Australian College of Midwives

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

Review of Primary Care After Hours Program and Policy

Issued April 2024

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 ***Review of Primary Care After Hours Program and Policy***. ACM represents the professional interests of midwives, supports the midwifery profession to enable midwives to work to full scope of practice, and is focused on ensuring better health outcomes for women, babies, and their families.

Background

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 midwives in Australia and 1,195 endorsed midwives[1]. ACM is committed to leadership and growth of the midwifery profession, through strengthening midwifery leadership and enhancing professional opportunities for midwives.

The Strengthening Medicare Taskforce Report 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 play in relation to improving universal access to reproductive healthcare in areas such as prescribing contraceptives, abortion services and additionally, maternal, child and family health.

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. 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 and women do not require a GP referral.

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. The Australian Government Woman-centred care *Strategic directions for Australian Maternity Services* 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.

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

Figure 1 – Continuity of Midwifery Care (CoMC)

ACM will respond to the consultation questions below:

Dimension 1: The extent to which the current after hours primary care service and funding system supports the provision of the right services, at the right time, in the right places, by the right providers

How effective are the current financial arrangements, including relevant MBS items and the After Hours Practice Incentive Payment, in supporting the provision of after hours primary care services? What changes to the current financial arrangements would better support practitioners to provide after hours services?

Babies are not cognizant of normal working day hours; they come when they are ready. Therefore, midwives have an important role to be considered by this review, and further to the Strengthening Medicare Taskforce report, in the provision of after-hours primary care midwifery services, whether working within a multidisciplinary team, such as in an Aboriginal Controlled Community Health Service (ACCHS) such as the Birthing On Country models or a GP practice, as an independent privately practicing midwife or working within a midwifery-led practice (for homebirth or with admitting rights to hospital).

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

The current funding system is not in the least effective for supporting women's choice of care and the financial viability of primary midwifery continuity of care which is shown to provide improved outcomes and better value care[2,3].

Changes to the existing financial arrangements should take into consideration the effectiveness of primary midwifery care and should enhance the accessibility and equity of claiming Medicare rebates, other incentives that are accessible to medical practitioners and other future developments in the after-hours funding space.

Currently the estimated MBS rebate for a typical birth across pregnancy, birth and postpartum 'caseload midwifery' is $3707.90 when a woman started antenatal care within the first trimester and completed postnatal care six weeks after birth[2]. The maximum recommended births per year for a caseload for a midwife is 30-40, thus if all 30-40 births are bulk-billed the annual pre-tax income of a private midwife is $111,237-$148.326. This is not sustainable when one takes into account insurances, rent, software, administration etc. It becomes clear that in comparison to other primary care professions, such as GPs who do have access to such incentives, financial arrangements for midwifery are found wanting.

ACM recommends that this review of future funding arrangements must incorporate midwifery as a core primary care profession, and that current barriers to this provision are removed. This will allow better support for the provision of after-hours services for women and families. Indeed for midwifery, after hours working is core business. ACM further notes that the NHRA Mid Term Report recommendation 13 for bundled funding for maternity care should take the 24 hour nature of midwifery care into account as the funding model is developed to incorporate the after-hours funding component.

How effective is the current after hours system in supporting the provision of multidisciplinary team based care to consumers in the after hours period? How could the system better support practitioners other than medical practitioners (e.g., nurses and nurse practitioners, allied health practitioners and Aboriginal and Torres Strait Islander health workers) to provide after hours services?

The current approach to funding after hours care is not effective. It disincentivises the multi-disciplinary team as it is focused on GP incentives. Currently midwives (and other non-medical professions such as nurse practitioners) are unable to claim any after-hours items through Medicare – unlike GPs. It inhibits engagement and deployment of true multidisciplinary health care teams, or for example a midwife-led practice, as only one provider or a cooperative led by a GP practice for example is incentivised. This gives a perception of a lower value attributable to all other health care provision in the after-hours period. Employers seeking health professionals for the after-hours period are severely limited by these disincentives.

Midwives, nurse practitioners and other non-medical professions must have equitable consideration to support them to work to full scope of practice in the after-hours environment. This is particularly acute in rural, regional, and remote Australia where there may not be a GP practice (or one with after-hours capability) available, and thus other non-medical professions who are in situ should be incentivised to provide after-hours care. The current funding model does not support this.

How does demand for services change across the after hours period, and how can the system support alignment between service availability and need?

Only 14% of women can access full midwifery group practice caseload care in Australia[3]. There are currently not enough MGPs in the public sector to meet consumer demand. With increased wait times in emergency departments, ambulance ramping, inability to access a GP in a timely manner, midwives do and are workforce ready to provide primary maternity care 24/7.

Dimension 2: The extent to which the after hour primary care system – and different models of after hours service delivery – meet the needs of consumers and the community

What are the specific needs of people living in rural and remote Australia, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, residents of aged care facilities and people receiving palliative care, people with disability and/or chronic illness, older people, children, and people in precarious or less flexible employment? How can these needs best be met?

The Strengthening Medicare Taskforce report states: '….universal health care, working hard to keep all Australians healthy and well in the community, and to deliver care that meets the needs of people and communities at all stages of life, no matter where they live.' The specific needs for individuals living in rural and remote, including First Nations and culturally and linguistically diverse backgrounds, women and children of women experiencing disability and chronic illness require improved access to healthcare services to compensate for geography and other barriers that reduce equity of access when compared to metropolitan areas.

All Australians have the right to access quality and 'universal healthcare'. These needs can be met by ensuring all health practitioners are enabled to work to full scope of practice. Place-based culturally safe and responsive multi-disciplinary care is the minimum standard, however where this is not possible, telehealth, translator and outreach services must be accessible as an alternate to care provision while long term barriers are prioritised and overcome.

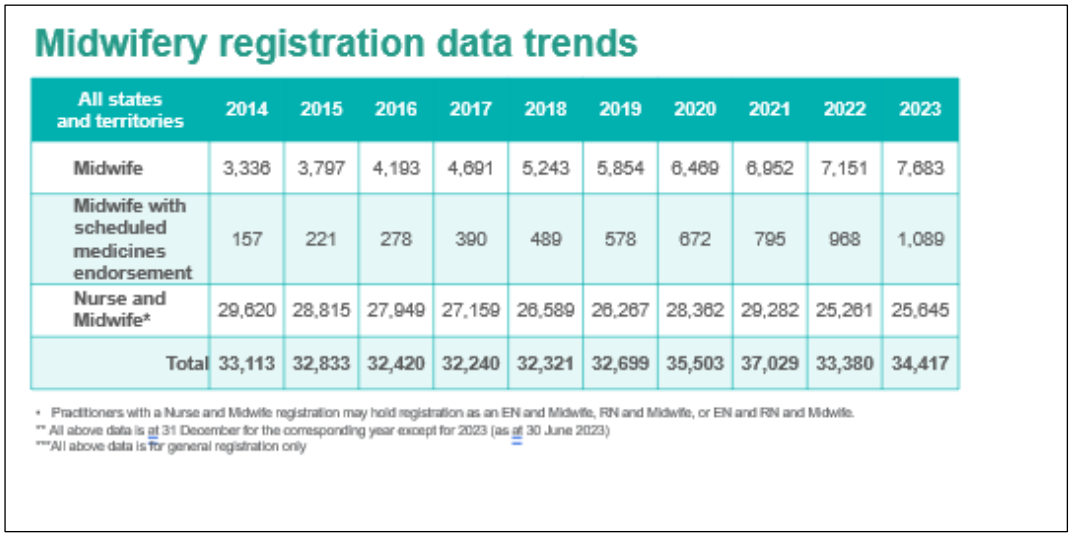
One midwifery example of increased accessibility in the rural and remote setting is the 'hub and spoke model'. Telehealth appointments are utilised within the caseload model of continuity of midwifery carer in the antenatal and postnatal period, with intrapartum care taking place in the hospital or where appropriate, the home. The caseload model of midwifery is a 24/7 model whereby the woman is allocated a primary midwife who partners with the woman throughout the childbearing period to provide essential maternity care, including referral for consultation if required , whilst maintaining the lead or primary maternity care role. This is well suited to rural and remote settings where there is very limited accessibility of care. A woman can contact her primary midwife at any time day or night, for example if she is concerned about bleeding, or contractions or postpartum if she has concerns re breastfeeding or mastitis etc. There is no after-hours incentive component for this model of care.

Culturally safe and responsive service delivery models, such as the Birthing in our Community (BiOC) models underpinned by Birthing on Country principles (and incorporating the RISE[4] framework) have shown significantly improved health outcomes for Aboriginal and Torres Strait Islander mothers, families and babies compared with standard services. This multi-disciplinary midwifery-led model provides a wrap-around service, including for example diabetes educators, for First Nations mothers and babies. There is no after-hours incentive component for this model of care, although it is 24/7.

What is the proper role within the system of different models of care, including telehealth and home visits? How can consumers be matched to the most appropriate services?

For midwifery, community-based care, telehealth and home visits are incorporated into the primary care midwifery model. The caseload model of midwifery continuity of care essentially enables the woman to call or request a home visit from her known midwife at a date and time that meets the individual woman, and family's needs. This can be any time over the 24-hour period, with after-hours usually reserved for emergent assessment, support, or intrapartum care. Many home visits are performed in the early evening and on weekends outside of traditional business hours to accommodate antenatal education and birth planning. This provides flexibility for women and their partners and does not disrupt their work hours, placing further financial impacts on women and families. Midwifery model of care, which regularly incorporates after hours services, is not currently recognized by any of the available funding systems.

The primary care landscape has changed. The After-Hours PIP guidelines came into effect in November 2016. Since then for example the number of endorsed midwives since 2016 (2016: 278, Dec 2023: 1,195) has increased fourfold and the trajectory is exponential.



Midwifery registration data trends

All states and territories	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Midwife	3,336	3,797	4,193	4,691	5,243	5,854	6,469	6,952	7,151	7,683
Midwife with scheduled medicines endorsement	157	221	278	390	489	578	672	795	968	1,089
Nurse and Midwife*	29,620	28,815	27,949	27,159	26,589	26,267	28,362	29,282	25,261	25,645
Total	33,113	32,833	32,420	32,240	32,321	32,699	35,503	37,029	33,380	34,417

* Practitioners with a Nurse and Midwife registration may hold registration as an EN and Midwife, RN and Midwife, or EN and RN and Midwife.
** All above data is at 31 December for the corresponding year except for 2023 (as at 30 June 2023)
***All above data is for general registration only

Figure 2: NMBA Data

Nurse practitioners have seen a similar increase by 46% since 2016 from 1477 (Dec 2016) to 2737 (Dec 2023).

The 'proper role within the system of different models of care, is for patients to have access to right services, at the right time, in the right places, by the right providers'. For pregnant women who have access to and choose primary midwifery care they should also have the right to equitable funding.

How can after hours services be made more accessible and easier for consumers to navigate? Would a 'single front door' or access point improve Australia's after hours system?

A simplified pathway for after-hours services to create access and equity for consumers using more coordinated resources is favourable, however it is important to consider that any 'single front door' model, or similar is not designed for an individual profession to control (i.e. the existing GP-led models, MyMedicare etc) as this will not provide sufficient access to the models described above. *Consumers should be able to access the 'right services by the right providers' when and where they seek and need it*. This may mean from a GP, but may also include non-medical professions both individually and as part of a multi-disciplinary team.

Health Literacy: building navigation tools for consumers.

Health literacy with regards to options for after-hours care require prioritisation. This was also a feature of the National Health Reform Agreement review[5] with regards to long term health reform. It is noted that to date progress has 'has lacked ambition, been constrained by lack of funding and resources and is not generating the system level improvements that the Addendum envisaged.' After Hours care information is an area where health literacy and care coordination would benefit consumers.

Another example is what options for care are available in the after-hours space. For maternity, midwifery-led continuity of care has not been prioritised for information transfer, despite it being the gold standard of care.

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.

In general, most accessible or hospitals public facing information indicates that women should go to their GP first for information. Health literacy for women needs to include information about Continuity of Midwifery Care with a known carer, the improved outcomes for women, and the benefits of normal birth.

Dimension 3: The experiences of primary care providers, and barriers and enablers to afterhours service provision

What are the factors which enable or obstruct practices and practitioners from providing after hours services – or from expanding the services they provide? Do those factors vary across service models (e.g., home visits, visits to registered aged care facilities, telehealth) and time of day? How do barriers and enablers vary across different practitioner types and different parts of Australia?

Barriers and enablers

For midwifery there are a number of factors which contribute to barriers and enablers to women accessing midwifery continuity of care, and thus after-hours services. These are clearly articulated in the Scope of Practice Submissions from October 2023 and Issues paper 2 in March 2024.

Below are some of the barriers relating to the review.

	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)

MyMedicare

Endorsed midwives do not require a GP referral to provide care to women. 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 which means a 24 hour service including after hours and in light of the NHRA recommendation for bundled maternity care, 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 an endorsed midwife unnecessarily via a GP. This is overservicing and an unnecessary cost to Government. There is no rationale for Midwife (and Nurse Practitioner) practices not to have direct access to MyMedicare (and thus enable futureproofing through bundled funding models as per above).

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. 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 are required for both mother and baby.

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 and family violence, and other 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.

Incentives

There are no incentives which provide funding for primary care midwifery, despite the 24 hour nature of midwifery continuity of care with a known midwife. Midwives do not have access to the Practice Incentive Program nor the Workforce Incentive Program as a primary care provider, despite the fact that midwifery-led practices are becoming more commonplace and improve access to care.

ACM recommends that midwifery is introduced to all existing and future incentive programs, to ensure that supports afforded to GPs, nurse and allied health in particular, are extended to midwives. These include, but are not limited to:

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

Insurance:

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

Midwifery continuity of care is evidence based best practice. The evidence shows that for best outcomes midwifery continuity of care includes intrapartum care. This model is practiced in multiple settings; however Birthing on Country is an example of this model. To maintain and grow evidence-based midwifery continuity of care practice including for BoC, an affordable midwifery insurance product, for both individuals and practices, is required. This includes removing the requirement to pay for three years run-off cover for midwives.

Provision of adequate insurance, including for home birth (which there is currently no insurance product for, it has an exemption under Health Insurance Act), is fundamental to ensuring endorsed midwives are able to work to full scope of practice, and expand the services they provide. A requirement is Government investment in an updated midwifery professional indemnity scheme which insures individual midwives and also practices appropriately, including through an additional subsidy, indemnity for practices through a high-cost claims scheme or equivalent and access to immediate run-off cover as soon as the midwife ceases practice in primary care.

What changes to after hours primary care policies and programs would be most effective in increasing after hours service provision?

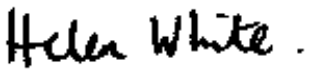
As per recommendation 14 of the NHRA, alterations to the funding model to ensure a payment that considers all elements of care provided i.e. a bundled or block funding model taking into consideration all primary care providers and not only medical clinicians will certainly assist access to after-hours care. Many professions are most needed outside hours – including mental health services, pregnancy and

perinatal care providers and nurse practitioners – the entry point to after-hours care needs to consider direct access for consumers to their chosen practitioner.

Conclusion

The role of the midwife working to full scope of practice in continuity of care 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. However currently there is no recognition of this 24/7 role of the midwife in the after hours incentives, indeed in almost all incentives. Midwifery is an autonomous profession which is undervalued and underutilised. ACM welcomes this consultation and is committed to ensuring that midwives can be recompensed appropriately to use their skills to provide women and families with the person-centred care that they have the right to expect and that they deserve.

ACM looks forward to ongoing engagement in this work.



Helen White

Chief Executive Officer

E: Helen.white@midwives.org.au

Alison Weatherstone

Chief Midwife

E: Alison.Weatherstone@midwives.org.au

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

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