Professor Bruce Robinson
Medicare Review Taskforce
RE: Participating Midwives Reference Group Report

7 June 2019

Thank you for the opportunity to provide comment and feedback on the draft Participating Midwives Reference Group (PMRG) report. Overall, the Australian College of Midwives (ACM) was pleased with majority of the report and commend the hard the work of the PMRG. We did notice a few omissions which we have addressed in our submission below. We have included our feedback in a table for ease of reading.

	Recommendation		ACM Response
Antenatal	1	Include a minimum time for initial antenatal attendance and align the schedule fee with average attendance duration.	Supportive.
	2	Amend the antenatal attendance items to appropriately reflect the time they take and introduce a new time tier for long antenatal attendances.	Supportive.
	3	Create a new item for complex antenatal attendance leading to a hospital admission.	Supportive.
	4	Restrict claiming of maternity care plans to instances where a woman has had at least two prior antenatal attendances	Unsure. ACM understands the reasoning behind this recommendation. We do however worry about unforeseen consequences, such as situations where women transfer care provider late in pregnancy

			or for women who attend very few antenatal visits. This could also have unforeseen consequences for rural and remote services.
Intrapartum	5	Change the time-tiering structure of intrapartum items to facilitate safe birthing and an earlier handover to a second midwife, if necessary.	Supportive. Language in item descriptions could be more woman-centred (e.g. birth where attended instead of birth where performed). Midwives do not perform births, they attend them.
	6	Increate per-minute rebates for intrapartum items.	Supportive.
	7	Enable intrapartum items to be claimed from the commencement of midwifery attendance with the woman for labour care (i.e. outside of hospital).	Supportive.
	8	Include homebirth in intrapartum items for women with low risk pregnancies.	Do not support. ACM supports Medicare rebates for midwives providing care in the environment chosen by the woman, be it in hospital, in a birth centre or in the home. However, it is highly problematic to use the ACM *National Midwifery Guidelines for Consultation and Referral* to determine who is eligible to access homebirth Medicare rebates and who is not. The aim of the guidelines is to provide an evidence-based, structured, decision-making framework for midwives caring from women from conception up to 6 weeks postnatal. It is not a tool to determine appropriate place of birth, nor should it be used to restrict access to Medicare rebates. While it is ideal that all women planning a homebirth are “low risk”, decisions around place of birth are made by a woman and her midwife/midwives based on local

			policies, individual risk factors, as well as the woman's own perception of safety and risk. It could confer unforeseen consequences to deny women access to rebates based on a risk category, which is not in itself meant to guide midwives or women about place of birth. We suggest this be changed to **"Include homebirth in intrapartum items."**
Postnatal	9	Amend the postnatal attendance items to appropriately reflect the time they take and introduce a new time tier for long postnatal attendances.	Supportive.
	10	Include mandatory clinical components and increase the minimum time for a six-week postnatal attendance. Amending the item 82140 descriptor to introduce a minimum duration of 60 minutes, and to include a birth debrief and mental health screening, as follows (changes in bold): **Item 82140** Postnatal professional attendance by a participating midwife with a woman not less than 6 weeks but not more than 7 weeks after birth of a baby**, lasting at least 60 minutes, and including:** **a) a labour and birth debrief, and** **b) mental health screening.**	Supportive.

Telehealth	11	Include general practitioners (GPs) as eligible specialists for existing telehealth items. Amending the item descriptors (items 82151 and 82152) to include GPs in the list of doctors who can participate in the video consultation, as follows (changes in bold): **Item 82151** A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics, obstetrics **or general practice**. and **Item 82152** A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient participating in a video consultation with a specialist / consultant in paediatrics or obstetrics **or general practice**.	Supportive.
	12	Facilitate telehealth consultations between women and midwives in the antenatal and postnatal period.	Supportive.

Missing Key Recommendations

The removal of mandatory collaborative agreements to access Medicare rebates.

Mandatory collaborative agreements have and remain a significant barrier for midwives in private practice and in women accessing Medicare Rebates. This has been included in the Nurse Practitioner's Report (Key Recommendation 8) "The Reference Group recommends removing the mandated requirement for NPs to form collaborative arrangements, in accordance with the *National Health (Collaborative arrangements for NPs) Determination 10*". ACM strongly recommends the inclusion of this recommendation in the report from the Midwifery Reference Group. The evidence outlined in the NP Report applies to the context privately practising midwives as well. Please see the suggested wording for the rationale below, as interpreted from the NP report.

Collaborative arrangements have become an impediment to growth of the endorsed midwife's role in improving access to quality care for all Australians. This was a key finding of the National Health and Hospitals Reform Commission. Midwives have also reported that collaborative arrangements work against true collaboration

Some of the reasons for this are:

- Collaborative arrangements can be difficult to develop, particularly in rural and remote areas. The availability and accessibility of medical practitioners with whom a midwife can establish the mandated collaborative arrangement—when this is the selected form of collaboration—remains a challenge in some rural and remote locations, reducing patient access to midwifery care. In addition, difficulty recruiting a medical practitioner to collaborate with (when that is the selected mechanism) and resistance to midwifery referrals has been reported. In metropolitan areas midwives report difficulty accessing collaborative agreements due to unwillingness from medical practitioners.
- Requiring a midwife to establish a collaborative agreement makes them dependent on the willingness and availability of medical practitioners to participate (when this is the selected form of arrangement), but there is no requirement for medical practitioners to do so.
- Collaborative arrangements can affect perceptions of the autonomy of midwives as legitimate health care providers.
- The original reasons behind establishing collaborative arrangements, such as avoiding •fragmented care (29) (30), do not justify the continued requirement for these arrangements.
- Collaborative arrangements for midwives were introduced in 2010 via the *National Health (Collaborative arrangements for NPs) Determination 2010*, as a prerequisite to a midwife providing health care services subsidised by the MBS. This was a ministerial determination made at the time of the legislative amendments to allow women access to rebates through the MBS for midwifery

services. Neither the presence nor the effectiveness of collaborative arrangements has been monitored by the Department or the DHS since implementation of the determination in 2010.

- We know from the audit of all homebirth midwives in 2017 that midwives effectively collaborate without formal agreements. Collaboration is already required formally within the standards of practice.
- Collaboration is ingrained in midwifery philosophy and is represented in the NMBA standards for practice. To meet the standards of practice (against which midwives are audited) collaborative practice must occur. A separate mandated collaborative arrangement is not required.
- There is no evidence to suggest that collaborative arrangements increase collaboration between midwives and medical practitioners.
- Collaborative arrangements are not required in comparable countries. For example, mandated collaborative arrangements are not required for midwives practising in New Zealand.
- Medical practitioners do not face increased liability by working with midwives in the absence of collaborative arrangements. Conversely, collaborative arrangements may expose medical practitioners to increased liability.

Nurses and midwives are the only health professionals required by law to establish an arrangement with a medical officer in order to participate in the MBS.

Thank you once again for the opportunity to provide feedback on this draft. We look forward to reading the final report.

Sincerely,

Hilary Rorison, Midwifery Advisor for the Australian College of Midwives