2023-2024
PRE BUDGET SUBMISSION

Maximising Health Outcomes For Women, Babies and Families

Australian College of Midwives

Contents

Australian College of Midwives

Foreword

The Australian College of Midwives (ACM) welcomes the opportunity to provide our budget submission ahead of the 2023-2024 budget. ACM is the peak professional body representing midwives in Australia. ACM is focused on ensuring better outcomes for women, babies and their families, supporting the profession and enabling midwives to work to full scope of practice.

Midwives are the principal primary maternity care providers for women, babies and their families.[1] There are 32,788 midwives in Australia[2] as at September 2022, of whom 909 work as endorsed (or eligible) midwives directly with woman and have prescribing rights and access to Medicare. Midwives scope of practice not only encompasses the continuum of maternity care but also sexual and reproductive health. Midwives are best placed to deliver person-centred care in multiple settings, including hospital and community settings, in private practice or in multi-disciplinary team-based models of care.

Improved women's health outcomes cannot be achieved without a well-resourced, robust, sustainable and retained workforce. This is not currently the case, in recent research[3] of over 1,000 midwives in Victoria, 27% of midwives plan to leave the profession in the next five years, 73% feel burnt out due to work, and 75% of maternity services have staffing deficits. A national midwifery strategy and workforce reform is required to futureproof high quality care for women by proactively growing and retaining the midwifery workforce. A national midwifery strategy and workforce reform is a priority of this submission.

It is proven that midwifery continuity of care with a known midwife is the best practice model of care for women, their families and babies. It improves health outcomes for women (including mental health), reduces preterm birth and still birth, reduces medical intervention, and increases workforce retention. It is the best start to life. If provided in the primary care setting it has been shown that total cost of care is significantly less than for standard care. The removal of barriers to primary maternity care is a priority of this submission.

This budget submission is provided with the intent of supporting and enhancing the already agreed principle of midwives as primary maternity care providers and midwifery continuity of care as the best practice model of care for improved health outcomes for women and their babies at low cost.

ACM has three priorities to maximise health outcomes for women, babies and their families.

1. National Midwifery Strategy and Workforce Reform
2. Remove Barriers to Primary Care for Midwifery
3. Update National Midwifery Guidelines

Australian College of Midwives

ACM's three priorities

Priority 1: National Midwifery Strategy and Workforce Reform

1. Develop a National Midwifery Strategy to futureproof the workforce and maximise better health outcomes for women, their babies and families.
2. Increase funding for Commonwealth Supported Places (CSP) for both undergraduate and postgraduate midwifery studies.
3. Fund ACM administered scholarships for registered midwives to undertake accredited training, post-graduate education in prescribing, diagnostics (endorsement for scheduled medicines) as well as sexual and reproductive health, including preconception care.
4. Increase fee subsidies for midwifery students and fund clinical placement costs including meals, travel and accommodation costs.
5. Digital Health Access provision for the development of digital integration into My Health Record for midwifery workforce.

Priority 2: Remove Barriers to Primary Care for Midwifery

1. Adopt Medicare Benefits Schedule (MBS Funding) changes for midwifery, namely:
    a Implements the Medicare items already endorsed by the MBS Taskforce.
    b Expansion of Medicare item numbers for midwives, to provide care across the pre and interconception continuum encompassing primary sexual and reproductive health.
    c Future focus: Government funds review and consultation of approaches to a tiered funding model allowing for a bulk payment model for maternity continuity of care as an alternative to a direct fee for service model.
2. Alignment of PBS subsidy access for Endorsed Midwives with other medical practitioners to create equity of cost for women and their families.
3. Amend legislation to enable endorsed midwives access to prescribe medical abortion.
4. Removal of Collaborative Arrangements Legislation.
5. Expand Continuity of Midwifery Care (CoC) by a known midwife by expanding and funding multi-disciplinary care models, including Birthing on Country models and Primary Rural Integrated Medical Health Service or PRIM-HS (formally RACCHO) models nationally.

Priority 3: Update National Midwifery Guidelines

ACM recommends the Australian Government commit funding of $500,000 over two years to review and update the 'National Midwifery Guidelines for Consultation and Referral'.

ACM Recommendations

National Midwifery Strategy and Workforce Reform

Recommendation 1:

Develop a National Midwifery Strategy to futureproof the workforce and maximise better health outcomes for women, their babies and families.

Midwifery, much like nursing and nurse practitioners, has workforce sustainability challenges. Workforce retention[3] is a challenge with 27% of midwives planning to leave the profession in the next five years, 73% feel burnt out due to work, and 75% of maternity services having staffing deficits. Regional, rural and remote settings have even more acute recruitment and retention attrition issues. The midwifery workforce is best placed to be primary maternity care providers including sexual and reproductive health and child and family health in all contexts. To ensure future-focused best practice woman-centred care, a National Midwifery Strategy looking at workforce sustainability, diversity of the profession and the challenges of regional, rural and remote midwifery, in collaboration with state and territory governments, is required. The omission of a national midwifery strategy in the Primary Health Care 10 Year Plan[4] risks the health and wellbeing of women, babies and their families.

ACM recommends the Government fund the development and implementation of a National Midwifery Strategy.

Recommendation 2:

Increase funding for Commonwealth Supported Places (CSP) for both undergraduate and postgraduate midwifery education.

Midwifery has workforce sustainability challenges. In this context ACM recommends that the Government funds increased places for both undergraduate and postgraduate midwifery education, including endorsement for scheduled medicines.

The endorsement for scheduled medicines course is oversubscribed (and there are no placement requirements for this course) and with limited places. This unnecessarily restricts the number of midwives able to work to full scope in the primary health care setting; increased funding for this course would in turn expand the opportunity for midwives to work in the primary health setting, including in multidisciplinary care models.

ACM recommends that the Government increase funding for Commonwealth Supported Places to proactively address workforce sustainability.

Recommendation 3:

Fund ACM administered scholarships for registered midwives to undertake accredited training, post-graduate/Masters education in prescribing, diagnostics (endorsement for scheduled medicines) as well as sexual and reproductive health, including preconception care.

ACM seeks funding for ACM administered scholarships for registered midwives to undertake accredited training, post-graduate/Masters education in prescribing, diagnostics and sexual and reproductive health, including preconception and interconception care to scale and skill up midwives and allow improved health outcomes for women, families and their babies nationally and particularly in rural and remote and indigenous settings.

Endorsed Midwives are best placed to provide midwifery continuity care, diagnostic and sexual and reproductive care in the primary health setting. The number of endorsed midwives has doubled in the last four years to 909 and is estimated to be at 2,000 by 2024. This workforce is critical to improving outcomes for women, retaining the midwifery workforce and providing care in rural, regional and ACCHO settings. In the Primary Health Care 10 Year Plan[4] the following is indicated: "*Support more GP training places and enhanced GP, nursing and midwifery, nurse practitioner, allied health and Aboriginal and Torres Strait Islander GP and health practitioner training, particularly in rural Australia*". This recommendation will enable midwives to work to their full scope of practice.

ACM seeks funding for postgraduate education scholarships education in prescribing, diagnostics (endorsement for scheduled medicines) as well as sexual and reproductive health, including preconception care.

Recommendation 4:

Increase fee subsidies for midwifery students and fund clinical placement costs including meals, travel and accommodation costs.

Fee subsidies: To ensure ongoing growth of the midwifery workforce, it is critical that barriers to study, including costs, are alleviated. Fee subsidies for midwifery have been largely absent in any of the primary health care initiatives to improve midwifery workforce recruitment and retention, as well as working to full scope to date. These gaps include but are not limited to:

- HELP debt removal for GPs and Nurse Practitioners and funding for NP Masters degrees.[5]
- Workforce Incentive Programs – Midwifery not listed.[6]

ACM recommends that HECS/HELP fees are subsidised and also ACM recommends that midwifery is included within the WIP system and the next iteration of the HELP debt removal pilot.

Clinical placements: Students of midwifery must complete mandatory clinical placement hours in order to fulfil the requirements of their courses. These clinical placements are critical components of midwifery education which mean, however, that students are frequently unable to work in paid employment while completing their placements. Many midwifery students need to work to support themselves through their education, the negative cost impact can act as a disincentive to completing their midwifery studies.

ACM seeks increased HECS/HELP fee subsidies for midwifery students and also funding for midwifery students clinical placement costs including meals, travel and accommodation costs.

Recommendation 5:

Digital Health Access - Provision for the development of digital integration into My Health Record for midwifery workforce.

The development and growth of digital health, including My Health Record, has now 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[4], 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 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. This is clarified in the Primary Health Care 10 Year Plan also: '*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 the development of compliant software for secure messaging and other applications.

ACM recommends that the Government include midwifery in the current change process and invest in digital health integration for midwifery.

Remove Barriers to Primary Care for Midwifery

Recommendation 1:
Adoption of Medicare Benefits Schedule (MBS Funding) changes for midwifery, namely:

a. **Implement the Medicare items already endorsed by the MBS Taskforce.**

b. **Expansion of Medicare item numbers for midwives, to provide care across the pre and interconception continuum encompassing primary sexual and reproductive health.**

c. **Future focus: Government funds review and consultation of approaches to a tiered funding model allowing for a bulk payment model for maternity continuity of care as an alternative to a direct fee for service model.**

1 (a) - Government implements the Medicare items already endorsed by the MBS Taskforce.

The Australian College of Midwives recommends that Government implements and funds MBS changes endorsed by the Taskforce that have not as yet been introduced by Government:

MBS Taskforce endorsed outcome 1 – Include a minimum duration for initial antenatal attendances and align the schedule fee with average attendance duration (90 minute) i.e. Increase time tier for item 82100 (booking visit) to a 90 minute minimum to enable screening for mental health and domestic violence as part of the health history

MBS Taskforce endorsed outcome 3 – Introduce a new item for a complex antenatal attendance leading to a hospital admission i.e. an extended visit of over 3 hours for complex care (leading to presentation/admission to hospital)

MBS Taskforce endorsed outcome 10 – Include mandatory clinical activities and increase the minimum time for a six-week postnatal attendance i.e. for item no. 82140 to a 90 minutes minimum as final postnatal visit to allow for birth debrief and mental health assessment

Further consideration for recommendations 2 and 9 by the Participating Midwife Reference Group, with consultation required.

1 (b) – Expansion of Medicare item numbers for midwives, to provide care across the pre and interconception continuum encompassing primary sexual and reproductive health.

The recent UNFPA State of the World's Midwifery Report indicates that midwives are able to provide 90% of the world's sexual and reproductive healthcare (SRH) needs. The ICM definition of midwifery scope scaffolds the scope of midwives' practice in Australia [1], it asserts: *The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood … women's health, abortion, sexual or reproductive health and childcare. A midwife may practise in any setting including the home, community, hospitals, clinics or health units*'.

Women are increasingly seeking continuity of midwifery care. This trusted relationship with their midwife makes midwives best placed to provide wraparound care including pre and interconception care, SRH, education and women's health care. However, midwifery's current limited access to existing Medicare items creates a barrier for women's access to this care as there is currently no Medicare rebate for preconception counselling, pap smears, contraception, including LARC, and sexual health services for midwifery except during pregnancy or in the six weeks after birth.

Pre-existing health practitioner workforce shortages, combined with midwives' expertise in this space, mean that Government must prioritise the enabling of this existing workforce to work to full scope of practice within the sexual and reproductive health space by funding specific Medicare items for preconception counselling, contraception access including LARC and medical abortions. Maximising women's options for care particularly for rural, regional and Aboriginal Community Controlled Health Organisation (ACCHO) settings is paramount.

1 (c) – Future focus: Government funds review and consultation of approaches to a tiered funding model allowing for a bulk/bundle payment model for maternity continuity of care as an alternative to a direct fee for service model.

Bulk funding as an alternative mechanism which funds the full episode of care including pregnancy, birth and postnatal care through a bulk/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.

Note this approach would not require new funding but would require a reallocation of existing funding as the number of pregnancies does not change significantly year to year.

ACM recommends the adoption of the recommended MBS funding changes for midwifery in 2023/2024.

Recommendation 2:

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

There is inequitable access to the PBS subsidy as not all medicines prescribed by an Endorsed Midwife attract a PBS subsidy currently. 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 some 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 and potential harm.

ACM recommends that the Government amend legislation to allow PBS subsidy access for endorsed midwives to align with medical practitioners to allow equity of cost for women and their families.

Recommendation 3:
Amend legislation to enable Endorsed Midwives access to prescribe Medical Abortion.

Early medical abortion is a safe, cost effective and acceptable alternative to surgical abortion.[8] In Australia 25% of pregnancies are unplanned, of which one third end in abortion.[9] The low number of health practitioners able to provide long-acting reversible contraception and medical abortions in Australia is a major barrier to women accessing timely and safe contraception and abortion care. The number and distribution of medical abortions could be increased by task-sharing contraception and medical abortion provision in the primary care setting with appropriately credentialed endorsed midwives as is done in many countries such as Sweden.

These measures will improve outcomes for women by increasing access to medical abortion throughout Australia and particularly in regional, rural and remote areas and in the Aboriginal Community Controlled Health Organisation (ACCHO) setting. Utilising the equipped and scoped midwifery workforce to address the nation's 'abortion deserts' is a key finding of a recent Australian study.[10] Midwives are well placed to provide reproductive care for women through the continuum of care. ACM recommends regulation reform to enable endorsed midwives to prescribe medical abortion.

ACM recommends that Government amends legislation to enable Endorsed Midwives access to prescribe Medical Abortion.

Recommendation 4:
Removal of Collaborative Arrangements (CA) for Midwives.

Current legislation mandates that privately practising midwives (PPMs) enter into a CA with a medical professional or health service. This has created a barrier for midwives to work to their full scope of practice and a barrier to women accessing Medicare rebates, as well as increased fragmentation of care. Reciprocally, there is no legislative requirement for health services or medical professionals to collaborate with PPMs.

By removing this legislation, namely the National Health (Collaborative Arrangements for Midwives) Determination 2010, the Health Insurance Amendment Regulations 2010 [No. 1] and associated MBS item descriptors, the Government will improve choice and outcomes for women, increase workforce retention, and reduce cost and pressure on and within the hospital system.

ACM recommends that Government remove the legislated collaborative arrangements for midwives.

Recommendation 5:

Expand Continuity of Midwifery Care (CoC) by a Known Midwife by expanding and funding Birthing on Country models nationally and by funding Rural CoC models i.e. Primary Rural Integrated Medical Health Service or PRIM-HS (formally RACCHO) models nationally.

As identified in the COAG 'Woman-centred care: Strategic Directions for Australian Maternity Services' [11] strategic direction 12, improved access to the midwifery Continuity of Care (CoC) model is identified as the best practice model for improved choice and outcomes for women, babies and their families, despite acknowledgement that 'current funding models are seen as supporting a more fragmented approach to care'. In the Primary Health Care 10-year plan 2022-2032 this is further confirmed: '*Reinforce and support best practice models of midwifery-led care (including continuity of care) for the multidisciplinary team in primary care and maternity services*'.

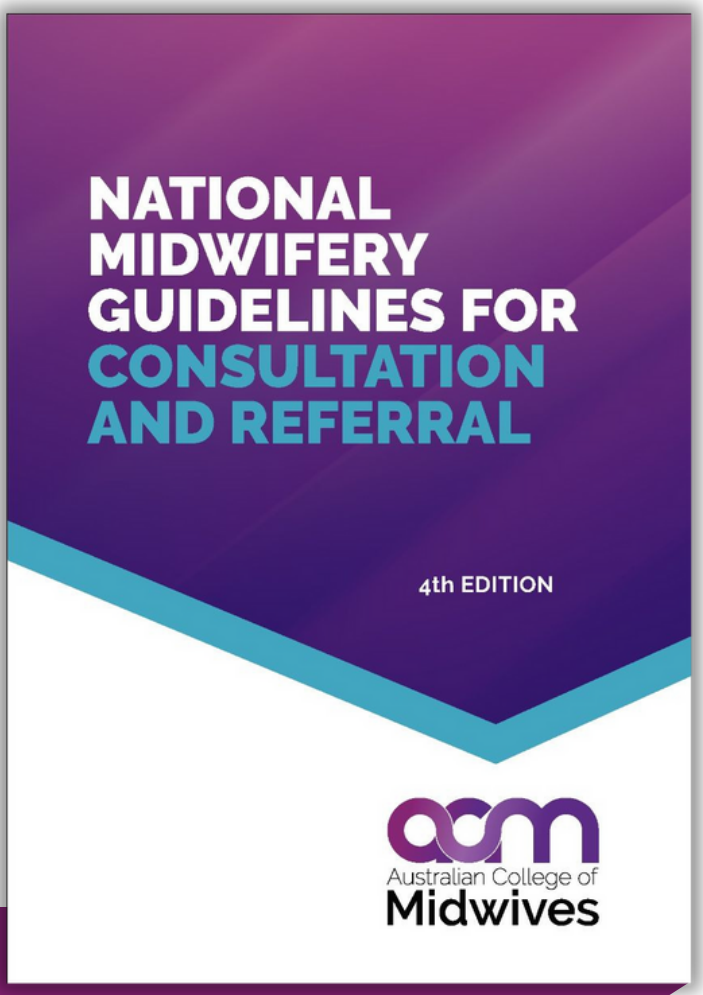
Nationally only 15% of women have a known primary midwife throughout the childbearing continuum. Multiple randomised control trials of over 17,000 women demonstrated that midwifery continuity of care saves lives and produces healthier woman and babies. Importantly research shows that it reduces preterm birth in the general population by 24%, and by 50% in Aboriginal and Torres Strait Islander babies. It reduces pregnancy loss/neonatal death by 16%, increases workforce retention by supporting midwives to work to their full scope and reduces cost by at least 20% compared with standard public fragmented care. These important outcomes for women and babies can be achieved through the expansion of CoC models nationally and by reducing structural barriers for CoC to operate in the primary care space, simplifying access to homebirth and community birth centres e.g. Waminda, and funding the expansion of birthing on country models and PRIM-HS models nationally.

ACM recommends funding for the expansion of and access to Midwifery Continuity of Care models, and in remote, rural and regional areas in particular.

Update the National Midwifery Guidelines for Consultation and Referral

Recommendation:

ACM recommends the Australian Government commit funding to ACM of $500,000 over two years to review and update the current edition 'National Midwifery Guidelines for Consultation and Referral'.



These Guidelines, developed by ACM are essential for guiding clinical midwifery care and are applicable to all health practitioners across all contexts. They are embedded in policy for jurisdictional departments e.g. NSW Health, NT Health; in national safety and quality guidelines for privately practising midwives, and form the basis for models of clinical service provision around Australia. The Guidelines were last updated in 2020 and require review, consultation and a 5th edition developed to remain current.

ACM seeks federal Government Funding of $500,000 over two years to undertake this work.

Australian College of Midwives

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ACM looks forward to working in partnership with Government, and the Department of Health and Aged Care in particular, to ensure a healthy future for all women, babies and their families.

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