MBS Review Advisory Committee
Telehealth Post-Implementation Review
ACM Submission

Issued November 2023

MRAC post implementation Telehealth 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 MRAC Review Advisory Committee Post Implementation Review of Telehealth Items. 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.

Midwives are primary maternity care providers working directly with women and families, in public and private health care settings across all geographical regions, including rural and remote. 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.

What is an 'Endorsed' Midwife? *(also known as Participating, Eligible, Independent, Authorised, 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[3]. 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***).

What is Continuity of Midwifery Care?

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*[4] 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. 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 scope 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**)[5,6,7] while also providing greater job satisfaction, through alignment with professional philosophy, increased autonomy and flexibility for midwives. Benefits realised by midwives working in CoMC models contribute to higher rates of professional wellbeing and workforce retention than observed in non-CoMC counterparts[8].

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)

Primary Maternity Care – Barriers and Enablers

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 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 Scope of Practice benefits the consumer, the health professional, and the employer; for this fulsome access to MBS telehealth items is required.

ACM notes there are already significant barriers to endorsed midwives working to full scope of practice in primary health, and asserts that key recommendations held within the *Telehealth Post-Implementation Review*, if implemented would create further barriers to midwives working to full scope of practice, over and above those indicated in the ACM submission to the Commonwealth Scope of Practice review.

MRAC Telehealth Post-Implementation Review ('Review')

Before responding to the specific recommendations ACM would like to provide comment on the following:

1. Consistency of approach with regards to non-GP practitioners

   ACM notes that references in the document to Nurse Practitioners and or Allied Health may have the intent of also referencing midwifery, but this is not explicitly stated throughout the document, thus ACM wishes to note that this may mean that we are not able to respond in all areas where relevant. Refer final 3 paragraphs of page 7 of the 'Review' e.g. including but not limited to: '*At present, the 12-month rule does not apply to nurse practitioners and allied health*' yet recommendation 8 specifically refers to midwives.

2. 12-month rule eligibility requirements

   Whilst ACM applauds MRAC's recognition of the importance of continuity of care (CoC) and wishes to align CoC to the 'Telehealth Principles' ACM notes that by its very definition - pregnancy (and MBS items thereof i.e. the antenatal, intrapartum and postnatal care to 6 weeks post birth) - does not extend to a 12 month period thus fundamentally the eligibility requirements are unable to be fulfilled.

   Telehealth services provided by midwives differ to those provided by other practitioners as the

care of the woman/patient is time limited across pregnancy and the post birth period which is cumulatively less than 12 months. This makes the "12 month" rule inappropriate for endorsed midwives as it is highly likely that they may not have seen the woman within the previous 12 months.

In a rural and remote setting, the endorsed midwife can be the first point of contact and able to order pathology and scans in early pregnancy to assist high value care and appropriate screening during early pregnancy via telehealth. Equally an endorsed midwife may provide postnatal telehealth services around breastfeeding and mental health services to women for whom they have provided no previous services within the last 12 months. Limiting provision of these services which are of low volume and, if following all other Telehealth principles, are not likely to disrupt relationships with other care providers, is unnecessary.

Furthermore, the requirement for midwifery to fulfill this criteria is not tenable as it creates the unintended consequence of precluding women and families from having the benefit of MBS telehealth items relating to midwife led-care. This would be particularly acute for women in rural and remote settings e.g. women on remote properties and First Nations women.

3. MyMedicare

Access to MyMedicare currently focuses on two aspects – the first is a GP practice accredited with RACGP and whilst access may be extended to Nurse Practitioners (potentially accredited via the Primary and Community Care Standards), there is no mention or inclusion of midwives. Additionally whilst a midwife will not be the primary care provider across the lifecycle, they may well be the primary care provider for the entirety of the perinatal period.

Access to MyMedicare therefore also fundamentally limits access of any non-GP practice to direct remuneration for example administrative workload as per recommendation 3. Midwives through the Continuity of Care model may manage complex patients in primary care. Pleasingly, it is the assertion of this Review that continuity of care might be improved by the introduction of MyMedicare:

'The MRAC noted that in relation to general practice, the introduction of MyMedicare has the potential to further improve continuity of care, and to replace and improve upon current arrangements through broader links to telehealth services.' Review Principle 3 P22.

However the limitation of access to MyMedicare means that the above statement does not currently hold true for non-GP practices, and in particular midwives, where evidence shows continuity of care provides fundamentally improved outcomes, particularly for the first 2,000 days including First Nations (Birthing on Country), rural and remote (telehealth combined service) and other priority populations:

Midwives (and other 'non-GP' services, including nurse practitioners) are not currently able to access appropriate accreditation, and therefore also precluded from providing best practice continuity of care with the recommended approaches.

ACM will comment on Recommendations 1, 3, 5, 8, 9 and 10 as they relate directly to midwifery practice and midwives' use, or opportunity for use of Telehealth.

Recommendation 1: Adopt the revised MBS Telehealth Principles.

ACM partly supports this recommendation with the following comments:

Principle 3: ACM supports the principle of continuity of care. The continuity a woman receives during pregnancy may be with an endorsed midwife or midwifery practice, or indeed a midwife within a GP practice for example. This provides continuity for the perinatal period only, noting that women may choose to return to the same provider/s for subsequent pregnancies, and pregnancy or reproductive related care. It is recognised that Principle 3 essentially refers to continuity across the lifecourse. It is important that endorsed midwives and the MBS telehealth items available to endorsed midwives are recognised as being generally currently limited to a 10-month period/s.

ACM further notes as per point 3 above, that endorsed midwives and practices thereof do not fulfill in general the criteria to apply for accreditation to be able to access MyMedicare. This GP-centric approach will limit access to evidence-based continuity of care in the midwifery context as endorsed midwives work autonomously without requirement of a referral from a GP for care provision. Restriction of access to telehealth items arbitrarily and unnecessarily defines access to care for patients and restricts scope of practice for care providers. Non-GP practitioners – in particular those currently accessing the MBS such as midwives, nurse practitioners need to be more broadly and actively considered as a priority by Government and committees thereof.

Recommendation 3: Consider how MyMedicare and other options could better remunerate clinicians directly for the additional administrative workload that is often associated with managing complex patients.

ACM supports Recommendation 3 only with the caveat that consideration of how midwives and other autonomous health practitioners such as nurse practitioners might be better remunerated for additional administrative workload who do not have access to MyMedicare and other funding options (as described in the review):

See general comment 3 above. The introduction of MyMedicare is currently limited to GP practices accredited with RACGP. Whilst ACM recognise the intention to extend MyMedicare access to Nurse Practitioners, there is no clear articulation of the inclusion of Endorsed Midwives. Endorsed midwives work in a variety of primary care models which may exist outside GP practices including midwifery-led practices, sole practitioner models and the public sector. At this point, midwifery practices, are generally not accredited and therefore will not be able to access funding benefits afforded by the introduction of MyMedicare.

MRAC should consider the wider context of primary care and consider funding streams related to administrative workload associated with managing complex care in relation to non-GP health practitioners, including midwives, nurse practitioners and allied health.

A key concern relating to Recommendation 3 is that the 'Other Options' as per the recommendation continue to exclude non-GP led models of care. Whilst this is not specific to Telehealth, it is important that the general funding principles applied to primary health being considered within the context of Telehealth, consider all existing providers of primary health care. In view of the NHRA Addendum funding review, bundled or blended funding payments are under consideration. This would work

effectively for maternity as per the 2017 IHPA review. However, if only accessible through MyMedicare and to GP practices as per bullet point 2 '*blended funding payments for general practices to support people with complex, chronic conditions who are frequent hospital users'* it would limit or rule out evidence-based continuity of midwifery care due to an inability to access the funding model.

Recommendation 5: Make temporary BBVSR MBS items with exemptions permanent, without any modifications to the referral process for BBVSR specialised care

ACM supports this recommendation with the caveat that it should further support the access to these MBS items where relevant with permanent exemption for midwives and nurse practitioners in the context of sexual and reproductive health.

ACM notes that in view of the very recent decision by PBAC to approve the prescribing of medical abortion being expanded to include endorsed midwives and nurse practitioners, that the BBVSR with permanent exemptions should be extended to midwives and nurse practitioners.

As per the commentary in the MRAC draft report, there is a requirement for the expansion of this service both due to people who may 'seek alternative providers to their regular GP', but also in rural and remote areas where there may be a thin market for a GP and the alternative provider may only be an endorsed midwife or nurse practitioner.

ACM further notes that the outcomes of the senate enquiry into universal access to reproductive healthcare have not been handed down as yet, but subject to these there may be further review with regards to expanding nurse practitioner and midwife access to MBS items such as these.

Recommendation 8: Extend eligibility requirements to nurse practitioner MBS and midwifery MBS telehealth items.

Recommendation 9: For initial consultations, make specialist MBS items available only face-to-face, with subsequent consultations available through telephone or video at the clinician's discretion.

The ACM does not support Recommendation 8 or 9: As explained above it is difficult to apply the eligibility or "12 month" rule to pregnancy care, in the current context of MBS items for midwives as the perinatal period is, in total, only around 10 months and midwives are unlikely to then see the woman again until the next pregnancy often a few years later. It is equally inappropriate to require that the MBS item is only available face-to-face for the initial consultation.

Midwives provide care to women from early pregnancy through the antenatal period and may provide intrapartum care and postnatal care but may be the first practitioner to provide pregnancy care. For many women this may be via telehealth to enable access to initial screening (pathology and radiology) to ensure all information is available as early in pregnancy as practical and often prior to a face to face "booking in" consultation. This is best practice to ensure the entire history of the woman and current results are available when the longer booking consultation takes place.

Endorsed midwives may also provide continuity of midwifery care over this entire period which is seen as best practice, or may provide care for one component of this period, such as postnatal care. It is also problematic for a woman to be required to have a face-to-face consultation prior to telehealth in

the early postnatal period where travel may be challenging. Limiting this care is likely to reduce access to breastfeeding and mental health support for example.

The care pathway for pregnancy is relatively predictable and claiming patterns for pregnancy and postnatal care that fall outside normal care are easily detected through audit and review. Requiring midwifery MBS telehealth items to comply with similar eligibility items to GP's is likely to unnecessarily prevent high value care for women in regional, rural and remote areas who may not have access to face-to-face care options. The number of claims related to telehealth for endorsed midwives is small and therefore anything that reduces access to these services is unwarranted.

Item	NSW	Vic	QLD	SA	WA	TAS	ACT	NT	Total
91211	1,210	728	1,059	67	721	2	35	5	3,827
91212	853	3,712	1,142	165	1,481	19	14	18	7,704
91214	610	522	818	33	566	22	59	0	2,630
91215	851	2,504	1,950	154	151	35	24	11	5,680
91218	4,002	7,039	8,935	8,223	22,551	239	138	98	51,345
91219	618	3,381	2,425	1,378	3,804	109	30	38	11,776
91221	2,750	2,871	4,380	2,420	10,172	821	353	45	23,812
91222	730	2,297	2,835	1,927	1,031	103	30	31	9,004

MBS TELEHEALTH ITEMS

Table 1: Midwife telehealth items

Service	Telehealth items via video-conference	Telephone items – for when video-conferencing is not available
Short antenatal attendance lasting up to 40 minutes	91211	91218
Long antenatal attendance lasting at least 40 minutes	91212	91219
Short postnatal attendance lasting up to 40 minutes	91214	91221
Long postnatal attendance lasting at least 40 minutes	91215	91222

Recommendation 10: Reintroduce GP patient-end support, and extend it to include nurse and allied health patient-end support for telehealth with a GP. If the MBS is not a suitable funding pathway for patient-end support services, explore other funding possibilities.

ACM only partially supports Recommendation 10.

Whilst the reintroduction of patient-end support is supported, ACM recommends this should not solely be GP patient-end support for people seeking GPs. Patient-end support and range should be extended to midwives, Aboriginal Health Practitioners, nurse practitioners, and other health professionals. There are a variety of situations where the patient-end support from Aboriginal Health Practitioners and nurses, particularly in rural and remote areas, is provided to endorsed midwives for example, and vice versa.

It is essential that these models are flexible enough to provide funding for patient centred care in the right place at the right time, to maximise their use and to ensure best practice.

ACM seeks consideration of the MBS items being expanded to include these possibilities or for consideration of the role of other health practitioners in patient-end support as a requirement if 'other funding possibilities' are explored. All health practitioners should have parity of funding access to such models. This recommendation limits patients' access to care, particularly in non-metro settings and thus creates disadvantage. Furthermore, it is a barrier for midwives and other practitioners to work to full scope of practice in such settings.

Summary

Whilst this post implementation review is welcomed by ACM and we support or partially support some of the recommendations, ACM does not support 8 and 9. ACM thanks MRAC for the opportunity to provide this submission, however notes that there was limited consultation with the midwifery community for this work and workshops were limited to 'general practice clinicians and managers and MBS claims data'. Clearly GPs are the primary provider of MBS telehealth with 6 out of every 7 services, however they are not the only provider. This approach has created an information gap, such as relating to the eligibility requirement for midwives, which is clearly highlighted in this document and ACM recommends a wider health practitioner lens on not only this review but also future reviews.

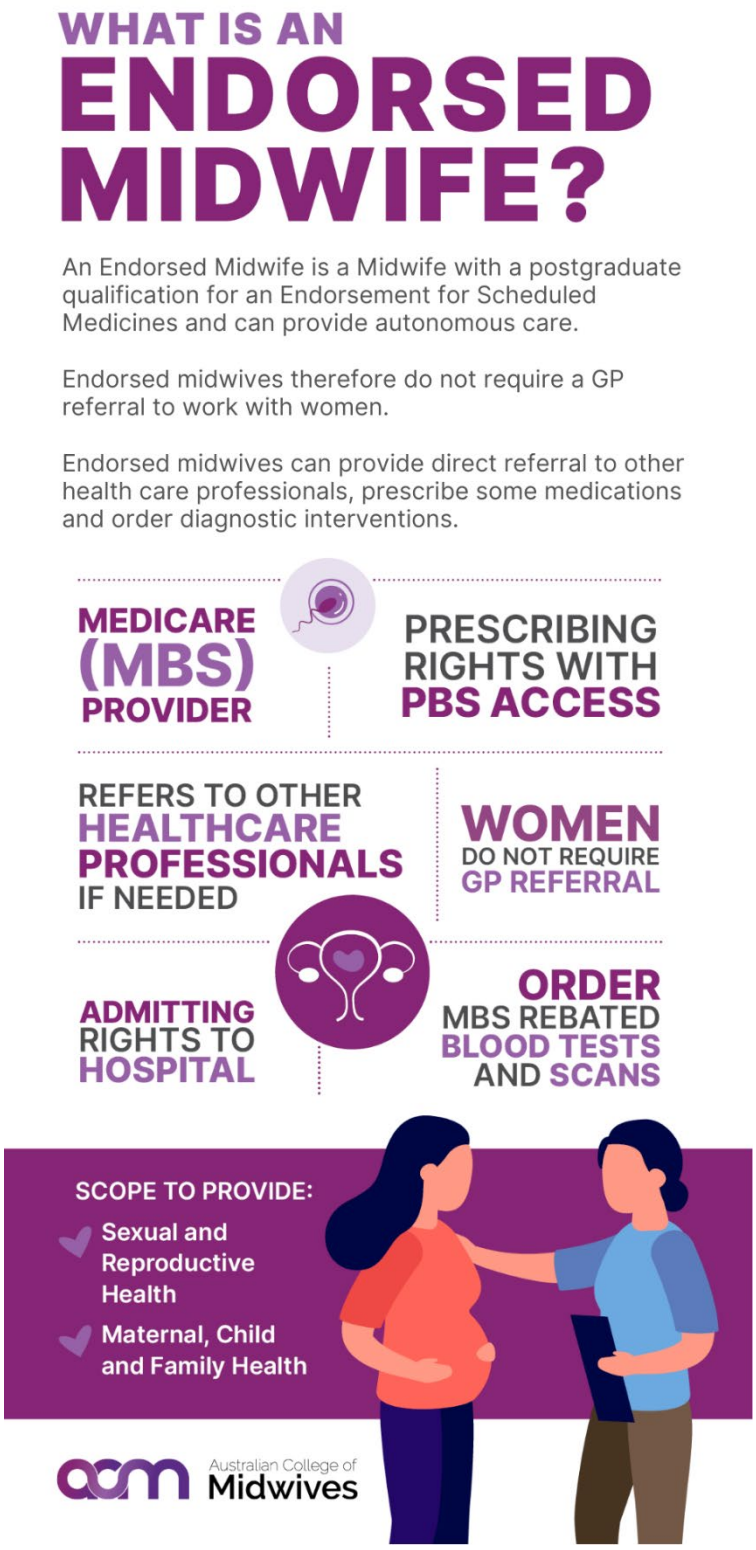
It is evident that the priorities of the Strengthening Medicare Taskforce including equity and access for patients, provision of patient-centred multi-disciplinary care, and to ensure all health practitioners might work to full scope of practice has not been actively considered within the bounds of this review. The limitations of funding access via MyMedicare for non-GP practitioners are also evident within this report. ACM is hopeful that the final report will take into consideration commentary provided and amend the report and its recommendations accordingly to allow midwives and other non-GP practitioners to be able to work to full scope in the context of all MBS funded services, including telehealth.

We are happy to provide further information, or consultation as required.

Helen White
CEO
Australian College of Midwives

Helen.white@midwives.org.au

Appendix A



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. 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.
4. 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
5. 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
6. 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
7. 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
8. 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.