ANMF Response to the Department of Health Primary Care Reference Groups Consultation

MEDICARE BENEFITS SCHEDULE (MBS) REVIEW TASKFORCE REPORT FROM THE PARTICIPATING MIDWIFE REFERENCE GROUP

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INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of 275,000 nurses, midwives and carers across the country. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions. Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

Currently the ANMF represents more midwives than any other Australian organisation, with more than 20,000 midwife members, which accounts for over 75% of the 26,369 midwives employed in Australia.[1]

The Federation has welcomed the opportunity to participate in the review of this report, and would like to commend the Participating Midwife Reference Group (PMRG) on their work. We strongly support the recommendations of the Reference Group that, if accepted by the taskforce, will increase the ability of midwives to provide the integrated, coordinated, individualised care at the heart of this model. Extending midwives' access to the recommended MBS items will allow midwives to deliver midwifery care in a framework that fully utilises the skills, knowledge, experience, and expertise of all members of the health care team, reducing risk while improving outcomes for women and babies.

BACKGROUND

It has long been our stance that midwives are well positioned to be the primary health care practitioners for women during pregnancy and birth, providing continuity of expert care which involves the advice, support, and facilitation of a natural process requiring minimal interventional processes. Continuity of midwifery-led models of care, where women are provided with a known midwife during pregnancy, birthing and the postnatal period, have been very well researched both in Australia and internationally, and are recommended by the World Health Organisation (WHO). Research shows that these models lead to better outcomes for women,[2] and a 2018 systematic Cochrane review demonstrated that midwifery continuity of care was the number one intervention to reduce preterm birth (PTB).[3] This continuity of care, combined with education and experience, means that women who are primarily cared for by midwives are well supported when medical review, advice, and/or intervention is required, and have an advocate when the woman has concerns about recommended intervention. As one study noted, "if one is competent to handle normal births, one will immediately notice when something is wrong."[4]

In 2018, the WHO recommended[5] that midwife-led continuity-of-care models should be accessible for all pregnant women, especially where there are pre-existing 'well-functioning midwifery programmes.'' PTB (before 37 weeks gestation) is the main contributor to newborn death and can have positive long term health implications for surviving infants. Yet, despite overwhelming evidence identifying the benefits of midwifery-led care, including reducing preventable complications and minimising interventions,[6] fewer than 8% of women have access to midwife-led continuity of care.[7]

Australia has an increasing rate of birth intervention.[8] Abundant, consistent research[9] supports the position that augmenting labour increases the likelihood of subsequent interventions, often referred to as a cascade; while this is necessary and life-saving in some cases, research draws a strong correlation between medical dominance of labour and increased incidence of interventions. A recent longitudinal study[10] of over 490,000 healthy Australian pregnant women and their children found a significant increase in short- and long-term health concerns (from neonatal jaundice to metabolic disorders, autoimmune disease, and infections, particularly respiratory, in early childhood) for the 62% of children born with interventions, compared with the 38% of children born via spontaneous vaginal birth.

The expectations women and midwives have of birth closely cohere,[11] with continuity of skilled care, normalising the process of birth, and escalation where appropriate all featuring prominently. This is one reason why consumer expectations are moving from a predominantly medical model of delivery to a more holistic, woman-centred, minimally-interventionist model. This shift is supported by meta-research that clearly demonstrates the benefits of midwifery-led continuity of care for women regardless of risk status,[12]

including fewer interventions (from induction of labour to Caesarean delivery)[13], similar or better outcomes for woman and baby when compared with other care models, greater maternal satisfaction, and lower levels of maternal fear.[14]

Reduction in maternal fear is important[15] - some 10% of women experience severe childbirth fear,[16] with a third of primiparous women described as highly fearful,[17] and 45% of women experiencing childbirth as a traumatic event.[18] High levels of fear result in experiencing labour pain as more severe, and contribute to greater likelihood of epidural or elective caesarean,[19] as well as an increased incidence of longer labour, more obstetric intervention, postnatal depression, and post-traumatic stress following birth.[20]

Extending MBS items will facilitate comprehensive assessment, evaluation, birth planning and delivery by midwives, which will reduce the number of health professionals with whom a woman interacts during her maternity care, and thus improve cohesion of care. Midwives work well in collaboration and are adept at recognising where the knowledge, expertise and skills of their colleagues are needed, then referring to, and liaising with, team members across the health professions. Indeed, this is the conclusion of the esteemed medical journal, The Lancet:

> The essential needs of childbearing women in all countries, and of their babies and families, are the focus of this thought-provoking series of international studies on midwifery. Many of those needs are still not being met, decades after they have been recognized. New solutions are required. The Series provides a framework for quality maternal and newborn care (QMNC) that firmly places the needs of women and their newborn infants at its centre. It is based on a definition of midwifery that takes account of skills, attitudes and behaviours rather than specific professional roles. The findings of this Series support a shift from fragmented maternal and newborn care provision that is focussed on identification and treatment of pathology to a whole-system approach that provides skilled care for all.[21]

Midwives are the people who spend most time with women during pregnancy, labour, and the postpartum period, a quality of the profession that articulates well to the requirements of primary health care delivery. Dealing with one primary health provider, who in turn consults with and refers to other health care providers, reduces the risk of conflicting advice or clinical decision making based on an incomplete picture, and facilitates a professional relationship between the pregnant woman and her health care professional.

We note research[22] demonstrating that women with reduced access to intrapartum maternity services because of geographic constraints have a higher rate of adverse outcomes for both the woman and baby. Adopting the proposed changes, and thus extending the range of MBS items midwives can access, will help to improve access to maternity care, particularly in rural and remote areas, while allowing all Australian women more choice when it comes to the direction, support, and outcomes of their pregnancies.

RESPONSE TO THE RECOMMENDATIONS

The ANMF strongly endorses the twelve recommendations made by the Reference Group, with suggestions and comments as follows:

Recommendation 1 - Include a minimum duration for initial antenatal attendances and align the schedule fee with average attendance duration

The ANMF notes that the National Health and Medical Research Council (NHMRC) - endorsed guidelines for initial antenatal consultation, as described in the Report,[23] are reflected in the current MBS fee schedule; the recommended change would bring the schedule into line with best practice.

Recommendation 2 - Amend the antenatal attendance items to appropriately reflect the time they take and introduce a new time tier for long antenatal attendances

We recognise the need for sufficient time to fully assess need and deliver care interventions for all pregnant women; complex cases necessitate a longer time period for midwifery care to be performed safely and competently. Adding an MBS item that reflects this requirement will allow midwives to provide these women with the comprehensive, individualised care their situation demands. ANMF agrees with the PMRG that safe, quality care requires not only education and expertise but also time, particularly with a maternal population of increasing complexity, and that the changes and new MBS item recommended are appropriate.

Recommendation 3 - Introduce a new item for a complex antenatal attendance leading to a hospital admission

As discussed in our preamble, midwifery-led care with continuity is strongly and positively tied to improved maternal and baby outcomes. This is still the case when antenatal complications and concerns require hospital admission, as outlined in rationale 5.1.6 (p. 32) of the report; we note and support both the item and the associated cap recommended by the PMRG.

Recommendation 4 Restrict claiming of maternity care plans to prevent low-value care

We agree with both the rationale of this change, and the fiscally-prudent recommendation that any resulting financial savings be directed toward covering the costs of new and extended MBS-claimable items.

Recommendation 5 - Amend time tiering of intrapartum items

Fatigue poses significant risks to both health practitioners and their patients; the ANMF has long been concerned about the effects of fatigue on midwives, and advocated for working conditions that reduce its degree and impact on both our members and those in their care. We wholeheartedly endorse the recommendation which, if adopted, will allow for continuity of midwifery-led care while improving safety for both the practitioner and the birthing woman. As the Reference Group notes, introducing the proposed items while retaining longer attendance items will allow midwives to assess their level of fatigue and the evolving situation, and either continue or handover to a colleague as appropriate.

Recommendation 6 - Increase the per-minute schedule fee for intrapartum care

Incorporating this recommendation into changes to MBS scheduling will both reflect the actual time involved, while allowing more Australian women to utilise this care mode. As discussed in the preamble, midwifery-led models of care not only result in better maternal psychological results than other approaches, but also fewer interventions while achieving comparable outcomes, which means that midwifery-led models of care are highly cost effective.[24]

Recommendation 7 - Enable intrapartum items to be claimed from the time the midwife attends the woman for labour care

Just as labour doesn't begin when a woman reaches hospital, nor does intrapartum care. As discussed (above, and in the PMRG report), the longer a labouring woman is in a clinical environment, the more likely she is to have an intervention – and each intervention increases the likelihood of intervention cascade. Allowing women to access rebatable midwifery care will increase access to midwifery services by reducing the financial impost on individual women and their families.

Recommendation 8 - Include home birthing in intrapartum items for women with low-risk pregnancies

The increasing medicalisation of birth[25] has resulted in home birth, even for low-risk women with low-risk pregnancies, being viewed through a lens of risk, which is in turn reducing the effectiveness of midwives' advocacy and autonomy.[26] This is despite the WHO's guidelines for care in connection with the promotion of normal birth, which emphasise that the woman should give birth at a place where she feels safe and is able to access appropriate care;[27] at least one study has demonstrated that women have a greater sense of safety and a lower level of fear when giving birth at home[28] – as discussed earlier in our submission, fear has a significant effect on both birth and on the woman's post-birth risk of psychological harm.

A substantial body of research demonstrates a clear connection between midwife-led planned home birth and positive maternal and baby outcomes. These outcomes include: reduced maternal anxiety throughout pregnancy and substantially less use of analgesia during pregnancy,[29] fewer anal sphincter tears,[30] a lower rate of postpartum haemorrhage,[31] and lower perinatal death and other adverse outcomes in home births than hospital births.[32] These findings are consistent with a 2011 study[33] of over 64,000 women which showed no significant difference in outcomes between low-risk null- and multiparous women who birthed at home compared with hospital.

Midwives using a continuity of care model that includes home birth demonstrate that negotiating and assessing risk is a central and active component of the role.[34] The cost of private midwifery in combination with restriction on Australian midwives' ability to attend and/or facilitate women's preference to home birth has seen an increase in free births, where the only attendant is an unregulated birth worker,[35] a trend not seen in countries like the Netherlands (where private midwives are fully funded and insured for homebirths).[36]

Recommendation 9 (Amend the postnatal attendance items and introduce a new item for a long postnatal attendance) and Recommendation 10 (Include mandatory clinical activities and increase the minimum time for a six-week postnatal attendance)

We agree with the recommendations which, if implemented, will improve quality and consistency of care and outcomes for women and their babies in the post-natal period when women are reflecting on and recovering from birth trauma, and at greatest risk for post-traumatic distress and post-natal depression. The higher rates of breast feeding that have been demonstrated with midwifery-led postnatal care will contribute to bridging the gap between Australia's current rates of breast feeding to at least 6 months, with the WHO recommending that all babies be breast fed for this long.

Recommendation 11 (Include general practitioners (GPs) as eligible specialists for existing telehealth items) and Recommendation 12 (Facilitate telehealth consultations between women and midwives in the antenatal and postnatal period)

It is the ANMF's position that adding MBS items that allow midwives to consult with women via teleconferencing, both with a GP and as the sole health practitioner, will contribute to better health care outcomes, particularly for women who are geographically isolated, physically incapacitated, or who have child care needs that make physical attendance onerous and would therefore have difficulty attending a face-to-face appointment.

Additional comments

The PMRG has not made a recommendation regarding the requirement for endorsed midwives to form collaborative arrangements, as defined in the *National Health (Collaborative arrangements for midwives) Determination 2010*,[37] with medical practitioners. By removing the current legislated requirement that collaborative arrangements be formed in order for participating midwives to access the MBS, women and families would benefit as this will improve access to affordable, universal, and high-value care.

While midwives work in collaboration with obstetricians, they are never supervised in their clinical practice by medical colleagues, nor by any other non-midwife health practitioner. Reliance on the good will of the collaborating doctor places the midwife in a dependent position, rather than on an equal professional footing. We also note that the mandated collaboration is vertical: obstetricians are not obligated to confer or collaborate with midwives, even when the woman has been under their care throughout her pregnancy. This is despite research consistently demonstrating better outcomes with continuity of care. Requiring vertical, formalised collaboration ignores other requirements of midwifery practice, including: existing protocols, consultation and referral guidelines, as well as ethical codes of conduct that successfully govern the day-to-day practices of Australian maternity units.

Clinical observation:

The gatekeepers have no knowledge of midwifery and they are the ones that stand in the way of true collaboration and woman centred care. – *Participating midwife, Qld*

The ANMF holds that midwives are competent, collaborative, and safe practitioners and is aware of the strong and consistent evidence that demonstrates that existing requirements for collaborative arrangements both restricts midwives' ability to practice to the greatest benefit of women and families, and impedes the ability of women to access a midwife of their own choosing.

Key points:

- Midwives are competent, collaborative, safe practitioners
- Current legislation requiring midwives to form collaborative arrangements is antithetical to legitimate collaboration
- There is insufficient evidence to support mandated collaborative practice requirements
- Current requirements for collaborative arrangements for endorsed midwives restricts midwifery practice
- Current requirements for collaborative arrangements for endorsed midwives inhibits benefits to women, babies, and families

A recent Cochrane systematic review[38] found that midwife-led continuity of care models, where the midwife is the lead professional starting from the initial booking appointment, up to and including the early days of parenting, provide benefits for women and babies without identified adverse effects. While women with existing serious pregnancy or health complications were not included, fifteen studies with 17,674 women and babies were included in the analyses. Seven key outcomes were examined: preterm birth (birth before 37 weeks of pregnancy), the risk of losing the baby in pregnancy or in the first month after birth, spontaneous vaginal birth, caesarean birth, instrumental vaginal birth, whether the perineum remained intact, and use of regional analgesia. Most studies reported higher rates of satisfaction with midwife-led continuity models of care and improved cost-savings compared to other care models. Overall, this review indicated that women who received midwife-led continuity models of care were less likely to experience intervention, more likely to be satisfied with their care, and experience at least comparable adverse outcomes for women or their infants than women who received other models of care. These findings are consistent with a retrospective study[39] that found higher rates of breast feeding and a lower incidence of perineal lacerations in women cared for by midwives.

Another high-profile study published in the Lancet[40] examined 461 systematic reviews, and highlighted the vast contribution to care made by midwives, identifying more than 50 short-term, medium-term, and long-term outcomes that can be improved by midwifery care, including: reduced maternal and neonatal mortality and morbidity, reduced stillbirth and preterm birth, decreased number of unnecessary interventions, and improved psychosocial and public health outcomes. The findings of this paper support system-level shifts from maternal and newborn care focused on identification and treatment of pathology for the minority to skilled care for all hinging upon midwifery's inclusion and integration in interdisciplinary teams within facility and community settings.

Clinical observation:

I still have GPs refuse to refer pregnant women to our care despite the known benefits to the woman and baby of continuity of midwifery care, a long career, earning a Bachelor and a Masters of Midwifery, and a postgraduate course in pharmacology screening and diagnostics, in addition to my experience as a lead maternity carer with a caesarean section rate of 2%, only two inductions of labour in the last four years, no stillbirths, no preterm births, and minimal PPH neonatal resuscitation and transfer to hospital. I have insurance, but the need for GP referral and collaboration remains a barrier with some hospitals that wrote back to us on each occasion with a letter advising that they will **not** collaborate with us. *– Participating midwife, Qld*

A recent mixed-methods Australian study[41] of 1,037 midwives revealed that almost half had considered leaving the profession, commonly attributing dissatisfaction with their organisation or with midwifery care/ their role as a midwife, as a reason for wanting to leave. Lack of opportunity to practice autonomously or work across their full scope of practice in the absence of midwifery-led continuity of care models in Australia and the prevalence of medically dominated, fragmented models of care appear to be linked to discontent, a conclusion supported by a recent Australian study of midwife satisfaction.[42]

Relationships with managers and doctors were also frequently described as unsupportive and obstructive, leading midwives to feel unvalued and ignored.

Clinical observation:

It was all too much for me - I would follow the 'letter of the law' by getting referrals from GPs and sending midwifery referrals to the hospitals, but I gave up on trying to find a GP or obstetrician who were prepared to 'collaborate.' – *Participating midwife, Qld*

Supportive interdisciplinary relationships are vital to sustainable practice and contribute positively to the workplace environment. In addition, midwife-led continuity of care models may offer a pathway to ensuring better workplace conditions for midwives, safer, more effective care for women and babies, improved relationships with colleagues, and greater midwife satisfaction[43] (increasing retention of midwives in the face of projected global shortfalls).

An exploration of midwives' responses to an increase in 'physician dominance' of labour and delivery[44] demonstrated that midwives who are obstetrician-directed, rather than operating within a midwifery-led model of care, are disempowered, discouraged from advocacy, and that the women they care for have a higher number of interventions in their labour.

Similar issues around midwife autonomy and collaboration, restrictions on scope of practice within medically-dominated models of care, and the benefits of midwife-led continuity of care models have arisen in another recent Australian study[45] that recommended initiatives to better support midwives in becoming primary caregivers promoting normal healthy birthing with women.

Clinical observation:

We work within a system that will not allow women who have B and C categories of risk to give birth at home, however informed or determined the women are, because [the doctors] don't even support women with no risk, low risk and category A pregnancies to have home births. So women's choices are eroded, along with midwives' autonomy and right to work to our full capacity. – *Participating midwife, Qld*

The objective of implementing nurse practitioner and endorsed midwife access to the MBS and PBS was to support consumer access to care.[46] Barriers to implementing collaborative arrangements including medical practitioners' understanding of the midwife role and collaborative relationship, and their availability and willingness to collaborate hinder the ability of midwives to set up private practice affording improved access for women and their families.

Collaboration between midwives and other health and medical care staff is a fundamental element of the Nursing and Midwifery Board of Australia's *Midwife standards for practice* (see Standard 2: Engages in professional relationships and respectful partnerships).[47] A 2016 study[48] conducted in Australia with privately practicing nurse practitioners argued that mandating collaborative arrangements through legislation creates barriers to establishing private practice services which potentially inhibits consumer access to care. As collaboration is already embedded in the way that midwives practice, mandating collaborative arrangements appears redundant and counterproductive.

Midwives are regulated, qualified health professionals and as such are responsible at law for the extent and scope of their practice, undertake risk mitigation for their own practice, and are required to have professional indemnity insurance as a requirement of their registration. Health professional colleagues, including medical practitioners, do not carry responsibility for the practice of a midwife.

Clinical case study:

Two women in my practice have been refused [referral and access to home birth] in the last week and the homebirth-supportive GP advised us of contact from their insurance to all of the GPs in the area, telling them not to refer women to us in case it is seen as collaboration. – *Participating midwife, Qld*

Midwives want genuine collaboration, while also working autonomously within a team, so removing this requirement will not reduce their willingness to confer with their cross-disciplinary colleagues. Removing this provision will, however, contribute to a health care system that is able to capitalise on midwives' full potential, while also creating an environment that facilitates mutually beneficial, genuine cross-disciplinary consultation, collaboration, and mentorship. Making this change will result in safer, better, and better integrated maternity care.

CONCLUSION

The PMRG review of midwives' access to MBS items has determined that changes to the Schedule (including additional items) will streamline the safe, timely provision of quality health care to pregnant and post-partum Australian women, reduce costs, duplication of work and documentation, and improve equity of access to those women who face disadvantage. The present restrictions on some of these items increases inequity in already disadvantaged women (particularly those living in rural and remote areas), and impede the delivery of midwifery-led care, despite the multiple significantly improved outcomes for women and newborns that result from this model.

The ANMF strongly supports the recommendations made by the *MBS Review Taskforce Report from the Participating Midwife Reference Group*. We also recommend removal of the legislated requirement that endorsed midwives form collaborative arrangements with medical practitioners, which we have demonstrated serves to impede women's access and midwives' autonomous practice, rather than act as a safeguard. Consistent with the PMRG's recommendations, making this change will remove a step and a barrier in the current process, facilitating and improving women's access to midwives and midwifery-led care.

The potential benefits to consumers, participating midwives and the health care system are thoroughly detailed in the report. These recommendations, supported by strong, relevant evidence, present a compelling case for changes to the MBS that are long overdue. If implemented, these recommended changes will improve women's access to safe, quality midwifery care, enable women to access rebates for a wider range of services, provide more timely delivery of midwifery care, reduce fragmentation of care, and support participating midwives to work to their full scope of practice, increasing their contribution to integrated, efficient maternity care for women and their babies.

We thank the taskforce for the opportunity to offer feedback to the Reference Group, and look forward to assisting with communicating the outcomes of this important work to our members following completion of the next phase of this project.

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