Background:

We have a maternity care system which denies women reproductive rights. The right to choose a care provider is limited (only 8% of women can access a known midwife), one in three women experience birth trauma involving disrespect and abusive care, choice in place of birth is limited (and medical lobbying continues to impede on a woman's choice in where and with whom she births) and the right to body autonomy is ignored.

The Cochrane review into continuity of midwifery care clearly demonstrates its exceptional outcomes, with lower intervention, yet there is much resistance to move towards an evidence based system that will improve the physical and emotional outcomes of women. This isn't a radical request; New Zealand and many Nordic countries have exceptional continuity of midwifery carer models, less intervention and high satisfaction. The WHO Pregnancy Care Guidelines also preference continuity of midwifery carer.

Other benefits include:

- Reduces fear and therefore caesareans (currently at 34%, the WHO suggest rates over 10-15% offer no benefit to mother/baby, but will start to cause harm).
- Economically sound- various studies of between $500-$1000 per birth are saved with this model of care.

Disrespectful maternity care:

The over-medicalised model is harming women.

Bowser and Hill (2010) described seven major categories of disrespect and abuse that childbearing women encounter during maternity care. These categories occur along a continuum from subtle disrespect and humiliation to overt violence:

Physical abuse

Non-consented clinical care

Non-confidential care

Non-dignified care (including verbal abuse)

Discrimination based on specific patient attributes

Abandonment or denial of care

Detention in facilities

Dr Princess Nothemba Simelela, WHO Assistant Director-General for Family, Women, Children and Adolescents recently said:

> "Disrespectful and non-dignified care is prevalent in many health facilities, violating human rights and preventing women from accessing care services during childbirth. In many parts of the world, the health provider controls the birthing process, which further exposes healthy pregnant women to unnecessary medical interventions that interfere with the natural childbirth process.
>
> Achieving the best possible physical, emotional, and psychological outcomes for the woman and her baby requires a model of care in which health systems empower all women to access care that focuses on the mother and child. "Women are also reporting high levels of disrespect and abusive care during facility-based childbirth in all regions and cultures."

Funding mechanisms for maternity care reward intervention, and an industrialised model of care. Because funding is from the Commonwealth (to the states, medicare, plus propping up private health) and State funding, there is a lack of accountability or responsibility of who is taking leadership in reforming maternity care. We have consistently (since mid 2017) raised Bundled funding as an opportunity de-incentivise the current over-medicalised model, whilst empowering women to make conscious decisions about their model of care, and ensure a more even distribution of funding across episodes of care (3 x trimesters, birth, postnatal care), yet there is no leadership to move towards a bundled funding system.

What previous reviews have found:

Reviews of maternity services in Queensland occurred in 2005 (Re-Birthing by Herst), along with the more recent National Maternity review in 2009. Victoria just completed their state Inquiry into perinatal services Both reviews suggested we have a medical model of care, consumers felt they lacked choice and had dissatisfaction with outcomes. Overwhelming, consumers have always showed a preference of continuity of midwifery carer, and have consistently highlighted the lack of access.

There was also notable mention of a move to primary care models- continuity of midwifery care with effective collaboration, which has good outcomes and is cost effective.

What the DHS is doing:

The National Strategic Approach to Maternity Services is being developed. There has been no review of the previous plan, nor commitment to ensure women have access to evidence based, continuity of midwifery carer. There are only 2 consumers on the Expert Advisory Group (yet there are 5 representatives from various private practicing doctor groups). The Inter-Jurisdictional Committee has state and territory representative, yet no consumers. Decisions about women are still made without them (and mostly by old, white, wealthy doctors).

The Medicare review of midwifery items has failed to deal with many of the barriers of consumer access to private midwives. Removing these structural barriers would allow an easy pathway (and not relying on the culture/personalities within each hospital) for women to access continuity of midwifery carer.

Outlined below is from the MBS review of private midwifery (which isn't addressing many of the structural barriers for private midwives):

Improving access to high-value care and removing structural barriers to midwifery services has been a focus of the Reference Group. There is a large body of evidence demonstrating the outstanding clinical outcomes, consumer satisfaction and financial efficiency associated with continuity of care models. However, access to this model of care in Australia is limited. Public hospital midwifery continuity models are limited in number and size, and despite the introduction of Medicare rebates for midwifery care, there are lower than predicted numbers of midwives working in this model. (33; 36)

The barriers to MBS-rebateable midwifery care fall into two main categories: financial and structural. The Reference Group views the removal of these barriers as a priority, with the goal of increasing access to midwifery continuity of care for consumers.

The financial barriers to midwifery continuity of care have been articulated throughout this report with common themes being;

The following requirements also impose regulatory barriers and government should give consideration to how they can support midwives to address these:

• The requirement for individual professional indemnity insurance with payment of five years of run-off cover makes it difficult for midwives to enter private practice.

The postgraduate prescribing qualification requirement (as opposed to including prescribing courses as a component of undergraduate midwifery education) is based on nurse practitioners, who require a large prescribing formulary. Midwives require a limited prescribing formulary.

There is no pathway into private practice as there are no Medicare rebates for a midwife who does not have endorsement. There is no funding model to support early career work in midwifery continuity of care in private practice, limiting women's access to a greater number of midwives. However, expansion of MBS items that currently exist for midwives working "for and on behalf of and under the supervision of medical practitioners" to include "participating midwives" would allow midwives who are working towards becoming participating midwives to transition under the supervision of a participating midwife. Item-level changes could be as follows.

- Item 16400: Extend this item to include "for and on behalf of and under the supervision of participating midwives" and remove the requirement for Modified Monash Model locality.

- Item 16408: Extend this item to include "for and on behalf of and under the supervision of participating midwives" for up to six postnatal visits.

Legislation dictates that a Participating Midwife must have a collaborative agreement with a named Obstetrician or a facility that has a designated Obstetric medical team/service. Collaboration is key to provision of a total package of care for a woman and the safe transition of care. However under the current arrangement the provision of an agreement relies solely on the organisation or Obstetrician offering this arrangement. Stakeholder presentations to the PMRG stated clearly that this is limiting to Midwives who wish to establish a practice under an MBS funding model.

An alternative would be to reference compliance with the NMBA's Safety and Quality Framework which requires midwives to work collaboratively with other appropriate medical professionals, such as GPs and Obstetricians.

External to Queensland there are only a very limited number of public health organisations (PHO) offering participating midwives access agreements to allow admission of a woman under their care. This means that many women who wish to have the care of a participating Midwife may only choose birth at home, they do not have the alternative of birthing with their Midwife in hospital.

Limited education and information are readily available about private midwifery continuity of care, leaving many consumers and health professionals unaware that the model exists.

In 2009, the Commonwealth maternity services review increased expectations of improved access to midwifery continuity of care. This has not occurred at the predicted rate (36; 33) as the barriers listed above have been underestimated and unaddressed.

Professional Indemnity Insurance: There is only one option for insurance available for participating midwives; insurance available under Government contract with Medical Insurance Group of Australia (MIGA) through the Commonwealth midwife indemnity support schemes. Participating Midwives are required to meet national registration requirements, be eligible to access the schemes and are required to undertake endorsement with the Nursing and Midwifery Board of Australia (NMBA); be self-employed, be directors of their own company, and have written collaborative agreements with doctors or healthcare services that employ obstetricians. Further, midwives who wish to be insured to provide intrapartum care in healthcare facilities must have access agreements with each facility they access, this is the same for obstetricians.

The Commonwealth midwife indemnity support schemes are crucial for participating midwives providing Medicare rebated care including homebirth. The current lack of insurance for intrapartum and birth care at home is a barrier to midwives providing homebirth services resulting in women occasionally choosing unsupported options.

As discussed under 5.2.8 the government has provided a Public Indemnity Insurance exemption until 2019, through MIGA. While the exemption has permitted home births to continue for the time being, consumers and Midwives do not have any certainty for the future.

Currently, private health insurers rebate hospital midwifery care at the MBS schedule fee. This is different to most of the obstetric items, for which the funds negotiate either a "no gap" or "known gap" arrangement that is above the schedule fee. This arrangement limits rebates even for privately insured women to be cared for by a participating midwife in the intrapartum period.

Supervision: There is a requirement that Midwives have undertaken 5000 clinical care hours in the previous six years prior to obtaining NMBA endorsement and a provider number. This caveat for instance prevents a very experienced Midwife who has been on reduced hours following maternity leave from transitioning to private practice. The requirements should be reviewed and consideration given to the removal of the provision that hours are amassed within the last six years, NMBA requirements stipulating recency of practice could apply here. There is no evidence that midwives require a specific amount of experience before making a transition into private practice, particularly with support. The precedent that was used to determine the number of required hours concerned nurse practitioners. Nurse practitioners have an extended scope of practice as compared to

registered nurses. Participating midwives are working in the very role they studied and trained to undertake, they are not working in roles with extended scopes of practice.

o In summary, there are a number of benefits to be realised by negating barriers and thus increasing access to midwifery continuity of care models In 2009, the Commonwealth maternity services review increased expectations of improved access to midwifery continuity of care. This has not occurred at the predicted rate (36; 33) as the barriers listed above have been underestimated and unaddressed.

o The community considers access to midwifery care in pregnancy to be a fundamental support. Women want support to birth safely and naturally and seek lower intervention approaches. Midwifery care is essential for consumers to achieve these objectives. (12)

o There would be a reduction in expensive interventions (for example, lower uterine caesarean sections) and secondary and tertiary care due to the expansion of primary care options (fewer inductions of labour, pharmacological pain relief used during labour, decreased time in hospital). (5)

o Major public health benefits are associated with expanding community-based continuity of primary maternity care.

- Proven health outcome benefits include increased breastfeeding rates, increased rates of normal vaginal birth, increased detection and treatment of mental health problems, decreased smoking during pregnancy, and a decrease in the rate of low birth weight in vulnerable populations. (8)

The Reference Group has taken many steps to reduce financial barriers to accessing the midwifery continuity of care model through the recommendations outlined in this report. Further financial considerations are contained in Section 5.6.

Bundled payment funding model

Bundled payment funding for midwifery care should be explored over the next 18 months. The Reference Group agreed that the current MBS fee-for-service model fits poorly with low-risk primary maternity care. It does not recognise midwifery services provided between consultations (for example, via phone, Skype, on call, case review, pathology review, diagnostics), or the fact that a midwife may be on call 24/7 for her “caseload” of women. It does not drive continuity of care for women.

The Independent Hospital Pricing Authority (IHPA) has explored the feasibility of bundled payments for women with low-risk pregnancies. (9) Specifically, the IHPA states that:

o There is potential to better align pricing incentives across settings by introducing bundled pricing approaches.

o Uncomplicated maternity care services are potentially amenable to bundled pricing as they follow a relatively predictable care pathway.

o Bundled pricing for uncomplicated maternity care could potentially support the implementation of nationally agreed-upon guidelines.

The Reference Group suggests the following bundles for maternity care episodes could be considered.

o Antenatal (one, two or three items).

- First trimester: booking visit (including existing requirements from the Pregnancy Care Guidelines), call cover throughout pregnancy, organisation and review of first trimester screening, baseline mental health screening (minimum of one visit).

- Second trimester: pregnancy care visits, including organisation and review of morphology scan, on call; care plan with pregnancy management; and planning fees and discussions (minimum of two to three visits).

- Third trimester: pregnancy care visits – number increased, on call, mental health screening, education (minimum of four to five visits).

o Labour and birth.

- All attendances relating to labour and birth, labour management up to 3o hours by a primary participating midwife and/or additional midwife as required to safely manage fatigue and wellbeing, conduct of birth if occurs (unless transferred to a

medical practitioner for escalation of risk), care for the immediate postpartum period.

o Postnatal.

- Postnatal care from birth until six completed weeks for both mother and baby including mental health screening, birth debrief, on-call support (minimum of eight visits; maximum of 12 visits).

The Reference Group agreed that this approach has several potential benefits.

o Exploring bundled payments in private midwifery care offers the opportunity to assess the success of this model in a small, contained group of care providers, without affecting the majority of Australian midwifery funding.

o Bundled payments would align better with community and consumer expectations of continuity of midwifery care. These expectations are highlighted in the 2007 Commonwealth maternity services review. (12)

o The cost of delivering maternity care could potentially be reduced.

- Midwifery continuity delivers better outcomes: fewer assisted births and birth interventions, fewer preterm births, increased breastfeeding rates and greater consumer satisfaction. (5)

- These benefits lead to cost savings at national and state levels.

- Bundling payments for midwifery care may lead more women to choose this model of care for their pregnancy, both because the payment model is easier to understand and because care is more affordable (assuming appropriate pricing).

- This in turn would lead to cost savings as more women complete their pregnancy care under a midwifery-led care model. The Reference Group noted the following risks.

o Bundled payments may increase complexity for women choosing or needing to change care provider.

o Bundled payments would be a departure from the fee-for-service nature of the MBS to date.

o Setting rebates appropriately across bundles of care is difficult and must ensure adequate access for women, adequate remuneration for providers and value for the health system.

o Most bundled payment models have been trialled in “clinical team” scenarios, with resultant improvements in continuity of care and clinical outcomes. The clinical gains may

not be as great in a midwifery continuity of care model, where these attributes are already evident