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HOW GOVERNMENT CAN ENABLE RAPID SCALE-UP OF BIRTHING ON COUNTRY SERVICES

POLICY RECOMMENDATIONS

For Federal Government

- Conduct a national audit of barriers to Birthing on Country Services to develop a strategic plan.
- Review Clinical Services Capability Frameworks to improve service provision for rural and remote maternity and Birthing on Country Services, and to develop an evidence-based, culturally appropriate, national tool to guide public and private maternity facilities.
- Contemporise and abolish regulatory requirement for 5,000 hours of clinical practice to gain midwifery endorsement; enable Medicare rebates for non-endorsed midwives while supervised by endorsed midwives.
- Implement all recommendations in the Participating Midwifery Reference Group Report to the Medicare Taskforce.
- Ensure an affordable professional indemnity insurance product covering all healthcare organisations with Commonwealth support for high-cost claims.
- Develop a Birthing on Country funding stream for First Nations Health Services to provide sustainable maternity services.

For State/Territory Governments

- Audit and map jurisdictional barriers to Birthing on Country Services to develop a strategic plan.
- Revise the *Neonatal services module (QLD):*[2]

Remove phrase *"access—24 hours— to registered medical practitioner able to attend within 30 minutes in normal circumstances."*[2] Insert instead *"access – 24 hours – to registered medical practitioner through a higher-level service in the network."*

Revise the *Private Health Facilities Regulation 2017 (NSW):*[3] Remove 38a & 38b from Part 10. Insert instead *"24-hour access to anaesthetists, obstetricians and paediatricians through a higher-level service in the network."*

Executive summary

There is a Referendum on a First Nations Voice to Parliament and unprecedented political commitment to respect the knowledge, voices, concerns, aspirations and demands of the Aboriginal and Torres Strait Islander peoples.[4] Closing the Gap Priority Reform 2 Target is to increase the amount of government funding for Aboriginal and Torres Strait Islander programs and services going through Aboriginal and Torres Strait Islander Community Controlled Health Services (ATSICCHS) and organisations.

Birthing on Country Services are evidence-based complex innovations for First Nations women and babies shown to improve outcomes[5] and experiences, and reduce costs.[6] However, ATSICCHS wanting to establish these services have encountered policy, economic and legal barriers that have delayed progress. We have critically analysed the barriers to implementation of Birthing on Country Services in two jurisdictions (Queensland and New South Wales) and have made policy recommendations.

Purpose

Australian maternity, health and social service systems fail First Nations women and infants and arguably continue to harm through inadequately addressing health inequities and systemic racism. First Nations women are 3-5 times more likely to die in childbirth, and babies are almost twice as likely to be born too soon (preterm), too small (low birth weight), to die during pregnancy (stillborn), soon after birth (neonatal death) or in their first year of life (infant mortality).[7] Most ATSICCHS provide some maternity services during pregnancy and the postnatal period, but some ATSICCHS aim to expand services to include intrapartum care by establishing maternity services and facilities which are:

> *"…community based and governed; allow for incorporation of traditional practice; involve a connection with land and country; incorporate a holistic definition of health; value Aboriginal and/or Torres Strait Islander and non-Indigenous ways of knowing and learning., risk assessment and service delivery; are culturally competent; and developed by, or with, Aboriginal and/or Torres Strait Islander people."*[8]

Endorsed midwives are the optimal midwifery workforce for ATSICCHS Birthing on Country Services because they can lever additional funding through Medicare; work to full scope of practice across pregnancy, labour and birth, and provide postnatal care up to six weeks; order diagnostic maternity care tests and ultrasounds; and prescribe a limited number of timely and relevant medications.
Birth centres are Level 2 capability maternity facilities that provide midwifery care to women and babies at low chance of developing complications, using seamless transfer procedures to access higher level medical services if required.[1] In all jurisdictions, birth centres owned and operated by non-government organisations are considered a private health facility.

Critical analysis

Barriers to use of endorsed midwifery workforce

Public hospitals get less funding

Endorsed midwives (employed by ATSICCHS) admit pregnant women as ‘private patients’ to public hospitals for labour and birth and continue providing direct care throughout the admission. When this occurs, **public hospitals receive a reduction in activity-based funding (ABF) due to private patient accommodation and service adjustments**. However, the hospital’s reduction in ABF is offset by savings on rostered midwifery staff who are not required for each private patient. Nevertheless, the reduction in ABF acts as a barrier to collaboration between ATSICCHS and public maternity facilities, especially for smaller hospitals. Therefore, we recommend a waiver of private patient adjustments for all women carrying a First Nations baby.

Midwives do not graduate ready for Birthing on Country Services

Unlike other countries, for example New Zealand, where midwives obtain the ability to prescribe and provide publicly billable services upon registration, midwives in Australia must meet additional cumbersome regulatory requirements. Specifically, the Nursing and Midwifery Board of Australia requires midwives to demonstrate 5,000 hours of post-registration clinical practice and completion of a postgraduate program in midwifery prescribing. The result is **<1,000 of the more than 30,000 registered midwives in Australia have endorsement**[9] and are therefore ready to work in Birthing on Country Services. In the short term, a review to either abolish or reduce to the clinical practice hours (e.g., 1,000 hours), would immediately increase the number of midwives able to apply for endorsement. In the medium term, midwifery prescribing could be required in undergraduate midwifery education so that midwives complete their degrees workforce ready. This change, combined with abolition of post-registration clinical hours, would result in **>10,000 midwives ready to prescribe and claim Medicare by 2033** (based on current >10% annual increase in midwife-only registrations[9]).

Medicare rebates for midwifery services fall short

In 2018, changes to the current Medicare Benefit Schedule (MBS) for maternity services were recommended by the multi-disciplinary Participating Midwife Reference Group (PMRG), as part of the overall review of the MBS.[10] Despite consensus from the PMRG, the Taskforce did not endorse the following critical recommendations:

- Amend the antenatal attendance items and introduce new items for long antenatal attendance and complex care leading to a hospital admission.
- Amend the postnatal attendance items and introduce a new item for a long postnatal attendance and extend the period for postnatal lactation services to 2 years.
- Addition of a small number of pathology and diagnostic investigations to the MBS rebate schedule for participating midwives as recommended by clinical guidelines.
- Expand medical indemnity insurance to support a mother’s choice regarding place of birth (e.g., homebirth).

No professional indemnity insurance product covers ATSICCHS for high-cost claims

Insurance is available for individual endorsed midwives through the Midwifery Professional Indemnity Scheme, which includes government support for high-cost claims. However, when organisations (like ATSICCHS) employ endorsed midwives, there is only one insurer who offers a policy that covers professional indemnity insurance for the organisation and their employees. This product is prohibitively expensive because it is not supported through Commonwealth subsidies or offsets for high-cost claims.

Barriers to First Nations birth centres

In Australia, licensing standards for private health facilities are determined by legislation that differ or conflict between jurisdictions and appear to have no evidence base. Clinical Service Capability Frameworks (CSCFs) Level 2 for maternity facilities are akin to birth centres where evidence demonstrates benefit for well mothers and babies in a non-medical midwifery environment.[11,12] In Queensland, the CSCF for Public and Licensed Private Health Facilities outlines the minimum requirements for a safe service, including modules that define minimum capability criteria.[13] The Neonatal Module now appears to include contradictory requirements, as evidenced by the following two statements:

"If birth in a facility without the necessary capabilities cannot be avoided, the infant should be stabilised and transferred to a higher level of care within the service network—one with the required capabilities to ensure the infant's optimal outcome."[2]

The second statement that relates to neonates, however, is dissimilar to the maternity CSCF because it requires medical attendance to the Level 2 facility:

"access—24 hours— to registered medical practitioner able to attend within 30 minutes in normal circumstances."[2]

In NSW, the Private Health Facilities Regulation 2017 (NSW)[3] has the following requirements for Level 2 maternity facilities providing intrapartum care:

"38. Normal risk pregnancies
(a) obstetricians, anaesthetists, and a paediatrician on call at all times
(b) a medical practitioner at the facility at all times."[3]

Additionally, this 2017 Regulation states that the licensee of a private health facility must ensure that a registered *nurse* is always on duty at the facility when a patient is admitted, and that a director of nursing be appointed.[3] These requirements are inconsistent with the clinical expertise and legally distinct professional roles of nurse and midwife, and the operational requirements for the Level 2 facility to be staffed by midwives. While the *Private Health Facilities Amendment (Birthing on Country Demonstration Facilities) Regulation 2023 [NSW]*[14] allows for one facility to be exempt from these requirements, the Regulation 2017[3] acts as a barrier to any other Birthing on Country facility in NSW meeting private licensing standards.

Conclusions and recommendations

Practical actions are required of federal and jurisdictional governments. It is time to respect the knowing, doing and being of First Nations women seeking culturally responsive and respectful birth practices on country to reduce unnecessary harm to mothers and their babies. It is time for the ATSICCHS sector to take the lead regarding policies that directly affect maternity care First Nations communities.

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