery leadership at the highest levels of the health system would enable strategic advocacy and effective midwifery-specific policy solutions to ensure appropriate and sustainable change and governance to promote midwifery models of care and advocate for the midwifery workforce and thus improve outcomes for women and families.

Recommendations

17. *Appointment of a Chief Midwife Nationally and in each state and territory.*
18. *Develop midwifery leadership competencies nationally.*
19. *Education program for medical professions, PHNs, Depts of Health nationally on role of the midwife, endorsed midwife and the benefits of CoMC.*
20. *Enable midwives to lead the profession of midwifery by holding positions that influence the leadership, management, practice and education of midwifery and maternity services at all levels.*

Health Literacy

Barriers

Low health literacy is associated with poorer health outcomes, and this can be most significant with regards to women's options for maternity, sexual and reproductive health and maternal child and family healthcare[29]. There is limited guidance to facilitate choice of model of care which is further complicated for priority populations (Aboriginal and Torres Strait Islander women, young mothers, culturally and linguistically diverse, women experiencing pregnancy complications and LGBTQIA+ community[30]. Recent national research revealed factors that influence GP referral to maternity care are complex and layered and have a direct impact on patient outcomes[31].

For 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.*

Pre-pregnancy check up

It is a good idea to have a chat with your doctor if you are planning to become pregnant… There is also an option of considering genetic carrier screening for some genetic conditions you may be at risk of passing on to your baby that you were not aware of. Discuss this with your doctor.

The role of the midwife on the Government's website https://www.pregnancybirthbaby.org.au/the-role-of-your-midwife does not explain the full scope of practice of midwives. This holds true, in general for jurisdictional information also.

In general, most accessible or hospital public facing information indicates that women should go to their GP first for information. Health Literacy for women needs to include information about CoMC with a known carer, the improved outcomes for women, and the benefits of normal birth. Midwives' expertise in primary sexual and reproductive health and maternity care means that they are best placed to provide the necessary assessment, education and care for all pregnant women.

Enablers

MCoC improves birth outcomes, however there is limited national and widespread information provided for women and consumers. Women are also in general not informed regarding the risks and benefits of instrumental birth or induction. An enabler for this would be improved and balanced health information for women and families with regards to their maternity choices as a public health initiative.

Recommendation

21. *Review and updating of the existing Commonwealth Government's website: https://www.pregnancybirthbaby.org.au/ to be informed by ACM*
22. *A National campaign for public awareness of the role of the midwife/endorsed midwife working to full scope, and the outcomes for women is resourced by the Commonwealth.*
23. *All education campaigns are culturally safe, inclusive and translated as relevant.*

Workforce

Barriers

Midwives working to full SoP can meet the increasing demand for maternity services, particularly in regions where there is a shortage of healthcare providers [23.33]. In addition the research shows us that midwives are essential primary health care providers in times of emergencies. Many rural positions request dual registration (nursing and midwifery) to fill vacancies. This prevents many midwives from applying for these positions. Single qualification midwives should not be disadvantaged, excluded, or discriminated against for rural midwifery positions. Recruiting and retaining midwives in rural Australia is an ongoing challenge. Efforts to improve workforce conditions and incentives for midwives to relocate are ongoing and essential.

In some remote Australian contexts, dual qualified Registered Nurse / Midwife are not able to work to midwifery scope as they are employed as registered nurses. As midwifery does not appear in the role description, the employee is not able to work in the capacity of a midwife while employed in those roles – as advised by Human Resources Department.

Recommendation

24. *Capitalise on the knowledge and skills of all health professionals enabling them to fulfill their professional scope within their registered profession. For example, a dietician, also qualified as a midwife should be able to fulfil their full extent of professional scopes without impediment.*

Looking to the future of advanced scope of practice

This submission has necessarily prioritised the identification of the system-wide transformation that is required to enable midwives in Australia to work to full scope of practise, where care is provided by the right professionals, in the right settings and in the case of maternity care; orientated around the woman's needs.

It is important to address identified, current barriers to scope fulfilment to ensure best value care for the Australian population. In planning for future workforce capacity and addressing the unmet needs of women and their families, it is also important to begin the conversation about advanced-scope midwifery. Many of the priorities listed in this submission, if addressed would further serve to enable and activate formalised, advanced scope midwifery within Australia. In a recent scoping review of advanced scope midwifery around the world, authors noted that

> "The reality is, that even in well-resourced health systems that reportedly have universal access, there are groups who would benefit from access to midwives with advanced scope. In addition, the leadership role that many of these midwives' hold is important and should be visible and supported in all areas where there are midwives working. Scope-fulfilled midwives being visible and holding senior clinical leadership positions enabling advanced skills, such as performing vacuum or forceps assisted birth, expertise in breech birth, genetics education and infertility counselling[5]."

The ACM is committed to advocacy for midwives to fulfil their professional scope of practice in all Australian settings.

Conclusion

The role of the midwife working to full scope of practice in all settings, and in primary care will improve outcomes for women, reduce cost to Government, and take pressure off the overburdened primary care system, in particular the decline in medical practitioners, GP obstetricians and General ruralists. Midwifery is an autonomous profession which is undervalued and underutilised. ACM welcomes this consultation and is committed to ensuring that midwives 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 would like to thank all of the midwife members who participated in this survey and the Government for recognising the role of midwives in primary care through the Strengthening Medicare Taskforce work and further in this consultation - Unleashing the Potential of our Health Workforce (Scope of Practice Review). ACM looks forward to ongoing engagement and enabling all midwives in Australia to work to their full scope of practice.

Acknowledgements

ACM acknowledges the contribution of Liz Wilkes (ACM Advocacy committee member and Dr Zoe Bradfield (ACM Vice President) in the preparation of this submission.

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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.

Appendix A – Endorsed Midwife infographic

Appendix B – Molly Wardaguga Research Centre - Safety and Effectiveness of CoMC in Rural and Remote Australia

MOLLY WARDAGUGA Research Centre
BIRTHING ON COUNTRY CRE

CHARLES DARWIN UNIVERSITY AUSTRALIA

Safety and Effectiveness of Continuity of Midwifery Carer in Rural and Remote Australia

Evidence Base: Midwifery Continuity of Carer Models

- Continuity of midwifery carer is best practice[1] positively impacting outcomes and popular with midwives and women, including low risk pregnancies,[2,3] complex pregnancies[4-6] young women,[7,8] women from a refugee background[9] and First Nations women.[8,10-16]
- Caseload midwifery attracts, motivates and enables midwives to go 'Above and Beyond' such that women feel empowered, nurtured and safe during pregnancy, labour and birth.[17]
- Caseload midwifery is associated with lower burnout scores, anxiety and depression; and higher autonomy, empowerment and professional satisfaction; whilst midwives working in shift-based models are at greater risk of psychological distress.[18,19]
- Continuity of midwifery carer buffers the effects of prenatal maternal stress on mothers and babies reducing depression and anxiety at 6-weeks postpartum[20] and improving infant neurodevelopment at 6-months: fine motor skills and problem solving.[21]
- Despite this evidence only ~15% of Australian women access MGPs and only ~2% access private midwifery.[22]
- A Cochrane Systematic Review[1] of continuity of midwifery care found outcomes for women and babies are significantly improved when care is offered by a known midwife. 15 randomised studies involving 17,674 mothers and babies found benefits include:

Reductions in	Increases in
↓ Fetal loss and neonatal death	↑ Women not needing analgesia or anaesthesia in labour
↓ Amniotomies (artificial breaking of waters)	↑ Spontaneous vaginal births
↓ Augmentation (Syntocinon)	↑ Women knowing their midwife at birth
↓ Epidural and spinal analgesia	↑ Satisfaction
↓ Episiotomies	↑ Women feeling more in control and more able to cope physically and emotionally
↓ Instrumental births (vacuum or forceps)	
↓ Preterm babies ~24%	
↓ Cost	

Challenges in rural, remote and very remote Australia

- 25% of non-First Nations and 64% of First Nations birthing women live outside of cities and have less choice in maternity care.[23]
- A higher proportion of First Nations birthing women live in remote and very remote areas (19% vs 2%) where they are less likely to have access to midwifery care or maternity services[24] and perinatal outcomes reflect vast inequity and disadvantage.[25,26]
- Nationally, there has been a 41% decline in rural maternity services (1992–2011) correlating with a 47% increase in unplanned out of hospital births, impacting 22,814 families exposing them to distress, increased clinical risk and poorer outcomes.[27]
- Maternity unit closures are an ongoing concern and inconvenience for women in rural and remote Australia meaning they must travel for birth resulting in greater financial, emotional, social, and cultural strain, distress and loneliness on families.[28-30]
- Women from Indigenous communities experience the loss of spiritual and cultural connections when unable to birth on country. This loss of connectivity has been associated with emotional distress, anxiety, stress and depression.[27]
- There has been slow uptake of evidence on best practice midwifery into practice in rural and remote Australia.[25,31,32]

Evidence to support continuity of midwifery carer in rural and remote Australia

- Midwives working in caseload models of midwifery care have decreased burnout and increased satisfaction with care provision.[33]
- Caseload MGP is a safe, satisfying and sustainable model of maternity care in a rural setting over 20-years.[34]
- Caseload MGP operating in a rural primary maternity unit with high populations of young women and First Nations women can be safe, sustained and provide excellent outcomes.[35]
- Success factors supporting caseload midwifery in rural areas include strong leadership across all levels of policy, health service management and, from the midwives themselves.[34]
- Embedding students in rural and private continuity models is highly beneficial to learning, promoting confidence & competence.[36]
- Caseload midwifery builds partnership between woman and midwives, enabling flexible working hours and increased autonomy.[37]
- Being on call allows the midwife to work on the whole scope of midwifery practice.[37]
- Continuity models may be a means to attract midwives to work in rural areas.[37]

Continuity of midwifery carer is a core component of Birthing on Country Services for First Nations Australians

- **Birthing on Country** is a metaphor for the best start in life for First Nations families7 recognising that when women give birth in Australia, they are doing so on the sovereign lands of the First peoples of Australia who have never ceded ownership of their land, seas and sky.[38]
- **Birthing on Country Services** are complex interventions recommended in national policy[39] where they are described as:
- *"community-based and governed; allow for incorporation of traditional practice; involve a connection with land and country; incorporate a holistic definition of health; value Indigenous and non-Indigenous ways of knowing and learning, risk assessment and service delivery; are culturally competent; and developed by, or with, Indigenous people".*[40]

- **MGP care is a core element of a Birthing on Country services for First Nations women** but there are only a few MGPs in Australia that target First Nations women despite high levels of acceptability.[16]
- Results from an NHMRC partnership project (Indigenous Birthing in an Urban Setting Study) conducted in Brisbane showed statistically significant improvements in care and outcomes for First Nations women receiving the Birthing in Our Community service compared to standard care:[14,41]

↓ Preterm birth by 38%	↑ First Nations governance and control
↓ Epidural pain relief in labour	↑ Cultural safety
↓ Planned caesarean sections	↑ First Nations workforce (~550%)
↓ Admissions to neonatal nursery	↑ Integration of wrap around services
↓ Cost ($4810 per mother infant pair[14])	↑ Women presenting early and more often
↓ Unborn notifications and babies removed at birth	↑ Continuity of midwifery and community-based care
	↑ Known midwife at birth
	↑ Physiological management of third stage
	↑ Exclusive breastfeeding at discharge

National Policy Supports access to continuity of midwifery carer in Rural and Remote Australia

In response to consumer demand and a reliable evidence base, Australian Governments have committed to improving rural and remote women's access to midwifery models of care over many years:

- In 2008, all Australian state and territory Governments committed to: *"extending and enhancing primary maternity services models as a preferred approach to providing pregnancy and birthing services to women with uncomplicated pregnancies."*[42]
- In 2019, these commitments were then embedded in Australia's national maternity policy document that supports woman-centred care and access to maternity services.[39]
- In 2019, the Australian Medical Association Rural Health Issues Survey identified the top 10 solutions for rural health care and the top priority was extra funding for resources and staff with the goal of creating a better workplace to attract long term staff.[43] Despite their recommendations the frameworks and guidelines are not being translated into practice in the rural sector. Consequently, there is an inequity between recommendations for best practice and what transpires into local policy and operating procedures.[44]

Primary Maternity Units (PMUs)

PMUs are defined as birthing services without onsite access to caesarean section, also known as birth centres and Level 2 maternity units in Australia. Access to an operating theatre is not required 24/7 in the context of low-risk birthing. There is strong evidence that PMUs provide safe perinatal care for women who are classified as low-risk including rural and remote areas.[35,45-49]

- They report higher spontaneous vaginal births, less caesarean section rates, reduced odds of intrapartum interventions and similar improved odds of neonatal well-being.
- Despite the evidence base for PMUs, we found few across Australia (3 urban; 17 rural; 0 remote), reflecting a lack of medical support in some cases, risk aversion and sustainability concerns in others[50].
- Additionally, strong evidence finds distance to care, accidental, out-of-hospital births, increased psycho-social stress, social and cultural vulnerability and unstable services lead to worsened outcomes for women and their babies[32].
- Whilst policy at the national level reflects a particular strategic intent for maternity services, there is a considerable gap between this intent and service delivery at local levels. Contributing factors were found to be ad-hoc local, non-evidence based decision-making, poorly prepared or supported leadership, lack of knowledge of contemporary models of care and inefficient use of maternity staff; absent clinical governance and inadequate workforce planning, misinformed perceptions of risk and a dearth of community consultation.[25]

Appendix C – Institute for Urban Indigenous Health: Birthing in Our Community Program

CASE STUDY

Institute for Urban Indigenous Health: Birthing in Our Community Program

Healthy and strong babies and families

> "It's about understanding what that family unit looks like, so we can put appropriate supports in place. We are not just here for antenatal care but for family wellbeing. It is about us leaning into each other, keeping out of the hospital system and creating a space where our families feel safe and can control their health journeys."
>
> **Kristie Watego, General Manager, Family Health and Wellbeing at the Institute for Urban Indigenous Health**

"We don't just want a beautiful baby born on the day, we are here to help raise strong, black, deadly families, so we build capacity within our families to be healthy and fit in mind, body and soul, and to know it's okay to lean into support that's offered."

This is how Bundjalung woman Kristie Watego describes her work as General Manager, Family Health and Wellbeing at the Institute for Urban Indigenous Health (IUIH).

IUIH is a partner in the Birthing in Our Community (BiOC) program in Brisbane with the Mater Mothers' Hospital and the Aboriginal and Torres Strait Islander Community Health Service.

BiOC's success made national headlines last year after National Health and Medical Research Council (NHMRC) funded research, published in the international Lancet Global Health journal, found that Aboriginal and Torres Strait Islander babies in the program were 50 percent less likely to be born premature.

The program also delivered other major benefits, with the research finding that mothers in the program were more likely to attend five or more antenatal appointments, less likely to need a planned caesarean or an epidural in labour, and more likely to be able to exclusively breastfeed on discharge.

Behind the outstanding clinical successes of BiOC is a powerful story of self-determination, of community creating and leading its own solutions, and a strong focus on cultural and social determinants of health, especially for Aboriginal and Torres Strait Islander women.

BiOC emerged from a Murri antenatal clinic run every Thursday at the Mater by Aunty Denise Watego. However, at that time, women still had to have their babies in mainstream systems, where they risked missing out on important social and cultural supports in fractured health systems and being subject to systemic racism and stereotyping.

PHOTO: Baby Luke born as part of the Birthing in Our Community program (Kristie Watego)

> "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**

PHOTO: Macca and her baby daughter from Birthing in Our Community program

This prompted local community and health leaders to think about what else was needed.

"Demonstrating from the start the respect for community leadership that is core for BiOC, they said, 'We don't know what's needed, let's go talk to mob'," Kristie said.

From those discussions in 2012, the BiOC program was established. The BiOC Hub opened in 2016. Located in community in south Brisbane, it provides a dedicated midwife from conception to six weeks, and a dedicated family support worker to walk with mums on a wellness journey until the baby is three years old.

Women and families also have onsite access to a social worker, psychologist, transport support, early learning programs, a child health nurse and allied health exercise groups. Milestones across babies' lives are celebrated through rites of passage celebrations, arts, connection, music and culture, community days and playgroups.

According to Kristie, at BiOC, women and families are welcomed with open arms. There is no staff room, rather a kitchen table where everyone tucks in, sharing meals and experiences, giving expectant mothers and families a safe space to disclose and share their needs.

"It could be as simple as 'I'm frightened and I don't know what to expect', to 'I've never had a mum, so I don't know how to do this', or it could be 'I'm in an unhealthy relationship and need support to exit it'," Kristie said.

BiOC works under a family-centred practice framework where care, like Aboriginal and Torres Strait Islander understandings of health, is holistic.

BiOC has never had to promote its services: the Murri grapevine alone means it is in huge demand, a true community measure of success. Another important indicator is that nine out of 10 women in the program are referred to it by nine weeks into pregnancy, optimising the chances for great care and outcomes.

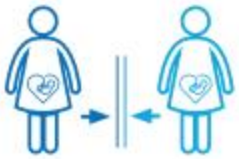
A BiOC service is now being rolled out on the north side of Brisbane, with models also in development in two other locations across south-east Queensland.

A five-year study of the BiOC program, funded by the National Health and Medical Research Council has shown dramatic improvements in many maternal and infant health outcomes.

These include:

- halving the national pre-term birth rate (six per cent compared to 14 per cent)

- almost closing the gap altogether in comparison with non-Indigenous pre-term birth rates

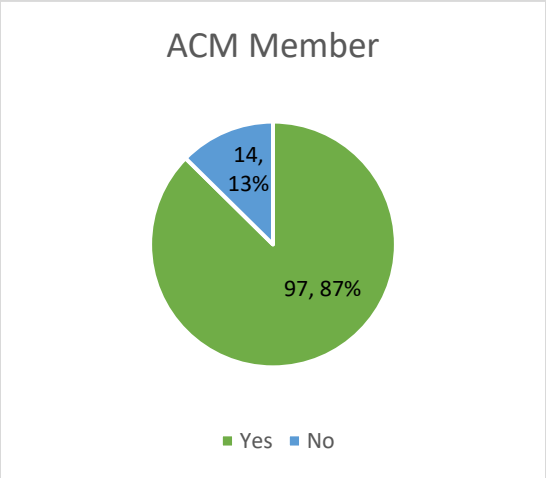


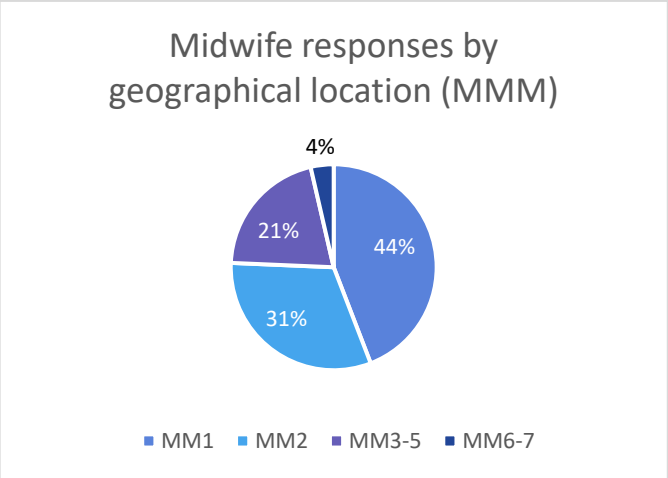
- halving the national rates of low birth weights and admissions to neonatal units (six per cent compared to 11 per cent, and 10 per cent compared to 22 per cent, respectively).[18]

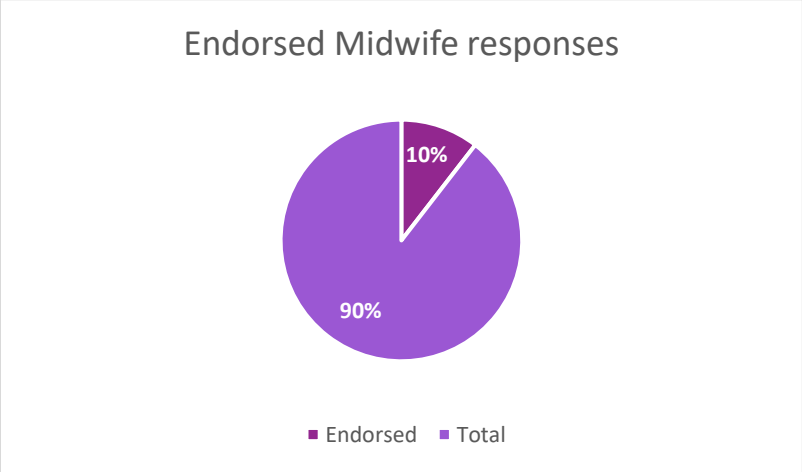
Appendix D - ACM: Midwife survey responses

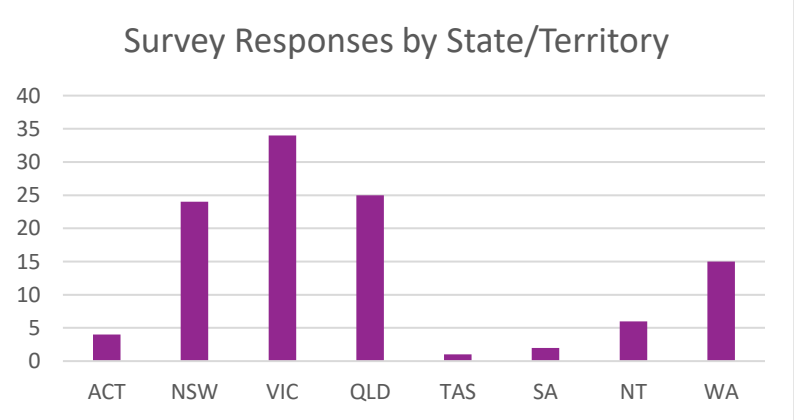
ACM: Midwife survey overview

ACM conducted a National member survey for midwives to gather a background of midwives' perception of scope of practice. There were 111 respondents ranging from students in midwifery to more than 30 years' experience as a midwife.









ACM's member survey demonstrated the following key themes;

- Role and Scope of Midwife
- Barriers to Role and Scope of Midwife
- Enablers to working to full scope

Role and Scope of Midwife for full and expanded scope:
Please describe in your own words, what you believe the following two options are for midwives:

Full Scope:

'Practicing to full scope of practice across all settings ante, intro & post postpartum periods. I.e. independent pathology ordering & interpreting, independent vaccination ordering, cannulation, perineal repair, discharge checks of newborns, contraception counselling & provision of Implanon if requested, independent midwifery home postnatal service but at all times loading with relevant colleagues in line with ACM consultation & referral guidelines & local policy.'

'Homebirth, Antenatal, postnatal, labour & birth care, possible Caseload of women to care for across the spectrum, cannulation, suturing, ordering necessary bloods, referring to specialist when required, speculum examination',

'Able to work to definition - across all areas and in partnership with women. Includes skills and decision making. Hoping soon this will include prescribing, needs to be embedded in all midwifery curriculum.'

Expanded Scope

'All midwives should be able to work to their full scope and be trained accordingly, making expanded scope have no meaning. Including Midwife prescribing and endorsement should be the norm for tertiary midwifery education.'

'The full scope of practice for a Registered Midwife is the STANDARD / CORE scope of practice obtained during higher education qualification. I believe that the word "full" should be removed when describing the role and responsibilities of practicing as a Registered Midwife. Expanded or specialised scope of practice should refer to those midwives who have undertaken further professional development and have been certified/credentialed to use this skill and practice where that pertains to their current working role.'

'Midwives have huge role in health promotion in early pregnancy midwives like myself from UK have provided pregnancy choices info and conducted medical Termination of pregnancy, miscarriage and bereavement support. We have experience in sexual health counselling and contraception.'

'I feel that the prescribing of medications during the perinatal period should be included in the training of midwives and all midwives, on registration, should be able to prescribe, like in NZ. Then midwives would have a "scope of practice" and not be confused with "an expanded" scope.'

'Under the current system, midwives are not used to their full capacity or in alignment with best primary health care principles - too often doctors are the head of the team, and midwives work under their direction, whereas in a truly PHC model midwives would have a more central role with greater authority and doctors would sit on the periphery - investigation and treatment should be fringe interventions, not core business in a PHC approach.

‘There should be no such thing as expanded scope! All midwives should be accepted for their training and capability equally and should be able to practice independently without having to have that tagged to their name’.

What do you see as the benefits of midwives being able to practice to full or with an expanded scope of practice?

Increased continuity of care resulting in better outcomes for women and babies

Professional satisfaction, feeling valued & respected. This can help retain midwives especially those with much experience. Cost effectiveness.

Given the healthcare industry workforce issues that are unlikely to ease over the next decade, or more, the benefits of midwives providing care to their "full"/core scope of practice, enables midwives to fulfil the elements of their role that they studied, paid and worked hard to be qualified to perform - which is exactly why midwives study to become midwives. The benefits of enabling midwives the ability to work within an expanded scope of practice provides a unique opportunity to make a significant impact on a multitude of levels.

Midwives providing standard and expanded scope of practice has the opportunity to free up specialist/medical/allied health staff to be able to focus on prioritising care to the patients that need their expertise

Increased job satisfaction Improved retention of midwives. Frees up Dr for more complex abnormal scenarios

Less wait times. More continuity of care Less miscommunication by having to have appointment with multiple different staff members . More job satisfaction

More cost effective; greater job satisfaction; better care for women in continuity of care models; able to maintain failing rural maternity services

Better outcomes Reduced birth trauma Renormalise birth Cost effective Higher breastfeeding rates Less readmissions postnatally

Midwives are women’s health experts. We are trained and experienced in all things gynaecology and obstetrics, but also women’s reproductive health across the lifespan.

Please provide best practice examples where you or colleagues have worked to full or expanded scope of practice, and the benefits this gave?

Independent midwife (endorsed) antenatal clinic sense of autonomy, more efficient service (not chasing doctors), full scope of intra partum skills can provide midwife led care meets needs of women & satisfying for midwives without compromising care. Cost effective generally reduced length of stay, midwife postnatal care at home sooner.

I worked within a small Pregnancy Day Stay Unit, which had only recently been brought in to relieve pressure on the Maternity Assessment Unit. Women requiring fetal wellbeing assessments beyond a CTG (i.e., for AFI, Doppler's or presentation scans) they would need to be referred for a formal ultrasound, which often meant waiting for appointment availability. Undertaking 3rd Trimester

Ultrasound Scanning training, and supported by being enabled to become credentialed through a tertiary maternity service, enabled point of care ultrasounds to be undertaken, which were by a clinician trained to do so, and freed up sonographer appointments for women required detailed ultrasounds, as well as improving throughput and satisfaction for women.

I have worked to full scope of practice in NZ benefits: less LUSCS, less assisted births, higher breastfeeding rates, better mental health, less cost for women, less cost for hospitals as women staying shorter, better for the environment, more job satisfaction

Women in antenatal appt with being able to receive and ultrasound or blood test request from midwife without having to have an extra visit with GP/Obstetrician. Being able to review blood tests/ ultrasounds with women and prescribe medication. Time to discuss the options available to woman and gain fully informed consent.

As a remote midwife I provide care from pre-conception, conception, antenatal, emergency births, post natal but also encompass STI screening, sex education session, women's health, knowledge of chronic disease and how that might impact on conception and pregnancy, as just some examples. Working with GP and obs and gyn Dr via phone and close collaboration with them and the women

Midwifery Leadership

Strong midwifery leadership, good policies/guidelines & governance which make scope of practice clear, support from obstetric colleagues who see the benefits & respect the midwifery profession. Strong midwife leaders with understanding of a midwife role and skills Lead midwife consultant midwife position role out role development

Working in hospitals that are supportive to staff to do so. My present hospital makes it difficult for midwives to work in all areas which frustrates staff and causes them to resign in search of hospitals that will supply them with these options.

The only way I can work to my full scope currently is by practising privately. the hospitals do not recognise my endorsement.

Organisational confidence and understanding of the role of a midwife.

Support from Doctors/Support from system

Medical staff busy and so have no time to check every room. Some of the medical staff have been working in obstetrics for less than 3 months and are sent to check the care given by midwives who have been practicing for 20 or 30 years.

Full support from both midwifery leadership team Support and recognition of abilities from other health workers such as medical staff.

Support from governing bodies, work-place management, Primary Health Clinic managers & staff including multidisciplinary teams (Specialists, Drs, nurses, ALO's, AHP's) E.g. Access & funding for Remote Outreach Midwives to complete the Family Planning NT Well Womens Health course to increase the rates of CST's, follow-up & referral to specialist services for management.

What are the barriers to midwives working to full scope of practice in the current context? Please give examples if possible.

Midwives/leaders who aren't aware of working to full scope & lack leadership to promote & provide governance for this. An e.g. was having no guideline for independent pathology midwife ordering across perinatal periods within scope of practice. No local guideline so unable to practice to scope.

Not enough funding or importance placed on midwifery group practice/ continuity of care models. Staff shortages and skill mix. Rostering. Lack of opportunity.

No Medicare rebate for homebirth. This makes it very expensive for women to have a private midwife.

No Medicare rebate for women who need more than 1 ultrasound after the morphology ultrasound.

Hospital administration and doctors unwilling to accept midwives both as a separate profession to nursing and as skilled practitioners.

Medical dominance of maternity care, funding mechanisms in the acute sector

Restrictive hospital policies, lack of understanding of the midwife professional role, obstetric resistance, power unbalance in collaboration

Professional regulatory restrictions - i.e. having to also be a nurse even though midwives are fully capable of meeting requirements if trained just as nurses are! Hospitals not acknowledging/accepting endorsement for scheduled medicines. Having to have agreements with doctors who often don't understand what that means as far as their professional responsibilities so just say no!

Even working in continuity of care models we are working under/reporting to a GP - we are not independent practitioners; we can't order pathology/imaging or prescribe medications.

What do you see, if any, as the risks or other impacts of midwives working to full scope or with an expanded scope of practice?

Only risks are related to poor governance if scope & processes are not clear. If audited, if supported by education team with accreditation & maintenance of accreditation processes made clear then risks are negligible.

There are no risks.

the only problem I see is midwives doing more work and not getting paid accordingly
Everyone has a different scope, and it can be difficult to ensure everyone works within their own individual scope of practice

More responsibility and workload

Risk of litigation if anything goes wrong (the midwife always gets thrown under the bus) midwives not recognising where their scope of practice ends and failing to make appropriate referrals

More unsubstantiated reporting to AHPRA by healthcare professionals that don't understand the scope of midwives

If you are aware of different or expanded scope of practice for midwives overseas, please provide examples including country and context of practice and evidence (or a link to) to support this if you have them.

I trained in the UK. You are actively encouraged from the day you qualify to learn how to suture and up-skill in every way possible. Your pay grade doesn't go up unless you up-skill. When I arrived in Australia, I was the only midwife who sutured. Midwives had a choice about doing these skills! It's your job to be able to do these skills - why should someone who isn't skilled in anything, but basic maternity care be paid the same as someone who is skilled in all areas? It's unfair and midwives should have more pride in their work in order for women to have one practitioner who can do everything for them.

Independent midwives in the USA offer full scope midwifery care, women's health across the lifespan, infant care and feeding, and mother crafting. https://www.holistichomebirthmidwife.com/

As mentioned above for NZ, but it's not "expanded". It is the scope of practice for a midwife

In other countries such as the UK, every woman has the right to midwifery care despite their choices e.g. if a woman chooses to birth her twins at home despite recommendations for gat she should have a hospital birth she is provided a midwife without risk to that midwife registration

Midwives provide safe abortion services, counselling, reproductive health and family planning, acupuncture, incorporate a multitude of alternative herbal remedies, traditional medicines, allied health practices, well baby checks.

Midwives in UK able to provide homebirth for any woman who wants it, regardless of their 'risk' criteria

Indonesian midwives also do child health

Better access to supported homebirth services e.g. in UK and in Netherlands Better support for full scope in NZ without ridiculous barriers from obstetric colleagues.

New Zealand https://www.midwife.org.nz/midwives/midwifery-in-new-zealand/scope-of-practice-of-the-midwife/

UK - midwives ultrasound and scrub for CS

Appendix E – ACM NHRA submission

20230608-NHRA
2022-25 Addendum

References

1. Department of Health and Aged Care. (2023). National Health Workforce Dataset. Retrieved August 12, 2023, from https://hwd.health.gov.au/nrmw-dashboards/index.html
2. Nursing and Midwifery Board. Ahpra. (2023). *Statistics. Nurse and Midwife – Registration Data Table – 30 June 2023.* Retrieved from https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx
3. International Confederation of Midwives. (2013). *Essential competencies for midwifery practice.* Retrieved from https://www.internationalmidwives.org/our-work/policy-and-practice/essential-competencies-for-midwifery-practice.html
4. Commonwealth of Australia (2022) Strengthening Medicare Taskforce Report https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_0.pdf
5. Toll, K., Sharp, T., Reynolds, K., & Bradfield, Z. (2023). *Advanced midwifery practice: A scoping review.* Retrieved from https://www.sciencedirect.com/science/article/pii/S1871519223002949?ref=pdf_download&fr=RR-7&rr=81a73755aa5ba97a
6. Nursing and Midwifery Board. Ahpra. (2022). *Fact sheet: Scope of practice and capabilities of nurses and midwives.* Retrieved from https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/Fact-sheet-scope-of-practice-and-capabilities-of-nurses-and-midwives.aspx
7. Nursing and Midwifery Board. Ahpra. (2020). *Decision-making framework (DMF) for nursing and midwifery.* Retrieved from https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Frameworks.aspx
8. Nursing and Midwifery Board of Australia (2017) Registration Standard: Endorsement for Scheduled Medicines for Midwives (http://www.nursingmidwiferyboard.gov.au/Registration-Standards/Endorsement-for-scheduled-medicines-for-midwives.aspx.
9. COAG Health Council (2019) Woman-centred care Strategic directions for Australian maternity services https://www.health.gov.au/sites/default/files/documents/2019/11/woman-centred-care-strategic-directions-for-australian-maternityservices.pdf
10. 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
11. 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
12. Gai, 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
13. Bradfield, Z., Hauck, Y., Kelly, M. et al. "It's what midwifery is all about": Western Australian midwives' experiences of being 'with woman' during labour and birth in the known midwife model. BMC Pregnancy Childbirth 19, 29 (2019). https://doi.org/10.1186/s12884-018-2144-z
14. Fenwick J, Sidebotham M, Gamble J, Creedy DK. The emotional and professional wellbeing of Australian midwives: A comparison between those providing continuity of midwifery care and those not providing continuity. Women Birth. 2018 Feb;31(1):38-43. doi: 10.1016/j.wombi.2017.06.013. Epub 2017 Jul 8. PMID: 28697882.
15. Australian Institute of Health and Welfare. (2023). *National Core Maternity Indicators.* Caesarean section. Retrieved from https://www.aihw.gov.au/reports/mothers-babies/national-core-maternity-indicators/contents/labour-birth/b5
16. World Health Organization. (2018). *WHO recommendations: non-clinical interventions to reduce unnecessary caesarean sections.* Retrieved from https://www.who.int/publications/i/item/9789241550338
17. 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
18. 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.
19. Hu Y, Zhang X, Callander E. Unlocking big data to understand health services usage and government funding during pregnancy and early childhood, evidence in Australia. Birth. 2023 Jul 11. doi: 10.1111/birt.12738. Epub ahead of print. PMID: 37434333.
20. Department of Health and Aged Care. (2023). National Health Workforce Dataset. Retrieved August 12, 2023, from https://hwd.health.gov.au/nrmw-dashboards/index.html
21. Matthews, Robyn; Forster, Della; Hyde, Rebecca; McLachlan, Helen; Newton, Michelle; Mumford, Sharon; et al. (2023). FUCHSIA Future proofing the midwifery workforce in Victoria: A state-wide cross-sectional study exploring health, well-being and sustainability. La Trobe. Report. https://doi.org/10.26181/21729068.v1
22. Nursing and Midwifery Notification Data. (2019-2022). Information collected at an in person NMBA presentation.
23. Watkins V, Nagle C, Yates K, McAuliffe M, Brown L, Byrne M, Waters A. The role and scope of contemporary midwifery practice in Australia: A scoping review of the literature. Women Birth. 2023 Jul;36(4):334-340. doi: 10.1016/j.wombi.2022.12.001. Epub 2023 Jan 9. PMID: 36631386.
24. Australian Commission on Safety and Quality in Health Care. (2021). *Draft credentialing and defining scope of Clinical Practice: A guide for managers and clinicians.* Retrieved from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/draft-credentialing-and-defining-scope-clinical-practice-guide-managers-and-clinicians
25. Australian Government. Services Australia (2023). *Requested Medicare items processed from July 2020 to June 2023.* Retrieved from http://medicarestatistics.humanservices.gov.au/statistics/do.jsp?_PROGRAM=%2Fstatistics%2Fmbs_item_standard_report&DRILL=ag&group=82120&VAR=services&STAT=count&RPT_FMT=by+state&PTYPE=finyear&START_DT=201007&END_DT=202306
26. Australian Institute of Health and Welfare. (2016). *Maternity Care Classification System: Maternity Model of Care Data Set Specification national pilot report November 2014.* Retrieved from https://www.aihw.gov.au/reports/mothers-babies/maternity-care-classification-system-maternity-mo/summary
27. 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 18 October 2023.
28. Independent Hospital Pricing Authority. (2017). Bundled pricing for maternity care. Final Report of IHPA and the Bundled Pricing Advisory Group
29. Zibellini, J., Muscat, D.M., Kizirian, N., & Gordon, A. (2020). *Effect of health literacy interventions on pregnancy outcomes: A systematic review.* Retrieved from https://www.womenandbirth.org/article/S1871-5192(19)30854-6/pdf
30. Shikha D, Kushwaha P, Gokdemir O, Marzo RR and Bhattacharya S (2023) Editorial: Health literacy and disease prevention. Front. Public Health 11:1128257.doi: 10.3389/fpubh.2023.1128257
31. 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
32. Catling C, Rossiter C. Midwifery workplace culture in Australia: A national survey of midwives. Women Birth. 2020 Sep;33(5):464-472. doi: 10.1016/j.wombi.2019.09.008. Epub 2019 Oct 30. PMID: 31676324.
33. Bradfield Z, Hauck Y, Homer CSE, Sweet L, Wilson AN, Szabo RA, Wynter K, Vasilevski V, Kuliukas L. Midwives' experiences of providing maternity care during the COVID-19 pandemic in Australia. Women Birth. 2022 May;35(3):262-271. doi: 10.1016/j.wombi.2021.02.007. Epub 2021 Mar 15. PMID: 33752996; PMCID: PMC9051255.