Australian College of Midwives

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

Nurse Practitioner and Midwife PBS Prescribing Consultation Survey

ACM Submission

Issued March 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 written submission to ***this Consultation Survey.*** 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 25,000[1] midwives in Australia and 1,123 endorsed midwives[2]. ACM is committed to leadership and growth of the midwifery profession, through strengthening midwifery leadership and enhancing professional opportunities for midwives.

Terms of Reference

This submission will address question 41 of the 'Nurse practitioner and midwife PBS prescribing consultation survey'.

Background

The ACM welcomes the 'Nurse practitioner and midwife PBS prescribing consultation survey' and applauds this step towards improving PBS access for nurse practitioners and endorsed midwives.

The ACM met with the Department of Health and Aged Care in October 2023 to discuss endorsed midwife prescribing on the PBS, and a list of proposed medications for endorsed midwife prescribing was presented at that time, so a specific list of medications will not be included in this submission. This submission will address broader barriers to endorsed midwife prescribing. In preparing this submission, the ACM consulted with endorsed midwives from around Australia, and quotes and case studies provided by endorsed midwives are included in this submission to illustrate the challenges described.

Note: Endorsed midwives are also known as eligible midwives and authorised midwives.

The priority opportunities for ACM as per qu. 41 include;

1. Remove the clinical requirement of 5,000 hours for Endorsement for Scheduled Medicines and incorporate prescribing into undergraduate programs via ANMAC
2. Expand the PBS list for midwives as per ACM's previous recommendations and the results of the survey in progress
3. Remove jurisdictional barriers and enable all endorsed midwives to prescribe all medications within their scope of practice nationally
4. Include all sexual and reproductive health medications including contraception options in the PBS list for endorsed midwives
5. Include peri/menopause treatment options in the PBS list for endorsed midwives
6. Review PBS listing and identify other pathways including funding options for medications which are not currently PBS-listed and are essential for best practice maternity care
7. Enable all endorsed midwives working in public healthcare across Australia to prescribe medications and order Medicare-rebatable diagnostics, as per their endorsement, without the requirement for extra credentialling

8. Review Medicare rebates for maternity services and enact recommendations of the Medicare Benefits Schedule Review Taskforce Findings: Participating Midwives Reference Group Report and the Medicare Benefits Schedule Review Taskforce: Telehealth Recommendations 2020
9. Review and increase Medicare-rebatable diagnostic tests available to midwives
10. Include a Medicare item number for contraceptive services which can be claimed by an endorsed midwife
11. Include a Medicare item number for peri / menopause which can be claimed by an endorsed midwife

41. What other barriers exist that impact on your ability to prescribe scheduled medicines to your full scope of practice? (e.g., state/territory legislation, access to specific Medicare Benefits Schedule items)

Endorsement process

Since endorsement for midwives was introduced in 2010, uptake has been slow, which indicates there are challenges for midwives gaining and utilising this additional qualification[3]. The endorsement application process for midwives is time consuming and challenging[4]. There are multiple barriers to midwives gaining endorsement, including the requirement for 5,000 hours of recent clinical experience, which is prohibitive for midwives working part time, midwives who take maternity leave, and midwives working in rural and remote settings who work in hybrid jobs which include a proportion of general nursing work. The post-registration clinical practice hours are not based on evidence, and there are calls to include prescribing in pre-registration programs so that midwives graduate workforce-ready[5]. Removing this requirement would result in a significant increase in the number of endorsed midwives, and consequently increased access to high-quality primary maternity care for women.

Recommendations

- Remove the clinical requirement of 5,000 hours for Endorsement for Scheduled Medicines and incorporate prescribing into undergraduate programs via ANMAC

PBS list

The Pharmaceutical Benefits Scheme is overly restrictive in terms of medications endorsed midwives can prescribe. Endorsed midwives in Australia are regulated to prescribe to scope of maternity care and sexual and reproductive health. Despite this regulation to in-scope prescribing, there are only 20 medicines listed on the PBS for midwives to prescribe. This means that if a midwife prescribes a medication not eligible for subsidy when prescribed by a midwife, the woman must either pay the full cost of the medication, or seek a prescription from a doctor[4]. This is inefficient, causes delays in treatment, and doubles the cost to Medicare[4].

‘My client saw a public hospital doctor who recommended clexane postnatally for her specific situation, but this doctor wasn’t the woman’s primary carer and didn’t give her a script. I was happy to prescribe clexane for the woman, but as it’s not PBS-listed for endorsed midwives, it was going to cost the woman $100. So she went to the GP to get it on the PBS. She now had an out-of-pocket cost to see the GP, not mention all this running around when she’s just had a baby!’

It also increases expense for the woman if she decides to pay full price rather than have a second appointment, or if her medical appointment is not bulk billed. In some instances, evidence-based first-line treatments are not included in the list, but inferior options are[3]. Midwives sometimes prescribe based on the cost for the woman rather than on the most appropriate medication[4].

There is inequitable access to the PBS subsidy. Not all medicines relevant to the scope of an endorsed midwife attract a PBS subsidy, but this is not the case for like professions such as medical practitioners. A further example of inequity is the fact that some medications which are in scope for midwives, such as ondansetron, aciclovir and clexane, are PBS-listed for nurse practitioners, but not endorsed midwives. The restricted PBS list for endorsed midwives creates an equity issue for access to medication for women who choose care with an endorsed privately practising midwife. This inequitable access results in barriers to patient care, overservicing and underservicing, potential patient harm, and is limiting for midwifery scope of practice (SoP).

Enabling all endorsed midwives to prescribe all medications relevant to their scope of practice would:

- Reduce delays in treatment
- Remove the need for costly and inefficient additional consultations
- Increase midwives' ability to practice autonomously to full scope of practice
- Decrease costs of medications for women and babies
- Improve safety, as first-line treatments would be more readily available for emergent and non-emergent care

Case study

Konakion, which is recommended for all newborns to prevent vitamin K deficiency bleeding, is on the PBS for medical practitioners but not endorsed midwives. Privately practicing endorsed midwife Zoe* struggles to access Konakion, but is sometimes able to access it through public hospital pharmacies. One day, she goes to a hospital pharmacy she has accessed Konakion through before, but the pharmacist refuses to dispense it, because the woman and baby live in the ACT, whereas the hospital is in NSW.

*All names have been changed

Recommendations

- Expand the PBS list for midwives as per ACM's previous recommendations and the results of the survey in progress

Non-PBS listed treatments

There are multiple medications which are essential to the scope of practice of an endorsed midwife, but are not included in the PBS. Some examples are syntocinon, syntometrine, and tranexamic acid IV. These are all first- and second-line treatments for post-partum haemorrhage, so delays in access to these medications could be life-threatening. Currently, the only process to PBS list a medication is for a pharmaceutical company to apply for PBS listing. This leaves a significant shortfall in essential medications in midwifery practice, to the detriment of best practice and the safety of women under the care of privately practicing midwives.

Recommendations

- Review PBS listing and identify other pathways including funding options for medications which are not currently PBS-listed and are essential for best practice maternity care

Jurisdictional variations

Medicines and Poisons Acts differ between jurisdictions. Endorsed midwives in most states and territories in Australia can prescribe any drug required within their scope of practice, yet endorsed midwives in Victoria and Tasmania have a specific and narrow drug formulary which limits their ability to provide evidence-based, scope-fulfilled care[4]. These drug formularies are restrictive, reduce access to care, and are particularly challenging for midwives practicing across state borders[4]. It is noted that the Victorian formulary is currently under review.

Case study

Hannah* is a midwife in Melbourne who is attending Hazel, who has just birthed at home. Bleeding is heavier than expected, and Hannah is familiar with the Safer Care Victoria Guidelines for prevention-assessment-and-management of post-partum haemorrhage which recommend a step-wise plan for management of post-partum bleeding.

The first line management medications are quickly administered, and the second line management recommends the woman be given Tranexamic acid or CarboPROST.

Unfortunately, Hannah cannot prescribe either of these medications as she is in Victoria and these medications are not included on the gazetted formulary. An ambulance is called, and the woman is transferred to hospital for further management.

During the debrief after this incident, Hannah consults with her colleague in Brisbane who says she had a similar case and was able to prescribe Tranexamic acid under the Queensland guidelines and the woman was able to receive the appropriate treatment without delay. Bleeding was controlled quickly, and the woman was able to remain at home.

*All names have been changed

Recommendations

- Remove jurisdictional barriers and enable all endorsed midwives to prescribe all medications within their scope of practice nationally

Endorsed midwives in public healthcare

Endorsed Midwives working in public healthcare often cannot exercise their prescribing authority, which restricts medication access for women[4] and leads to workarounds such as blank pre-signed pathology forms[3]. Since 2017, South Australian endorsed midwives working in the public sector have been able to prescribe medications, however this is not widely implemented[3]. South Australian midwives are required to undertake a credentialling process which is different in each Local Health Network, and they are not able to order Medicare-rebatable diagnostics[6]. While this is a step forward for South Australian midwives, varied credentialling processes restrict midwives from working autonomously to their full SoP, and are inefficient. Other states. such as Western Australia for example, have introduced policy to enable

endorsed midwives employed within the public health system to utilise their prescribing authority and order diagnostic tests.

In order to fully harness the potential of endorsed midwives working in public healthcare, midwives must have the ability to order Medicare-rebatable diagnostics as well as prescribe the medications to treat diagnostic findings. Allowing one without the other is illogical and needlessly hampers midwives from providing their full scope of care for women and babies.

Some endorsed midwives working in public healthcare are able to utilise their endorsement at specific rural and remote sites as part of the COAG s19(2) Exemptions Initiative, which allows endorsed midwives to claim against the MBS for outpatient services. Limiting the ability of endorsed midwives to exercise their endorsement in public healthcare to certain locations or services (only MBS or only PBS) limits midwives' scope of practice and reduces access to care for women. These barriers also restrict the number of midwives who choose to go through the process to become endorsed, because they can see they will not be able to use the endorsement in their professional life if they put in the considerable time and effort to become endorsed.

'Working in the rural public system there are minimal doctors available, and women miss routine serology, screening, and ultrasounds, due to accessibility and cost. This would be eliminated if eligible midwives in our facilities could work to their full scope of practice. But NSW Health won't credential a midwife who is a permanent employee - so we literally can't do anything!'

Recommendations

- Enable all endorsed midwives working in public healthcare across Australia to prescribe medications and order Medicare-rebatable diagnostics, as per their endorsement, without the requirement for extra credentialling

Medicare rebates

Medicare rebates for appointments are inadequate, as found in the Medicare Benefits Schedule Review Taskforce Findings: Participating Midwives Reference Group Report and the Medicare Benefits Schedule Review Taskforce: Telehealth Recommendations 2020. There is also a lack of equity with medical practitioners. For instance, endorsed midwives cannot claim item 4001 – Non-directive Pregnancy Support Counselling Service. Medicare rebates are not sufficient to cover the cost of a midwife in private practice, especially in remote areas where the midwife may need to travel long distances for an appointment. This leads to the need to charge a gap fee, reducing the availability of affordable maternity care options for women[3]. Planned birth at home is safe for mothers and babies[7,8]. In rural and remote locations, planned home birth may be a safer option than travelling large distances while in labour or relocating prior to birth. Despite this, indemnity insurance and Medicare rebates are not available for planned homebirth, which means that this safe and evidence-based option is expensive and thus unavailable for a lot of women. In November 2023, the Australian Government supported the reintroduction of indemnity insurance for endorsed midwives attending a woman in labour at home prior to a planned hospital birth. While this is a positive step forward, the ACM calls on the Government to extend this support to planned birth at home, so that Australian women can have access to true choice of maternity care provider and place of birth.

It is essential that endorsed midwives also have access to MBS items for diagnostic tests (ultrasounds and pathology), so that they can prescribe the appropriate PBS medicines. The number of Medicare-rebatable diagnostic tests available to midwives is restrictive and not fit for purpose [3]. Diagnostic tests which attract a Medicare rebate when ordered by an endorsed midwife can be found here. There are 26 pathology tests and five imaging services included. Important common diagnostic tests during the perinatal period, which are within the necessary scope of practice of an endorsed midwife, are not included in this list, but could be ordered by a medical professional, for instance iron studies.

These Medicare issues impact on the ability of endorsed midwives to exercise their PBS prescribing rights in a number of ways:

- Less midwives choose to work in private practice
- Less women can afford to choose a Privately Practicing Midwife
- Midwives need to refer to medical providers to order diagnostic tests

Recommendations

- Review Medicare rebates for maternity services and enact recommendations of the Medicare Benefits Schedule Review Taskforce Findings: Participating Midwives Reference Group Report and the Medicare Benefits Schedule Review Taskforce: Telehealth Recommendations 2020
- Review and increase Medicare-rebatable diagnostic tests available to midwives

Reproductive health

PBS coverage is limited for endorsed midwives to provide contraception. Endorsed midwives can prescribe contraceptives listed on the PBS for midwives, however, the list is very restrictive and both intrauterine devices listed on the Pharmaceutical Benefits Scheme are not available for midwives to prescribe despite national regulation that supports prescribing and credentialing that enables procedural insertion. Levonorgestrel (Mirena) is PBS listed for nurse practitioners but not endorsed midwives. This limitation in PBS access for midwives needs to be addressed as it restricts accessibility to contraceptives for women in a trusted midwifery continuity of care (MCoC) setting. It is discriminatory as it necessitates private script pricing vs PBS pricing for women prescribed some contraceptives by a midwife. It can disrupt midwifery continuity of care due to the prohibitive cost of gaining a private script or the requirement to seek a script from an alternative health practitioner which contributes to unnecessary over servicing by a medical practitioner to bridge this access deficit. This also leads to a delay in care. It does not allow the midwifery workforce to work to full scope of practice, which limits sexual and reproductive health care for women, particularly in rural and

> 'I work in a Birthing in our Community service. I was recently caring for a First Nations woman who wished to get a Mirena for birth control postnatally. The client was connected to our service and felt comfortable attending. I could not prescribe the Mirena without incurring a cost of $168 that she could not afford. I recommended she attend the GP to receive the device at a reduced rate of $31. She did not attend the GP as she did not feel comfortable. Due to the contraceptive device not being included on the PBS for midwives, this client did not receive contraception.'

remote areas and those with known barriers to access such as Aboriginal and Torres Strait Islander people, migrant and refugee women, adolescent mothers etc. Midwives are the only profession in Australia that routinely assess and provide care for each of the 300,000 women a year that give birth in the nation. Preconception, postnatal and interconception care are key periods when individuals seek contraception. Midwives are well scoped to provide this care.

MS 2 Step (medical abortion) is now listed on the PBS for endorsed midwives to prescribe, with removal of the Commonwealth requirement for mandatory education. With the roll out of legislative changes nationally, there are jurisdictional moves towards implementing educational and other competency or credentialing requirements for prescribing of MS 2 Step. ACM cautions this process to ensure unnecessary over-regulation is not an unintended consequence as a result of the Commonwealth barrier being removed. This will inadvertently reduce accessibility of MS 2 Step for women.

Midwives' expertise in primary care means that they are often the first profession a woman has contact with once she is pregnant. Counselling and education regarding contraception that is not able to be provided at point of care is an opportunity cost for health optimisation, agency, and bodily autonomy. Broadening midwives' presence in primary care models through an expanded MBS preconception funding would improve midwives' ability to enhance individuals' awareness of contraceptive options and considered approaches to reproductive life planning as well as proactive screening and management of Sexually Transmissible Infections (STI) by integrating testing into existing health service delivery (as per Fourth National STI Strategy 2018-2022. Enhanced and equitable access to MBS funding is imperative to improve access. Midwives should be able to provide any individual seeking contraception with the education and the supply of a contraceptive agent within the one appointment. Adding barriers such as impeded PBS access, variable medication access, and reduced access to LARC, contributes to negative health outcomes.

Recommendations

- Include a Medicare item number for contraceptive services which can be claimed by an endorsed midwife
- Include all sexual and reproductive health medications including contraception options in the PBS list for endorsed midwives

Midwives and peri / menopause care

The State of the World's Midwifery 2021 report notes that midwives, when fully integrated and supported by multidisciplinary teams, can provide about 90% of sexual, reproductive, maternal, newborn, and adolescent healthcare across the life span. The National Women's Health Strategy 2020-2030 outlines the need to increase access to menopause services, especially in rural and remote areas. **Rural and remote** areas are under-serviced with healthcare, and the numbers of general practitioners (GPs) is inadequate to meet demand[9]. Women's health services in particular are lacking in some rural and remote locations[10]. There is an opportunity to increase the availability of healthcare services for peri/menopausal women across Australia, and especially in rural and remote locations, by educating midwives to provide this care, and expanding the PBS approved list for Endorsed Midwives to include treatments for perimenopause and menopause. Midwives are already experts at counselling women through challenging reproductive and hormonal life changes, so they are well placed to foster trusting relationship with women through the experience of perimenopause and menopause.

Recommendations

- Include a Medicare item number for peri / menopause which can be claimed by an endorsed midwife
- Include peri/menopause treatment options in the PBS list for endorsed midwives

Conclusion

The ACM welcomes this survey and the positive step towards improving PBS access for nurse practitioners and endorsed midwives. There are a number of important considerations in terms of wider barriers to efficient functioning of the PBS for endorsed midwives. These include a prohibitive endorsement process, restrictive PBS list, state-based formularies, essential medications which are not PBS-listed, insufficient Medicare rebates, and barriers to midwives utilising their endorsement in public healthcare. In addition, the PBS does not adequately support midwives to provide care in the areas of sexual and reproductive health or peri / menopause care, which are both areas midwives are well scoped to work in.

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Consent to publish

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

Consent to provide further information

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

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