Australian College of Midwives Submission:

Mid-Term Review of the NHRA Addendum 2020-2025

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Overview

The Australian College of Midwives (ACM) is the peak body for midwives in Australia and we welcome the opportunity to provide this submission to the mid-term review of the National Health Reform Agreement (NHRA) Addendum 2020-2025.

The 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 care providers working directly with woman, in public and private health care settings across all geographical regions (metropolitan, regional, rural and remote – Modified Monash (MM) 1-7). There are over 34,000 midwives in Australia of whom 1,028 are endorsed to prescribe scheduled medicines (NMBA, March 2023).

Maternity Care: A Case Study for Addendum

This submission will focus on maternity care as an example of where the Addendum is, and is not, meeting stated objectives. These objectives relate to improving health outcomes, access, equity and innovation and also the submission will consider whether the Addendum's architecture is fit for purpose in view of the emerging priorities for integrated person-centered care.

Maternity care is an excellent and important example to consider for demonstrating the requirements of this Review. For example, maternity care is one of the leading causes of hospital admission (Independent Hospital Pricing Authority (IHPA), 2017) and is thus a key driver of public hospital costs. IHPA (now Independent Health and Aged Care Pricing Authority, IHPACA) outlines that in the 2014/2015 financial year the cost to Government of maternity care was $1.51 billion, with 76% of this figure being related to inpatient care for birth. Maternity care is a predictable care pathway which, in Australia, almost universally leads to a hospital admission for birth care. The funding is therefore both relatively predictable with around 300,000 births annually and reflects a comparatively fixed cost. The maternity care sector encompasses both primary and secondary (acute or urgent) care. It is fundamentally multi-disciplinary. This makes the current funding model ineffective and thus maternity is a good case study for where change and innovation need to occur. Integration of primary and secondary care is not just desirable, but necessary.

We also know that maternity care is under significant pressure – Australia is not performing well in terms of equity and access to maternity care, not is the maternity workforce utilised wisely. Maternity care for women in rural and remote areas, in particular, is limited and in places non-existent. There is a fundamental inequity in outcomes for women living rurally and First Nations women and babies with rates of intervention leading to long term negative health outcomes increasing.

Maternity Care Funding

Maternity care funding is fragmented, spanning the MBS (for primary care by general practitioners (GPs) and general practitioner with obstetrics (GPO's), endorsed midwives and specialist obstetricians), public hospital funding and private health. This means that the overarching funding model is inefficient, costly and non-integrated. A key driver for the need to reform funding is the lack of funding integration between primary care and the acute care sectors. Approaches to this will be discussed in this submission as there is an urgent need for change given current models of funding have a negative impact on women having choice and access to best practice and timely care; in particular barriers to midwifery continuity of care (MCoC) by a known midwife - established as best practice in the Woman-Centred Care, Strategic directions for Australian Maternity Services (2019). Importantly the current models do not allow health professionals to work to full scope, are more costly and outcomes are poorer.

Furthermore, in the existing model, all funding for maternity is deemed to be 'acute care' within the IHPACA. However, this is incongruous as the majority of women who birth in each setting do not fit this descriptor given pregnancy and birth is a normal physiological process and most women are healthy.

Continuity of Midwifery Care as best practice: the evidence

Evidence shows that primary midwifery care is the 'Best Start to Life' which improves health outcomes through the life course. Current systems and funding design are a barrier to a woman's choice of care and thus the downstream effect is longer-term health implications (including ongoing health issues for babies born prematurely through to the long-term impact of perinatal mental health) for Australians and increased cost to Government.

Continuity of midwifery care involves a known midwife providing care across the childbearing continuum. The woman will mostly access to both the primary care and secondary care sectors. Her care will require integrating with the multidisciplinary team and the woman's care will move from primary to secondary care and back again. Research demonstrates significantly improved health outcomes for women within continuity of midwifery care models:

- Preterm birth is reduced by 24% (Sandall, et al., 2016) and by 50% in Aboriginal and Torres Strait Islander babies (Kildea, et al., 2021).
- Reduction in both small for gestational age (29%) and preterm birth (26%) in low socio-economic groups (McRae, et al., 2018).
- Pregnancy loss and neonatal loss is reduced by 16% (Sandall, et al., 2016) .
- Mental health is improved as a result of having a known and trusted carer, who is also able to provide on-going counselling and support in a community setting (Cummins et al., 2022).
- Continuity of care reduces direct health costs by as much as 20% (Callander et al. 2021).
- Continuity models are sustainable and support workforce retention by enabling midwives to work to full scope in a flexible model of care (Fenwick et al., 2017) and align with the key recommendations of the Primary Health Care strategy 2022-2032, Woman-Centred Care Strategy (2019), National Breastfeeding Strategy (2018), National Obesity Strategy (2022),

National Preterm Birth Prevention Plan (2022), National Stillbirth Action Plan (2022), Closing the Gap (2022) and National Mental Health Plan (2021).

However, the current funding model does not facilitate best practice models including midwifery continuity of care. Indeed the IHPA in 2017 sought to identify a bundled pricing for maternity care model, which did not eventuate. This work was, however, deemed to be a valid option moving forward it if challenges such as the need for a Voluntary Patient Record, which is now under development, were addressed. This is now a feasible option to revisit.

'IHPA considers that a bundled pricing approach could support principles outlined in its Pricing Guidelines including price equivalence across settings, fostering clinical innovation and improving efficiency and timely/quality care. While the configuration of health services is the responsibility of states and territories as system managers, a bundled price can broaden the possibilities for care redesign as hospital managers would no longer be financially deterred by a pricing approach based around traditional care settings and tied to the volume of services. A bundled price could also help drive greater standardisation along evidence-based pathways for the delivery of antenatal and postnatal care. It would also simplify payments for public hospital services in a way which is easily understood.'

Why was maternity service utilized as the model?

'IHPA and stakeholders considered that maternity care was suitable for bundled pricing for a variety of reasons including:

• It was believed to have a relatively predictable care pathway, with clear start (ten weeks gestation) and end points (six weeks postpartum) to the pathway which should allow for identification of clinically warranted and unwarranted variation in care.

• Maternity care involves a high volume of patients and services and there appeared to be variation in outcomes and costs, meaning that small improvements in service delivery could result in significant efficiencies to the health system.

• Some clinical stakeholders advised that it could potentially support greater use of new models of care, such as (midwifery) continuity of care models which are associated with higher patient satisfaction and significant reductions in the intervention rate.

• Bundled payment schemes for maternity care were identified in operation overseas which could provide a model for implementation in the Australian public hospital funding context.

IHPA notes that bundled pricing for maternity care could drive a change in how and what services are delivered, with the impact dependent on the scope of patients, stages of care and services in the bundle, as well as the degree of risk adjustment and the pricing approach. For example, a single price across the antenatal and birth stages of care could send a price signal which supports a greater focus by public hospitals on preventative care during the antenatal period to reduce the complexity of the birth.' (P9 of Final Report)

ACM below will outline examples of where the Addendum is and is not effective and provide examples to substantiate issues and solutions; this will include bundled funding to prioritise multi-

disciplinary care across the primary and secondary care continuum and also primary maternity care models, such as Birthing on Country models.

Discussion point: Implementation of the long-term reforms and other governance and funding arrangements, and whether practice and policy in place delivers on the objectives of the NHRA and the Addendum.

ACM supports the intent of the 'Preliminaries' of the Addendum, including a partnership approach between the Commonwealth and States and Territories, systems integration, and outcome-driven, integrated person-centred care as well as equitable access to care regardless of geographic location, and a focus on Closing the Gap. In relation to maternity care, we recognise the need for delivering safe, high-quality care **in the right place at the right time,** noting that there are currently significant deficits particularly in relation to access to care in rural and remote areas.

The existing funding model does not have a "whole of health" fit. Whilst the Addendum seeks to ensure efficiency, sustainability, equity, accessibility and safety – currently in the maternity context in particular the Addendum does not deliver well.

A range of models to provide midwifery continuity of care (MCOC) are already in place within both the primary and secondary settings to facilitate best practice midwifery continuity of care e.g.:

- Midwifery group practices directly linked within networked multidisciplinary teams either within the public hospital sector or in primary care models e.g. Maryborough MGP, or Gold Coast University Hospital
- Private endorsed midwifery practices with visiting access to public hospitals
    - Including 'hub and spoke' models utilising telehealth for antenatal and postnatal visits in rural settings including My Midwives midwifery private practice working across western Queensland (with birthing in Toowoomba) and regional Victoria (with birthing in Northern Health)
- Birthing on Country models with endorsed midwives employed in Aboriginal Community Controlled Health Services providing care to First Nations women with wrap around services and with admitting rights to public hospitals. e.g., BiOC North Brisbane, developing service Waminda in Nowra

However, current 'Innovative Models of Care' funding do not include the maternity sector. Models such as the above are based on localised innovation, or Commonwealth grant approaches. There is no overarching long-term funding approach to deliver MCoC nationally which restricts the ability to implement and scale this model.

Furthermore, the DRG is in general linked to a medical event e.g., birth or for example an acute asthma episode. It does not fund care as a continuum e.g., caseload care which is focused on keeping healthy pregnant women and their unborn baby well, and to prevent unnecessary hospital attendance and/or admission. Caseload care is where a midwife is responsible for 30-40 pregnant women in a 12-month period. The woman has access to this midwife 24/7 and thus this allows best practice antenatal and postnatal care: if you have a concern you can call the midwife or text her, ask her to visit or email her. Care that suits the woman's circumstances. This is not a 'medical event' and thus funding for publicly funded MGP models for example is complicated by misalignment of and indeed a gap in funding options: funding wellness and health optimisation via model with a woman at the centre.

The DRG based funding model currently limits innovation, it is a limitation of the Addendum and of the IHACPA and disincentives progression towards best practice.

Case Study: DRG Issues

In St Elsewhere hospital the team have been considering how they will be able to sustain their maternity unit. One option is to develop a midwifery group practice (MGP) model. The community were consulted in a forum recently and the clear outcome was that MGP was their preferred model of care. The hospital is concerned about the increase in staffing costs (to put the midwives on to an annualised salary via the Caseload model) and the fact that their research shows that some other medium size units have reported that there have been a range of additional costs with this model. They have been told that their funding may be impacted. Previously their site held a Medicare exemption Clause 19.2(b) of the Health Insurance Act, but they no longer have access to this provision due to restricted rurality definition changes. Funding for midwifery activity (rather than activity based DRG funding) is not available in the current pricing model for acute care so most of the activity related to relational based care, postnatal care, and ensuring mental well-being is not funded. Thus, due to limitations of the pricing model it is challenging to get the hospital executive to agree to a model change.

To ensure all health practitioners, including midwives can work to full scope, integrated primary and secondary sector funding should be prioritised within the Addendum review. The current construct of the Addendum does not provide for long term reform to shape the maternity care system to provide women with '*new models of care, such as midwifery continuity of care models which are associated with higher patient satisfaction and significant reductions in the intervention rate.' (IHPA)*

Recommendations:

1. Introduce bundled funding for maternity care to provide best health outcomes, with choice of care, at lowest cost through a new IHACPA modelling project, to include all-risk models of care and care for women with complexity.

2. Introduce a specific funding stream for integrated primary care and admitted acute care for Birthing on Country models for First Nations families and models for admitted care from an endorsed midwife (particularly in rural areas).

3. Provide long-term funding and/or incentives/innovative models of care funding for state and territory governments to facilitate long-term embedding of best practice models e.g., rural MGP networked with the multidisciplinary team to address variability and under-servicing.

4. Review existing provision within the Health Insurance Act and amend Section 19.2(b) to encompass primary maternity care, and specifically for all eligible midwives to provide seamless care.

Note: These recommendations utilising MCoC reduce intervention rates which clearly aligns with Clause 13g: 'continuing to focus on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions. This clause is a fundamental premise of the

primary reform agenda of Government and maternity clearly sits squarely in this space.

Discussion point: Provide any unintended consequences such as cost-shifting, perverse incentives or other inefficiencies that impact on patient outcomes have arisen, and the capacity of Parties to adopt and deliver innovative models, as a result of financial or other arrangements in the Addendum

DRG's – vaginal birth vs caesarean sections

Activity based funding provides a perverse incentive for activity (i.e., medical intervention) in a sector where the consumer is (predominantly) healthy. As an example, the Diagnostic Related Group (DRG) for vaginal birth in Queensland in a major city is $4,857 and a caesarean birth in Queensland in a major city is $10,807. This cost differential creates the effect that actions to reduce caesarean section rates may not be actively prioritised as they will reduce the funding available to the hospital providing care. (Note: current Caesarean section rate is 37% v WHO recommended guide of 10-15% (AIHW, 2018). This has been evident when discussing the possibility of scaling up service models that reduce interventions with health services. Business cases show a projected reduction in funding due to changes to activity and this works as a disincentive to adopt best practice service models. It is well known that this has been an issue in both large and small rural hospitals who have fundamental concerns that reducing the bottom line in activity-based funding will translate into reductions in staffing.

Bed fees for women admitted by private practice (endorsed) midwives.

The use of endorsed midwives working across primary and secondary care provides an additional option in care for women and increases access to continuity of care/r models. This model sits within the Maternity Care Classification System (MaCCS) framework as one of the few models that afford complete continuity of care across the perinatal period (AIHW 2022). The current funding model and legislation for admission into public hospitals requires women being cared for by endorsed midwives to be admitted as private patients (regardless of whether they have private health insurance or not). This is a result of the professional indemnity insurance that endorsed midwives hold only allowing care of admitted private patients and because the funding model only provides access to the MBS i.e., the woman must be admitted as a private patient in order for the midwife to be paid. Where women are admitted as private patients, they (or their insurer) are then also expected to pay the hospital an additional bed fee for that admission.

This model is also the default model for the Birthing on Country approach for First Nations Women, such as Waminda in Nowra, which is being developed as a national centre of excellence in this space via discrete Commonwealth Funding.

Case Study – Bed fees for women without private insurance

Sally* is 19 years old when she discovers she is 10 weeks pregnant. She lives in Miles in rural Queensland – a town with no on-site birth facility. Her parents live in Toowoomba and her partner works in a local mine. She has a BMI of 38 at the commencement of pregnancy and has a fear of hospitals due to previous negative experiences. She is not eligible for midwifery continuity of care (called Midwifery Group Practice (MGP) within the public hospital at Dalby as her BMI excludes her

birthing at that facility, and she lives outside the catchment for the MGP at the larger referral site of Toowoomba. Her mother suggests care with private midwives from an endorsed midwifery practice in Toowoomba who provide midwifery continuity of care, with admitting rights to the public Toowoomba Hospital. Sally* sees midwife Jo* who provides an initial antenatal consultation in Toowoomba and Sally* determines she is really keen for this option. Jo* provides a mix of face to face and telehealth consultations with Sally* through her pregnancy and communicates by email (there is no ability to share data) with Sally's* Miles based GP. Sally* also has a consultation with the Obstetric Specialist at Toowoomba hospital due to her BMI. As Sally's* parents live in Toowoomba she is able to relocate into Toowoomba to await her birth at about 36 weeks gestation with her partner intending to come in just prior to birth.

As Sally holds a Health Care Card, the endorsed midwifery practice bulk bills Sally for her antenatal consultations. Her birth care has an out-of-pocket cost of @$300 for the endorsed midwife, but her bed fee ($403/night/shared room) which the hospital in Toowoomba charges is not covered, as Sally does not have private health insurance.

Unfortunately, Sally needs an induction of labour (she has a scan at 37 weeks gestation as recommended due to her BMI which demonstrates baby has an estimated fetal weight below the 10% centile). She is admitted and is in hospital for two days for cervical ripening. Fortunately, she has a vaginal birth however as the baby is Small Gestational Age it needs to remain in hospital for 48 hours post birth for blood glucose level monitoring.

This 5 days in hospital results in a bed fee of $2,015 which Sally* has to pay as a private patient of the endorsed midwife. The hospital has not waived the bed fee.

* Real case study, names have been altered.

National Efficient Pricing model – adjustment for private admission status

Whilst we recognise and understand the rationale for the use of the National Efficient Price model there are current adjustments that impact maternity models of care. One example is the Birthing on Country (BOC) model where First Nations Women are admitted by endorsed midwives who are employed by the Aboriginal Community Controlled Health Service (ACCHS). The National efficient price varies jurisdictionally but is also altered by private admission status and Indigenous status of the 'patient'. Where the women are admitted as private patients (any model where an endorsed midwife (not employed by a public hospital) admits the woman) the hospital receives a lower amount under the current National efficient pricing model. The below table shows that for every 100 women, the hospitals are potentially losing between $143,610 to $227,473 (20% to 32% relatively) DRG via adjustments made through the National Efficient Pricing model depending on the state, where women are admitted as private patients (and therefore have a private patient adjustment) and have an adjustment for indigenous status.

This is counter to clause A44 of the Addendum.

100 women	O60C Vaginal Delivery Single Uncomplicated (LOS 1.5 day) -65.0%	O02B Vaginal Delivery W GIs Minor Complexity (LOS 3.0 days) -8.9%	O01C Caesarean Delivery, Minor Complexity (LOS 5.0 days) -26.1%	Total hospital payment	Absolute difference	Relative difference	Absolute difference per birth
QLD Private-Major city-Indigenous	$4,140	$8,385	$8,420	$563,489	-$143,610	-20%	-$1,436
QLD Public-Major city-Indigenous	$5,003	$10,265	$11,132	$707,099			
VIC Private-Major city-Indigenous	$3,760	$7,749	$7,637	$512,692	-$194,407	-27%	-$1,944
VIC Public-Major city-Indigenous	$5,003	$10,265	$11,132	$707,099			
SA Private -Major city-Indigenous	$3,430	$7,815	$7,526	$488,932	-$218,167	-31%	-$2,182
SA Public -Major city-Indigenous	$5,003	$10,265	$11,132	$707,099			
WA Private -Major city-Indigenous	$3,760	$8,593	$8,531	$543,537	-$163,562	-23%	-$1,636
WA Public -Major city-Indigenous	$5,003	$10,265	$11,132	$707,099			
TAS Private -Major city-Indigenous	$3,673	$8,074	$7,917	$517,237	-$189,861	-27%	-$1,899
TAS Public -Major city-Indigenous	$5,003	$10,265	$11,132	$707,099			
NSW Private-Major city-Indigenous	$3,512	$7,704	$6,921	$477,484	-$142,190	-23%	-$1,422
NSW Public-Major city-Indigenous	$3,658	$10,265	$11,132	$619,674			
ACT Private-Major city-Indigenous	$3,250	$8,084	$7,526	$479,626	-$227,473	-32%	-$2,275
ACT Public-Major city-Indigenous	$5,003	$10,265	$11,132	$707,099			
NT Private-Remote-Indigenous	$5,272	$11,236	$10,943	$728,293	-$195,883	-21%	-$1,959
NT Public-Remote-Indigenous	$6,539	$13,417	$14,549	$924,175			

The reduction in price per birth (reflected above) when women are admitted as private patients under an endorsed midwife (either in a BOC model or within private practice) is a disincentive to hospitals to prioritise best practice care. Whilst there are other savings from BOC models which benefit the whole health system (Gao, 2023) and which have not been included in this modelling, from the perspective of the individual hospital there is no way of recouping the reduction for admitting the women as private patients.

Bed fees within Birthing on Country models

Additionally, within the BOC models where an endorsed midwife has private admitting rights there is still a theoretical cost to the woman for the bed fee. Whilst it is a relatively small cost comparative to the benefits for the hospital, the Aboriginal Community Controlled Health Services must seek permission to implement this model of care by requesting, on a hospital-by-hospital basis, for the hospital to incorporate a waiver of bed fees for First Nations women and women carrying First Nations babies being cared for within BOC models. This is not an efficient process by any measure. Large hospitals (e.g., Royal Brisbane and Women's Hospital) have recognised that the benefit for the system with respect to a health workforce saving (as they are not paying the midwife who attends with the woman and provides all care – this is a Commonwealth cost), improved outcomes for the woman and baby receiving care, and an ability for MBS claiming by medical workforce if required.

However, for smaller hospitals, such as regional hospitals in NT, waiving the bed fee per woman receiving care in a BOC model creates a further disincentive to scaling up this model.

Case Study: Birthing on Country

When women receive care through a Birthing on Country (BOC) service model, compare to standard care, the estimated cost reduction for government is -AU$4810, [95% CI −7519, −2101] per mother infant pair. This is driven mostly by a reduction in preterm birth for First Nations families (by 5.34%). BOC models have demonstrated significant cost benefit. These service models cost more in the antenatal period (more care is delivered), less in the intrapartum period (less birth interventions and neonatal admissions) and more in the postnatal period (more care is delivered).

For example, if a new BOC service was to be established to provide care for 120 women annually by Medicare Endorsed midwives this would equate to a cost saving of $577,200 ($4810*120) for Government. However, this equates to a reduction of $172,332 (QLD) to $272,967 (ACT) in activity-based funding including bed fees ($235,059 if in the NT) for the hospital and is acting as a barrier to establishing these services.

The additional expenditure required to achieve equitable health spending based on need for First Nations Australians is approximately $4.4 billion per year ($5,042 per person per year x 863,576). Redirecting funds and removing barriers to establishing more BOC services would result in cost savings to government and improved health outcomes across the life trajectory. In 2019, there were 18,086 First Nations babies born in Australia. BOC services have the potential to reduce the number of First Nations babies born preterm each year by 965 (18,086*5.34%) and save $86,994,021 (18,086*$4810.02) in Australian health expenditure.

The 'unqualified' neonate

Another example of where financial arrangements within the Addendum is no longer efficient and is impacting on patient outcomes is that of the 'unqualified neonate'.

The 'qualified baby' is defined under Health Insurance Act 1973 regulations, which state a baby qualifies as a funded patient when they:

- are nine days old
- occupy a bed of an accredited neonatal intensive care facility
- are a second or subsequent child of the same mother or are admitted without their mother.

All other babies are considered unqualified, which means, in terms of staffing ratios and funding, the woman and unqualified baby are considered one person. This is despite the level of acuity and care required specific to each of them; the level of which have both steadily increased over time.

Review of maternity funding and workloads for those providing care have recently focused on the growing workload in caring for the neonate as part of the well-mother baby dyad. Up until recent times there was a view that a baby remaining outside of secondary care (i.e., a baby not admitted to a Special Care Nursery of a Neonatal Intensive Care Unit) had the majority of its care attended to by its mother and that additional staffing resources required were negligible. Recent work by entities, such as the Queensland Nurses and Midwives Union Snapshot Report has demonstrated that there is significant work in attending to the newborn in view of the acuity of the mother baby dyad in-patient and that there is a need for funding for the neonate during a routine admission.

Further to the above commentary, below are ACM's priority recommendations for consideration within the Addendum review.

Priority Recommendations

Prioritise integrated funding models, via system-wide change or via innovative models of care funding:

a. specific to the whole maternity system; and/or

b. specific to midwifery continuity of care models; and/or

c. specific to ACCHO led Birthing on Country models.

ACM reasserts the requirement to review and action the significant work undertaken by IHPA previously to consider a bundle of funding for continuity of care/r models in maternity for one payment to be assigned for the entire package of care (see above).

Options for funding alteration to remove perverse funding models and incentives best practice include:

1. Develop and trial a bundled payment model across primary and acute care for the care of all women; and/or
2. Trial a bundled payment across primary and acute care for a cohort of women e.g., all those receiving maternity care from a known midwife or a subset (low risk women) receiving care from a known midwife.

3. Extend and harmonise nationally, the Health Insurance Act S19.2 Medicare exemption to any midwifery continuity of care model to incentivise this option across sectors.
4. Extend funding to include all neonates requiring care on the maternity ward. This is not limited to neonates admitted to SCN or NICU but includes those who may require treatment on the postnatal ward for any complexity or potential complexity.
5. Develop a funding stream for non-medical practices in primary care providing maternity and women's health services where the practice is integrated with a multidisciplinary team either via a GP practice or public hospital.
6. Introduce an adjustment in the NWAU 22 Admitted Acute Calculation Breakdown calculator to remove the private adjustment for First Nations women and babies in BOC models.
7. Extend the private adjustment to rural maternity services to incentivise primary maternity models that include continuity of care model where the provider is based in primary care.
8. Provide an adjustment for hospitals to cover the waived bed fee for First Nations women and models for admitted care from an endorsed midwife (particularly in rural areas).

Discussion point: For small rural and small regional hospitals, whether they continue to meet the block funding criteria determined by the Independent Health and Aged Care Pricing Authority (IHACPA)

Small rural and small regional hospitals are of significant concern for the ACM due to the critical role that maternity services play in ensuring these facilities remain viable. Access, and equity of access, are two priorities which ACM strongly aligns with in relation to maternity care in rural and regional areas. Block funding, whilst more appropriate than ABF funding, has limitations which need to be considered in ensuring funding for rural and regional facilities is sufficient. ACM reiterates the points it has made in relation to options for funding reform in terms of maternity care but recognises that in facilities where there are low levels of activity, there will need to be additional considerations in funding streams.

Recommendation: All rural and regional hospitals require additional attention as to the most appropriate funding model for maternity care. ACM has recommended a range of funding model alternatives for maternity care generally but also notes that rural and regional hospitals will continue to require additional funding via block funding or other funding models.

Discussion point: The performance of the national bodies against their functions, roles and responsibilities

i. Australian Commission on Safety and Quality in Health Care

The Australian Commission on Safety and Quality in Health Care has a role to play in ensuring transferability across jurisdictions for the midwifery and maternity care workforce. Currently midwives are registered after an undergraduate degree and undertake practice to consolidate a variety of skills which fall within scope. The proposed work to be undertaken by the Commonwealth around the scope of practice of health professionals, announced in the May Budget, could then be aligned by the ACSQHC to ensure that there is a standard ability to practice to full scope across Australia and that completion and competence of a variety of skills are recognised nationally.

Case Study example: credentialling issues:

Jenny*, a midwife of 30 years who has had admitting rights to Somewhere hospital since 2011, has been asked to assist the establishment of a Birthing On Country model in another state at Anywhere hospital. She has been able to suture for 20 years, has held waterbirth competency since 2006, can cannulate, has completed an induction of labour package and regularly completes this skill and has worked in a home birth setting for 12 years. This all indicates Jenny*fulfils the usual and regulated scope of a midwife's practice.

On arrival at Anywhere hospital Jenny* is advised that none of these skills will be recognised and before she commences her credentialing process for admitting women in her care, or for in fact performing these skills as a hospital employee during orientation, she will have to observe 3 episodes of suturing, complete a package and be observed by a consultant obstetrician in suturing (the consultant registered in 2010) and deemed credentialed. She is not employed by the hospital and as her insurance only covers the admission of private patients, she will have to get a casual contract before she can start this process. This is repeated for waterbirth, induction, cannulation and she will also have to complete all emergency skills packages on site as these are also not recognised. The various training courses are only available every three months so the ability to complete them has no timeline.

* Real story, names have been altered.

Recommendations

1. Support for national applied approach to credentialing for all healthcare practitioners to promote transferability across jurisdictions and eliminates the need for healthcare practitioners to redefine and demonstrate clinical skills when they move across hospitals and/or jurisdictions. This is particularly problematic for the non-medical workforce.
2. A requirement for the admitting rights process for health care practitioners built into NHRA around Birthing on Country models.

ii. Independent Health and Aged Care Pricing Authority

The role of IHACPA is defined as '*IHACPA's primary function is to calculate and deliver an annual NEP. The NEP is a major determinant of the level of Australian Government funding for public hospital services and provides a price signal or benchmark for the efficient cost of providing public hospital services. We undertake several major areas of work designed to inform the annual determination of the NEP, including ongoing consultation with all Australian health departments, expert advisory committees and key stakeholders.'*

By this very definition, the IHACPA's role of providing 'independent and transparent advice in relation to funding for public hospitals' does not prioritise the reform agenda of 'integrated person-centred care' which is a stated implementation priority of the Addendum in clause 19a. It also does not require IHACPA to place focus on clause 18c 'better coordination between the hospital, GP and primary health care, disability services and aged care systems is needed to ensure the health system meets the need of the communities.'

That said, the IHPA maternity care bundling work from 2017 showed a clear innovation agenda which reflects the intent of the clauses above. This primary and secondary sector integration, such as the bundled funding approach will need to be incorporated as a primary function of IHACPA if the

Strengthening Medicare Taskforce's premise of woman-centred care maternity care is to be actualised.

For maternity specifically, the majority of women and babies are healthy and therefore funding within the acute care sector, based on medical activity as it currently occurs does not support positive outcomes and perversely incentivises intervention as per ACM's earlier commentary.

Recommendation

ACM recommends that the role of IHACPA be reviewed to provide expanded scope to consider how pricing is determined in the current context as it is critical in developing funding models to prioritise woman-centred integrated care, such as maternity care.

iii. Australian Institute of Health and Welfare

The AIHW work in the maternity data space is recognised. It is critical that data is contemporaneous, and holistic and that the Commonwealth and jurisdictions sit alongside the AIHW in ensuring that there is timely access and review of data. Integration of data collection within all sectors of maternity care, including private hospitals and private providers, is critical including where antenatal and postnatal occurs. The collection of data is currently limited to hospitals and to those providing intrapartum care.

Discussion point: Reform in the primary care sector

Throughout the Addendum there is no definition of the meanings of the terms 'GP and Primary Healthcare'. It would be relevant to align the definition from the Strengthening Medicare Taskforce report (2022) to ensure that it is clearly inclusive of all primary health practitioners i.e. 'GPs, allied health professionals, primary care nurses, nurse practitioners, midwives, pharmacists, Aboriginal and Torres Strait Islander Health Workers, and others' The ACM considers in view of reform in the primary care sector the Addendum must consider and clearly define the primary care workforce within its remit and thus in the formal definitions.

With an aging population, increases in chronic health conditions and challenges in access to healthcare, particularly outside urban areas, the focus on primary care and ensuring funding is fit for purpose and maximising high value care has never been more important.

The ACM is supportive of primary care reform inclusive of all health practitioners and recognises the commitment government has made to nurses, midwives, nurse practitioners and allied health practitioners to ensure that the workforce is able to practice to full scope, particularly within the context of primary care. This includes a commitment to review scope of practice and various funding commitments.

Currently the Addendum does not support seamless efficiency of the interfaces between primary and secondary care. The antenatal period is a period of 40 weeks where at any point the woman may need to attend her booked hospital. Therefore, the ability to communicate and share records and information is critical. This does not occur and causes significant frustration for the primary care practitioner, the hospital and the woman and family. Where there is an ability for the primary care practitioner to admit to hospital some of the frustration may be minimised as they will be able to provide the information required when the woman attends or is admitted to hospital.

The introduction of VPR may provide for an ability to integrate services. Recognising that the current suggestion is that VPR will commence for those who attend hospitals more than 10 times per year, ACM also recognises the opportunity for VPR to be utilised to test this methodology for predictable care pathways for consumers, such as pregnant women and thus maximising efficiency for practitioners who provide primary maternity care. This model, similar to other models internationally including in New Zealand, would allow the funding to follow the woman at the centre of care. She would be able to register with her preferred primary care provider under a VPR model and be funded for that care in bundles (as suggested previously). Introduction of VPR will enhance digital health in GP practices and increase the use of My Health Record; it should also be developed to have the capacity for all primary health practices. The impact or use in the non-GP sector is still unclear, however it is critical if we ensure appropriate use of all health practitioners in primary care, particularly in the maternity care sector.

Midwifery and other primary care professions e.g., Allied Health require integration into the My Health Record strategy and the MyMedicare/VPR strategy as a priority workforce within the Australian Digital Health Agency Strategic Plan in order to be able to deliver maternity care within an integrated primary and secondary care system as indicated in this document. If not prioritised, new models such as bundled funding for maternity care will not be able to be efficiently actualised.

Aligning bundled funding for integrated and seamless primary and secondary care

There are a finite number of births in Australia (approximately 300,000 per annum) and regardless of the mechanism for funding it is unlikely that the overall cost to the Commonwealth would be significantly increased. There is evidence that public MGP care costs 22% less than standard public care (Callander et al., 2021) which aligns with the evidence we have seen above regarding BOC models. There is most certainly professional resistance between groups as to the best approach to funding of maternity care, however if we are to see significant amelioration in maternity care and an ability to provide the seamless care through both primary care, secondary care and integrated care, funding should be reallocated to ensure that it fits the purpose of care. This would be possible if the outcomes of this review were to recommend reconfiguring maternity care funding across all sectors, via bundled funding approaches.

Reconfiguring maternity care funding to enable expansion of midwives in primary health care settings would have flow on effects in other areas of sexual and reproductive healthcare. Where there are limitations in access, a change in funding models to integrate primary care and hospital-based funding in small rural centres would ensure midwives have a sustainable funded pathway to improve access and reduce costs further down the health pathway (Nove et al., 2021). There are a number of benefits for actively enabling greater access for midwives to work to full scope - for example where access to contraception is improved, there will be a reduction in unplanned pregnancy and need for abortion services (Grzeskowiak et.al., 2021). Furthermore, access to screening and treatment for sexually transmitted infection is improved when long term complications are reduced due to early identification and treatment of these infections (Fullerton et al., 2021). Whilst Medicare reform is outside the remit of this review, enabling blended funding models would expand a range of opportunities in this sector and would recognise the role and skills of midwives who are often frustrated by system barriers, and this would lead to improved retention of the workforce. As review of the role of the PHN's is also within the remit of this review it is important to also consider the role they have in sexual and reproductive healthcare and access to these services.

The role of the PHN continues to be centred around the GP even following the 2023/24 Budget announcements. Whilst GPs are an important component of primary care, there is a significant non-medical workforce which is integral to the primary care model and this includes midwives, nurse practitioners, nurses and other allied health providers. In particular the Strengthening Medicare Taskforce has highlighted the need for all health practitioners to be able to work to full scope. There are a range of situations where the importance of midwives working to full scope have been outlined within this response. It is important that whilst the role of the PHN's is strengthened that this does not add an additional layer or barrier to funding for the non-medical workforce.

Recommendations

1. Provide funding to develop practices run by non-medical practitioners integrated with a multidisciplinary team e.g., Midwifery group practices outside of public employment models, walk-in nurse practitioner clinics and rural maternity clinics.
2. Ensure PHN funding includes opportunities to consider sexual and reproductive healthcare through commissioning for services in primary care.
3. Consider the IHPA 2017 recommendations around bundled funding in the light of the VPR process whereby bundled funding could be provided to women who register for all or a component of primary care under the VPR process with a midwife or GP.
4. Resolution of the insurance issues around intrapartum care which may have flow on impacts for multidisciplinary practice who employ, engage or are led by midwives who seek to provide MCoC including admitting women for birth care.

Insurance situation

- Insurance that covers intrapartum care within acute care is an issue (currently there is no insurance available for birth care at home). Self-employed endorsed midwives who are admitting to public hospitals have one choice of insurer – MIGA – who are contracted by the Commonwealth to administer the Midwife Professional Indemnity Scheme (MPIS). Endorsed midwives who are employed by an entity such as an Aboriginal Community Controlled Health Service or a midwifery private practice may have their own insurance or be covered entirely by the entities Healthcare practice policy. Currently only one Healthcare practice policy is available also through MIGA.
- The Commonwealth's support in the area of high and exceptional claims only covers situations where an individual requires support i.e., if the individual midwife is sued. This is historical because in medical practice generally only one doctor is responsible for the birth. In midwifery models of care the midwife may require involvement of a backup midwife as she is present for the entire period of labour (i.e., this may be over 12 hours and require relief for fatigue, a doctor is not present for the entire period of labour).
- The net result of this issue is that the policies for Healthcare practices are very high (in the hundreds of thousands).
- In the ACCHS sector this is a barrier for implementing the Birthing On Country model. Currently the Department of Health has provided additional grant funding to pay for the insurances for a selection of models. This is not sustainable.
- The issues this will create in expanding multidisciplinary team-based models in the primary care sector (with admitting rights for intrapartum care to provide MCoC) has not been tested. It may be a limiting barrier for development of these models of care in rural areas.

Discussion point: The NHRA recognises the importance of a patient centric system focused on engagement outcomes and experience. Could the NHRA be improved in relation to this area?

Long-term reform would be improved with the use of patient reported outcome measures (PROM) and patient reported experience measures (PREM) in maternity care. Review of these outcomes in slow in uptake in the maternity care sector in Australia. Where these have been examined the results demonstrate significantly better outcomes for women in midwifery continuity of carer models such as caseload care provided within public MGP models (Miller et al., 2022). Further examination could provide incentives for funding shifts to incentivise midwifery continuity of care.

Other

Discussion Point: Health Literacy and Co-Design

Clauses C29-34 within the Addendum provide a robust reform agenda for both the improvement of health literacy and co-design of health services around patient's needs. Whilst health literacy initiatives and co-design are prevalent in Australia these initiatives are fragmented. We can see example of excellence in co-design, such as the Maryborough MGP, which was co-designed with the community, and has led to improved outcomes for women and babies and improved health literacy with regards to pregnancy and the first 2,000 days (Best Start to Life). This can also be seen in the Birthing on Country models such as the BiOC model across Brisbane and the Waminda model in Nowra, as mentioned earlier.

The Recommendations from the recent report from the Senate Inquiry into universal access to reproductive health care also highlight the need for health literacy among priority populations. E.g., Recommendation 35:

'The committee recommends the Department of Health and Aged Care work with jurisdictions and the health sector to implement options for targeted public awareness and sexual health literacy campaigns in target communities, including for the LGBTIQA+ community, community-led initiatives for First Nations and culturally and linguistically diverse groups, and sexually transmitted infections campaigns in vulnerable cohorts'.

However, without a national implementation plan to underpin recommendations such as the above and reforms as agreed in Clause 31 of the Addendum, health literacy improvements and community co-design will not be actualised and thus population health outcomes, particularly in priority populations will continue to be diminished.

Recommendation: The commitment to clauses C29-34 for a health literacy national implementation plan.

Discussion point: Cultural Safety

Clause 9gii with regards to Closing the Gap states: 'working to achieve cultural safety in the health system with Aboriginal and Torres Strait Islander people by co-developing and co-delivering culturally safe and secure health services'. Cultural Safety is referred in multiple locations in the agenda, not only specific to First Nations populations, e.g., Clause 33. However, there is no national approach to cultural safety.

It is acknowledged unilaterally that Cultural Safety in the health system has not as yet been achieved, both for health professionals and consumers alike. With regards to nursing and midwifery. ACM acknowledges the work done by the Congress of Aboriginal and Torres Strait Island Nurses and Midwives (CATSINaM) in this regard with the GENKE II strategy (2022) and ACM supports this strategy. We note that national harmonisation of an approach to developing and working with both health professionals and consumers with regards to cultural safety is paramount to achieve cultural safety for First Nations people as well as the CALD and LGBTQI+ communities and all priority populations. This requires also a national implementation plan.

Recommendation: The commitment to the development of a national implementation plan for cultural safety in the health system.

Summary: Priority Recommendations

1. Develop and trial a bundled payment model across primary and acute care for the care of all women; and/or trial a bundled payment across primary and acute care for a cohort of women e.g., all those receiving maternity care from a known midwife or a subset (low risk women) receiving care from a known midwife. Consider the IHPA 2017 recommendations as foundational to the development of bundled funding being included in the VPR process - whereby bundled funding could be provided to women who register for all or a component of primary care under the VPR process, with a midwife or GP.

2. Extend and harmonise nationally, the 19.2 exemption to any midwifery continuity of care model to incentivise this option across sectors – this will expand the use of publicly employed endorsed midwives.

3. Extend funding to include all neonates requiring care on the maternity ward. This is not limited to neonates admitted to SCN or NICU but includes those who may require treatment on the postnatal ward for any complexity or potential complexity.

4. Develop a funding stream for non-medical practices in primary care providing maternity and women's health services where the practice is integrated with a multidisciplinary team either via a GP practice or public hospital.

5. Introduce an adjustment in the NWAU 22 Admitted Acute Calculation Breakdown calculator to remove the private adjustment for First Nations women and babies in BOC models.

6. Extend the private adjustment to rural maternity services to incentivise primary maternity models that include continuity of care model where the provider is based in primary care.

7. Provide an adjustment for hospitals to cover the waived bed fee for First Nations women and models for admitted care from an endorsed midwife (particularly in rural areas).

8. Support a nationally applied approach to credentialing for all healthcare practitioners to promote transferability across jurisdictions and eliminates the need for healthcare practitioner to redefine

and demonstrate clinical skills when they move across hospitals and/or jurisdictions.

9. Include a requirement for the admitting rights process for health care practitioners (including midwives) to be built into NHRA around Birthing on Country models.

10. Provide funding to develop practices run by non-medical practitioners integrated with a multidisciplinary team e.g., Midwifery group practices outside of public employment models, walk-in nurse practitioner clinics and rural maternity clinics.

11. Ensure PHN funding includes opportunities to consider sexual and reproductive healthcare through commissioning for services in primary care.

12. Resolution of the insurance issues around intrapartum care – these include issues for the organisations employing midwives who provided MCoC including admitting women for birth care. These issues are impacting BOC models and will impact development of multidisciplinary and primary care models.

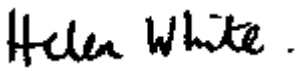
13. Ensure that the revised NHRA provides a national implementation plan.

Conclusion

Whilst ACM supports the intent of the 'Preliminaries' of the Addendum, including a partnership approach between the Commonwealth and States and Territories, systems integration, outcome driven integrated person-centred care, equity and access, it is clear that the current Addendum is not fit for purpose to actively enable multi-disciplinary primary reform agenda and visibility of the non-medical workforce in terms of funding. Changes are required to ensure all practitioners are able to work to full scope. This, combined with the post COVID digital health actualisation, requires the substantial review of the practical drivers of this Addendum to ensure a Reform Agreement which can incorporate transformative integrational change between primary and secondary health, whilst maximising patient outcomes. The next iteration must also incorporate as an implementation plan.

ACM has provided clear examples of pragmatic approaches to transformative change within the bounds of this Agreement which, whilst maternity specific, will not only provide improved health outcomes for women and babies and efficiencies, but will also provide the reviewers opportunity to consider alternative models which may allow for wider discussion around multi-disciplinary care approaches within the primary reform agenda in broader terms.

ACM thanks the Reviewers for the opportunity to provide a submission and undertake an interview and we are happy to enter into further discussions or provide further information at your convenience.



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What is an endorsed midwife?

Endorsed midwives (also known as eligible, or participating midwives) have a postgraduate qualification in prescribing and hold the Nursing and Midwifery Board of Australia's *Endorsement for scheduled medicines for midwives*. Endorsed midwives can apply to Medicare Australia for both a Medicare provider number under the Medicare Benefit Scheme (MBS) and a prescriber number under the Pharmaceutical Benefit Scheme (PBS). With access to both a provider number and prescriber number, midwives can provide Medicare-rebatable maternity services to women, order relevant Medicare-rebatable diagnostics and prescribe relevant medicines within their scope of practice. Endorsed midwives are a growing cohort of midwives who now total 1,028, and the number is doubling every three years. They work directly with women in the primary health system and can also use their endorsement in both public and private sector roles. They can have admitting rights to hospital, and provide sexual and reproductive healthcare including contraception, including Long-Acting Reversible Contraceptives (LARCs). The current cohort of endorsed midwives can care for 13% of pregnant women. In three years', time this will be enable primary midwifery care for a quarter of all births in Australia.

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