



# Post Consultation Report from the Participating Midwife Reference Group

2019

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### Important note

This report does not constitute the final position on these items, which is subject to:

- Consideration by the MBS Review Taskforce;

Then

- Consideration by the Minister for Health; and
- Government.



## Table of contents

<b>1. Executive summary.....</b>	<b>9</b>
1.1 Introduction .....	9
1.2 Review of midwifery MBS items .....	9
1.3 Key issues .....	9
1.4 Key recommendations .....	10
1.5 Other Issues .....	11
1.6 Consumer impact .....	12
<b>2. About the Medicare Benefits Schedule (MBS) Review.....</b>	<b>14</b>
2.1 Medicare and the MBS.....	14
2.1.1 What is Medicare?.....	14
2.2 What is the MBS? .....	14
2.3 What is the MBS Review Taskforce?.....	14
2.3.1 What are the goals of the Taskforce?.....	14
2.4 The Taskforce's approach .....	15
2.4.1 What is a primary care reference group?.....	16
2.4.2 The scope of the primary care reference groups .....	17
<b>3. About the Participating Midwife Reference Group.....</b>	<b>18</b>
3.1 Participating Midwife Reference Group members .....	18
3.2 Conflicts of interest.....	19
3.3 Areas of responsibility of the Reference Group.....	19
3.4 Summary of the Reference Group's review approach.....	21
<b>4. Main themes in Maternity care in Australia.....</b>	<b>22</b>
<b>5. Recommendations.....</b>	<b>26</b>
5.1 Antenatal attendances.....	26
5.1.1 Recommendation 1 – Include a minimum duration for initial antenatal attendances and align the schedule fee with average attendance duration	26
5.1.2 Rationale 1 .....	27
5.1.3 Recommendation 2 – Amend the antenatal attendance items to appropriately reflect the time they take and introduce a new time tier for long antenatal attendances .....	28



5.1.4	Rationale 2 .....	29
5.1.5	Recommendation 3 – Introduce a new item for a complex antenatal attendance leading to a hospital admission .....	31
5.1.6	Rationale 3 .....	31
5.1.7	Recommendation 4 – Restrict claiming of maternity care plans to prevent low-value care.....	33
5.1.8	Rationale 4 .....	34
5.2	Intrapartum care .....	35
5.2.1	Recommendation 5 – Amend time tiering of intrapartum items.....	35
5.2.2	Rationale 5 .....	36
5.2.3	Recommendation 6 – Increase the per-minute schedule fee for intrapartum care .....	38
5.2.4	Rationale 6 .....	39
5.2.5	Recommendation 7 – Enable intrapartum items to be claimed from the time the midwife attends the woman for labour care .....	40
5.2.6	Rationale 7 .....	40
5.2.7	Recommendation 8 – Include home birthing in intrapartum items.....	41
5.2.8	Rationale 8 .....	41
5.3	Postnatal attendances .....	44
5.3.1	Recommendation 9 – Amend the postnatal attendance items and introduce a new item for a long postnatal attendance .....	44
5.3.2	Rationale 9 .....	45
5.3.3	Recommendation 10 – Include mandatory clinical activities and increase the minimum time for a six-week postnatal attendance.....	47
5.3.4	Rationale 10 .....	47
5.4	Telehealth attendances.....	48
5.4.1	Recommendation 11 – Include GPs as eligible specialists for existing telehealth items.....	48
5.4.2	Rationale 11 .....	49
5.4.3	Recommendation 12 – Facilitate telehealth consultations between women and midwives in the antenatal and postnatal period.....	50
5.4.4	Rationale 12 .....	51
5.5	Enhance access to lactation support .....	53
5.5.1	Problem identified .....	53
5.5.2	Recommendation 13 Add a new item to the MBS for claiming for participating midwives to conduct ongoing lactation support.....	53
5.5.3	Rationale 13 .....	54



5.6	Facilitating the Consumer Journey – expanding midwife access to pathology and diagnostic investigations.....	56
5.6.1	Problem identified.....	56
5.6.2	Recommendation 14 - Addition of a small number of pathology and diagnostic investigation to the MBS rebate schedule for participating midwives as recommended by professional clinical guidelines .....	56
5.6.3	Rationale 14 .....	58
5.7	Improving Women’s Access to Midwifery Care by Removal of Mandated Collaborative Agreements .....	58
5.7.1	Problem Identified.....	58
5.7.2	Recommendation 15 - Removal of the need for mandated formal collaborative agreements .....	59
5.7.3	Rationale .....	59
<b>6.</b>	<b>Access to midwifery care .....</b>	<b>62</b>
6.1	Consumer access to midwifery continuity of care.....	62
6.1.1	Structural barriers.....	62
6.1.2	Professional Indemnity Insurance .....	63
6.1.3	Recency of practice.....	63
6.1.4	Midwifery Prescribing Pathway .....	63
6.1.5	Early career Pathway to Midwifery Private Practice .....	64
6.2	Financial barriers.....	64
6.2.1	Bundled payment funding model .....	65
6.3	Summary .....	67
<b>7.</b>	<b>Impact statement .....</b>	<b>67</b>
<b>8.</b>	<b>References</b>	<b>69</b>
<b>9.</b>	<b>Glossary</b>	<b>75</b>
<b>Appendix A</b>	<b>Full list of in-scope items.....</b>	<b>78</b>
<b>Appendix B</b>	<b>Full list of recommendations .....</b>	<b>80</b>
<b>Appendix C</b>	<b>Summary for consumers .....</b>	<b>90</b>
<b>Appendix D</b>	<b>Mapping new intrapartum items to clinical cases .....</b>	<b>105</b>
<b>Appendix E</b>	<b>Comparison of obstetric and midwifery care during birth.....</b>	<b>107</b>
<b>Appendix F</b>	<b>Response provided to GPPCCC referred questions .....</b>	<b>108</b>



<b>Appendix G</b>	<b>Pathology and Diagnostic investigations currently omitted from the 2010 Midwifery approved MBS list. ....</b>	<b>109</b>
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## List of tables

Table 1: Participating Midwife Reference Group members .....	18
Table 2: Items 82100, 82105, 82110 and 82115 .....	26
Table 3: Items 82120 and 82125 .....	35
Table 4: Items 82130, 82135 and 82140 .....	44
Table 5: Items 82150–82152 .....	48
Table 6: Pathology and diagnostic investigations that the PMRG recommends should be available for participating midwives.....	56
Table 6: Pathology and diagnostic investigations that the PMRG recommends should be available for participating midwives.....	88



## List of figures

Figure 1: Drivers of benefit growth, 2011/12 to 2016/17 .....	20
Figure 2: Midwifery item groups ordered by service volume .....	21
Figure 3: Rebate attendance at a case conference by non-doctor health professionals	<b>Error! Bookmark not defined.</b>



# 1. Executive summary

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## 1.1 Introduction

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is undertaking a program of work that considers how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health (the Minister) that will allow the MBS to deliver on each of four key goals:

- Affordable and universal access.
- Best-practice health services.
- Value for the individual patient.
- Value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by clinical committees, primary care reference groups (PCRGs) and working groups.

## 1.2 Review of midwifery MBS items

The Participating Midwife Reference Group (the Reference Group) was established in 2018 to make recommendations to the Taskforce on MBS items in its area of responsibility, based on rapid evidence review and clinical expertise.

The PCRGs provide recommendations to the Taskforce in a review report. Once endorsed by the Taskforce, the review reports are released for targeted stakeholder consultation. The Taskforce considers the revised review reports, which include stakeholder feedback, before making recommendations to the Minister for consideration by Government.

## 1.3 Key issues

Throughout the review process, several consistent themes became apparent to the Reference Group, based on extensive group discussions, data and literature reviews, consumer feedback, and stakeholder representation. These themes are relevant not just to



the recommendations contained in this report, but also to the current challenges and future directions of maternity care in Australia. The four themes identified were:

1. There is overwhelming evidence that midwifery continuity of care results in outstanding clinical, financial and consumer satisfaction outcomes that benefit families and the community.
2. Across Australia, less than 10 per cent of women can access continuity of midwifery care, despite strong demand. Significant barriers currently prevent consumer access to MBS-rebated midwifery continuity of care in Australia, despite the benefits associated with the model. These barriers include legislative, regulatory and insurance impediments.
3. “Bundled payment” funding models may more appropriately reflect the model and increase the uptake of midwifery continuity of care in Australia. This funding model would also be simpler for consumers, as would a single rebate provided for their maternity care.
4. Optimal maternity care requires cooperation between care providers. While there is compelling evidence that continuity of care by a known midwife results in enhanced outcomes for a woman and baby, collaboration between clinicians is essential to ensure the best outcome for women and babies in all possible scenarios.

## 1.4 Key recommendations

The Reference Group has recommended significant amendments to existing items and the creation of new items. These recommendations promote high-quality care and safe practice through the MBS, in alignment with current guidelines for supporting mothers and their babies through pregnancy and birth.

The Reference Group’s recommendations are as follows:

- Antenatal attendances
  1. Include a minimum time for initial antenatal attendances and align the schedule fee with average attendance duration.
  2. Amend the antenatal attendance items to appropriately reflect the time they take and introduce a new time tier for long antenatal attendances.
  3. Create a new item for complex antenatal attendance leading to a hospital admission.
  4. Restrict claiming of maternity care plans to instances where a woman has had at least two prior antenatal attendances.
- Intrapartum Care



5. Change the time-tiering structure of intrapartum items to facilitate safe birthing and an earlier handover to a second midwife, if necessary.
  6. Increase per-minute rebates for intrapartum items.
  7. Enable intrapartum items to be claimed from the commencement of midwifery attendance with the woman for labour care (i.e. outside of hospital).
  8. Include homebirth in intrapartum items.
- Postnatal attendances
    9. Amend the postnatal attendance items to appropriately reflect the time they take and introduce a new time tier for long postnatal attendances.
    10. Include mandatory clinical components and increase the minimum time for a six-week postnatal attendance.
  - Telehealth attendances
    11. Include general practitioners (GPs) as eligible specialists for existing telehealth items.
    12. Facilitate telehealth consultations between women and midwives in the antenatal and postnatal period.
  - Lactation and Infant feeding
    13. Addition of a new item to enable Participating Midwives to conduct ongoing lactation support until an infant is 2 years of age.
  - Diagnostics and Investigations
    14. Addition of a small number of pathology and diagnostic investigation to the MBS rebate schedule for Participating Midwives as recommended by professional clinical guidelines.
  - Barriers to Midwifery Continuity of Care
    15. Removal of the need for mandated formal collaborative agreements.

The Reference Group considers the recommendations on MBS intrapartum items (Recommendations 5 to 8) are a priority, in order to ensure the sustainability of the model for consumers.

## 1.5 Other Issues

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.

Section 6 addresses the issue of access to midwifery care, under two main headings:

- Structural barriers
- Financial Barriers

In outlining these issues the Reference Group proposes that the Government further explore:

- Ways of removing or overcoming barriers to access of midwifery services
- Financial models, such as the bundling of services, for midwifery services that supports women over the full term of the pregnancy and the post-natal period

The Reference Group suggests that these issues be followed up over the next 18 months.

## 1.6 Consumer impact

All recommendations have been summarised for consumers in Appendix A - Summary for consumers. The summary describes the midwifery service, the recommendation of the clinical experts and the rationale behind the recommendations.

The Reference Group has developed recommendations that are consistent with Taskforce objectives, with a primary focus on improving the quality of private midwifery services for women. Consumer representatives in the Reference Group stressed the importance of a “woman-centred” approach that optimises the environment for her and her growing baby in a way that is important to her and her family. This is enshrined in several of the group’s recommendations.

The Reference Group’s recommendations will benefit mothers and babies in the following ways:

- **Access:** Strengthening midwifery practice in Australia is necessary so that all women, regardless of their location or personal circumstances, have the choice to access a model of care that is safe and consistently evaluated to result in birth outcomes equal or superior to other models of care. Mothers want real birthing choices and support along their journey through pregnancy and into parenthood.
- **Consumer control of their care experience:** Building trust with a known midwife lessens apprehension during pregnancy and ensures a mother’s birth preferences are supported. From a consumer perspective, the recommendations in this report are also an important step forward to support consumer choice.



- **High-value care:** The recommendations in this report support midwifery continuity of care, which evidence demonstrates provides high-value care to women. The recommendations to tackle structural barriers to midwifery care in Australia build on the more immediate changes to MBS items proposed in this report.
- **Building a culture of collaboration:** Women value and come to rely on the relationship with their midwife, however there are circumstances that require collaboration between clinicians or the transfer of care in the antenatal, intrapartum and postpartum period in order to provide the best outcome for that woman. It is essential that the MBS reflects these professional inputs appropriately and recognises the importance of both professionals throughout sometimes complex clinical scenarios.



## 2. About the Medicare Benefits Schedule (MBS) Review

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### 2.1 Medicare and the MBS

#### 2.1.1 What is Medicare?

Medicare is Australia's universal health scheme that enables all Australian residents (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost.

Introduced in 1984, Medicare has three components:

- Free public hospital services for public patients.
- Subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS).
- Subsidised health professional services listed on the MBS.

### 2.2 What is the MBS?

The MBS is a listing of the health professional services subsidised by the Australian Government. There are more than 5,700 MBS items that provide benefits to patients for a comprehensive range of services, including consultations, diagnostic tests and operations.

### 2.3 What is the MBS Review Taskforce?

The Government established the Taskforce as an advisory body to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also modernise the MBS by identifying any services that may be unnecessary, outdated or potentially unsafe. The MBS Review is clinician-led, and there are no targets for savings attached to the review.

#### 2.3.1 What are the goals of the Taskforce?

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of four key goals:

- **Affordable and universal access**—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade,



access to many specialist services remains problematic, with some rural patients being particularly under-served.

- **Best-practice health services**—one of the core objectives of the MBS Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base when possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.
- **Value for the individual patient**—another core objective of the review is to have an MBS that supports the delivery of services that are appropriate to the patient’s needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.
- **Value for the health system**—achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

## 2.4 The Taskforce’s approach

The Taskforce is reviewing existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce’s brief, there is considerable scope to review and provide advice on all aspects that would contribute to a modern, transparent and responsive system. This includes not only making recommendations about adding new items or services to the MBS, but also about an MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach, and to seize this unique opportunity to recommend changes to modernise the MBS at all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues. The Taskforce will also develop a mechanism for an ongoing review of the MBS once the current review has concluded.

As the MBS Review is clinician-led, the Taskforce decided that clinical committees should conduct the detailed review of MBS items. The Taskforce also established PCRGs to review MBS items largely provided by non-doctor health professionals. The committees and PCRGs are broad-based in their membership, and members have been appointed in an individual capacity, rather than as representatives of any organisation.



### 2.4.1 What is a primary care reference group?

The Taskforce established the PCRGs to focus on items that are primarily or exclusively provided by non-doctor health professionals, and which have a close relationship to primary care. The MBS Review Taskforce established five PCRGs:

- Aboriginal and Torres Strait Islander Health Reference Group
- Allied Health Reference Group
- Mental Health Reference Group
- Nurse Practitioner Reference Group, and
- Participating Midwives Reference Group.

The PCRGs are similar to the clinical committees established under the MBS Review. Each PCRG reviewed in-scope items, with a focus on ensuring that individual items and usage meet the four goals of the Taskforce. They also considered longer-term recommendations related to broader issues (not necessarily within the current scope of the MBS) and provided input to clinical committees, including the General Practice and Primary Care Clinical Committee (GPPCCC). Each PCRG has made recommendations directly to the Taskforce, as well as to other committees, based on clinical expertise, data, and evidence collected by members of each PCRG.

The PCRGs are unique within the MBS Review for several reasons:

- **Membership:** Similar to clinical committees, the PCRGs include a diverse set of stakeholders, as well as an ex-officio member from the MBS Review Taskforce. As the PCRGs focus on items that are primarily or exclusively provided by non-doctor health professionals, and which have a close relationship to primary care, membership includes many non-doctor health professionals, as well as an ex-officio member from the GPPCCC. Each PCRG also includes a GP, a nurse, and two consumers.
- **Connection to the GPPCCC:** As part of their mandate from the Taskforce, the PCRGs were tasked with responding to issues referred by the GPPCCC. The GPPCCC ex-officio member on each PCRG helped to strengthen the connection between the two bodies and supported communication of the PCRGs' responses back to the GPPCCC.
- **Newer items:** The items reviewed by the PCRGs have a shorter history than other items within the MBS; many were introduced only in the last decade. While this means that there is less historical data for PCRG members to draw on, it also means that there are fewer items under consideration that are no longer relevant, or that no longer promote best-practice interventions, compared to other committees.



- **Growth recommendations:** Several of the PCRGs' in-scope items have seen significant growth since their introduction, often with the potential to alleviate cost pressures on other areas of the MBS or the health system, or to increase access in low-access areas. As a result, many recommendations focus on adjusting items that are already working well, or expanding recently introduced items through increased access or expanded scope.

#### 2.4.2 The scope of the primary care reference groups

All MBS items will be reviewed during the course of the MBS Review. Given the breadth of the review, and its timeframe, each clinical committee and PCRG developed a work plan and assigned priorities in line with the objectives of the review.

The PCRG review model approved by the Taskforce required the PCRGs to undertake three areas of work, prioritised into two groups.

- Priority 1 - Review referred key questions on draft recommendations from the GPPCCC and develop recommendations on referred in-scope MBS items.

As part of this work, the PCRGs also reviewed and developed recommendations on referred issues from other committees or stakeholders where relevant.

- Priority 2 - Explore long-term recommendations.

These included recommendations related to other MBS items beyond the PCRGs' areas of responsibility, recommendations outside the scope of existing MBS items, and recommendations outside the scope of the MBS, including recommendations related to non-fee-for-service approaches to health care.



## 3. About the Participating Midwife Reference Group

The Participating Midwife Reference Group (the Reference Group) was established in 2018 to make recommendations to the Taskforce on MBS items within its area of responsibility, as well as long-term issues, and to respond to referred questions from the GPPCCC.

### 3.1 Participating Midwife Reference Group members

The Reference Group consists of 12 members, whose names, positions/organisations and declared conflicts of interest are listed in Table 1.

**Table 1: Participating Midwife Reference Group members**

Name	Position/organisation	Declared conflict of interest
Ms Donna Garland	Operations Director, Women's and Newborn Health, Westmead Hospital	Nil
Prof. Jonathan Morris	Professor of Obstetrics and Gynaecology, The University of Sydney; Maternal Foetal Medicine Specialist, Royal North Shore Hospital, Northern Sydney Local Health District (NSLHD), Sydney	Nil
Prof. Sue Kildea	Professor of Midwifery, Director of the Midwifery Research Unit, Mater Research Institute University of Queensland, UQ School of Nursing, Midwifery and Social Work, Mothers, Babies and Women's Services, Mater Health Service	Nil
Ms Elizabeth Wilkes	Registered midwife, Endorsed midwife; Managing Director, My Midwives	midwife using Medicare items in private practice
Ms Marijke Eastaugh	Registered midwife, Endorsed midwife; International Board-Certified Lactation Consultant	midwife using Medicare items in private practice
Ms Julianna Badenoch	Registered Nurse and midwife	Nil



Name	Position/organisation	Declared conflict of interest
Dr Gwendoline Burton	Chair, Royal Australian College of General Practitioners (RACGP) Antenatal and Postnatal Care Network	Nil
Ms Alecia Staines	Director, Maternity Consumer Network	Nil
Ms Penelope Lello	Director, Deepening Change; Committee roles held at: South Australian Health and Medical Research Institute; Department for Health and Wellbeing South Australia; Central Adelaide Local Health Network (CALHN) Allied Health Clinical Governance; and the Women's and Children's Hospital Network	Nil
Dr Bev Rowbotham (Taskforce ex-officio)	Associate Professor of Pathology, University of Queensland	Nil
Adj. Prof. Debra Thoms (Dept. medical officer)	Chief Nursing and Midwifery Officer, Department of Health	Nil
Dr Ewen McPhee (GP Committee ex-officio)	General Practitioner and President of Rural Doctors Association of Australia	Nil

## 3.2 Conflicts of interest

All members of the Taskforce, clinical committees and PCRGs are asked to declare any conflicts of interest at the start of their involvement and reminded to update their declarations periodically. A complete list of declared conflicts of interest can be viewed in Table 1.

It is noted that two Reference Group members share a common conflict of interest in reviewing items that are a source of revenue for them (i.e. members claim the items under review). This conflict is inherent in a clinician-led process, and having been acknowledged by the Reference Group and the Taskforce, it was agreed that this should not prevent members from participating in the review.

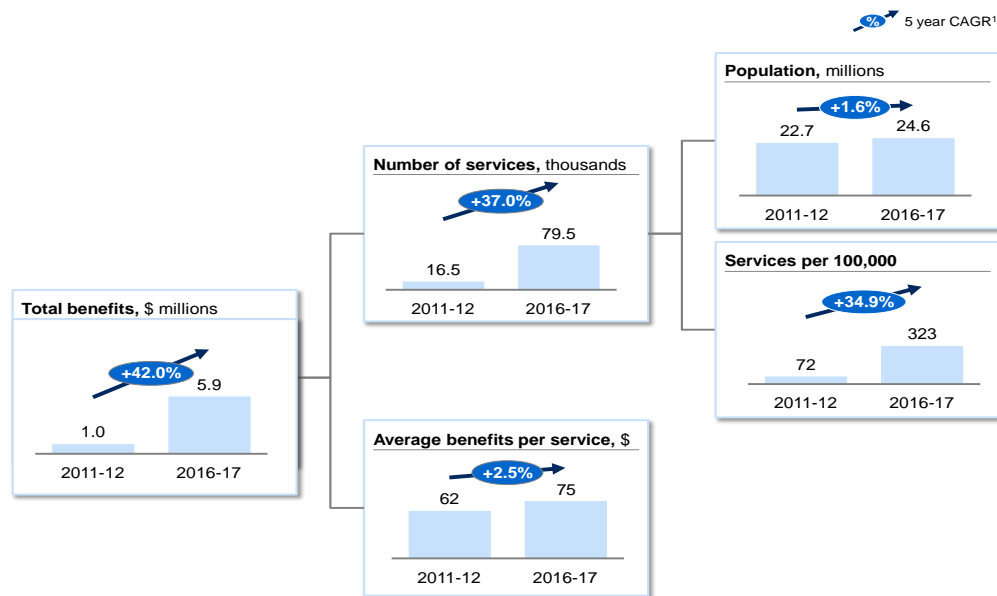
## 3.3 Areas of responsibility of the Reference Group

Items for participating midwives were added to the MBS in 2010. These MBS items are provided by participating midwives, i.e. midwives endorsed by the Nursing and Midwifery Board of Australia (NMBA) who work in a collaborative arrangement as defined in legislation. The Reference Group was asked to review the 12 items in MBS group *M13: Midwifery Services (82100–82152)*.



These 12 items cover antenatal, intrapartum and postnatal (up to seven weeks post-birth) periods of care. In 2016/17, approximately 79,500 services were claimed and \$5.9 million was paid in benefits under these items. Over the past five years, service volumes for midwifery MBS items have increased by 37 per cent (compounded annually), and the cost of benefits has increased by 2.5 per cent (compounded annually) (Figure 1).

**Figure 1: Drivers of benefit growth, 2011/12 to 2016/17**



Source: MBS Data 2011/12 – 2016/17

In 2016/17, long antenatal and postnatal professional attendances lasting at least 40 minutes accounted for approximately 67 per cent of service volume. Long postnatal professional attendances had the highest service volume, at 28,844 services (Figure 2).



**Figure 2: Midwifery item groups ordered by service volume**

Item	Descriptor	Service volume (FY2016/17) Thousands	Benefits (FY2016/17) \$ Millions
82135	Long postnatal professional attendance by a participating midwife, lasting at least 40 minutes, within 6 weeks after delivery	29	2.00
82110	Long antenatal professional attendance by a participating midwife, lasting at least 40 minutes.	24	1.16
82105	Short antenatal professional attendance by a participating midwife, lasting up to 40 minutes.	12	0.35
82115	Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks	6	1.71
82100	Initial antenatal professional attendance by a participating midwife, lasting at least 40 minutes	4	0.18
82130	Short postnatal professional attendance by a participating midwife, lasting up to 40 minutes, within 6 weeks after delivery	3	0.11
82140	Postnatal professional attendance by a participating midwife on a patient not less than 6 weeks but not more than 7 weeks after delivery of a baby	1	0.05
82120	Management of confinement for up to 12 hours, including delivery (if undertaken)	1	0.30
82125	Management of confinement for in excess of 12 hours, including delivery where performed; when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife)	0	0.08
82152	A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	0	0.00 <sup>1</sup>
82151	A professional attendance lasting at least 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	0	0.00 <sup>1</sup>
82150	A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	0	0.00 <sup>1</sup>

Source: MBS Data 2011/12 – 2016/17

### 3.4 Summary of the Reference Group's review approach

The Reference Group completed its work across four full-day meetings and a number of teleconferences, during which it developed the recommendations and rationales outlined in this report.

The review drew on various types of MBS data, including data on:

- utilisation of items (services, benefits, patients, providers and growth rates)
- service provision (type of provider, geography of service provision); patients (demographics and services per patient)
- co-claiming or episodes of services (same-day claiming and claiming with specific items over time); and
- additional provider and patient-level data, when required.

The review also drew on information available in relevant national and professional guidelines, medical literature, and other high-quality sources of evidence, all of which are referenced in the report.

The Reference Group reviewed and considered hundreds of relevant stakeholder submissions to the MBS Review in making its recommendations.



## 4. Main themes in Maternity care in Australia

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Throughout the review process, several consistent themes became apparent to the Reference Group, based on extensive group discussions, data and literature reviews, consumer feedback, and stakeholder representation. These themes are relevant not just to the recommendations contained in this report, but also to the current challenges and future directions of maternity care in Australia. The four themes identified were:

- 1. There is overwhelming evidence that midwifery continuity of care results in outstanding clinical, financial and consumer satisfaction outcomes that benefit families and the community.**

### **Optimal clinical outcomes:**

- Throughout the developed world, normal birth rates are decreasing and interventions are increasing, yet there is no improvement in maternal and neonatal mortality as a result. Government plans such as “Towards Normal Birth” (NSW Health) and WHO recommendations highlight the need to reduce unnecessary interventions (1; 2; 3; 4). Over the past 10 years, midwifery continuity of care models internationally and in Australia have continually demonstrated outstanding clinical outcomes, including (5; 6):
  - Normal birth rates above 80 per cent.
  - Decreased intervention rates compared to other maternity care models.
  - Improved outcomes for mothers and infants, including reduced preterm birth and foetal and neonatal death.
  - No associated increases in maternal or neonatal mortality.
- Importantly, midwifery continuity of care has been shown to mitigate the effects of high levels of stress on postnatal maternal mental health (6).
- The Reference Group agrees that any strategies that promote access to this model of care for women and families should be supported.

### **Fiscally advantageous model:**

- Midwifery continuity of care avoids many high-cost interventions and improves clinical outcomes, leading to lower health costs (for example, increased breastfeeding rates, improved mental health outcomes and improved immunity) (7). The M@NGO



study compared the cost of continuity of midwifery care with standard maternity care for women at all risk levels in Australia. The study demonstrated that the total cost of care per woman was \$566.74 (95 per cent) less for midwifery continuity of care than for standard maternity care. When infant costs were included, this increased to \$838.17 per mother/infant pair (8).

- The current national efficient price (2018/19) for an uncomplicated normal birth (O60C) is \$4082 (wt 0.8145). This price is for the in-patient component of labour, birth and postnatal care only (excludes antenatal care and postnatal home visits). (9). Although states and territories are funded at this amount for the care they provide to women, the MBS schedule fee for the same care provided by a private midwife is \$753.30, despite the midwifery model resulting in enhanced outcomes compared to most standard hospital models.
- The Reference Group contends that increasing access to midwifery continuity of care would decrease the overall cost of maternity care by redistributing funding.

**Consumer satisfaction and demand:**

- The consumer voice for maternity care in Australia is strong, persistent and consistent in its messaging. All reviews of maternity services conducted over the last two decades indicate that consumers want choice in their care and access to continuity of care.
- The most recent consumer feedback comes from the first round of consultation on the National Strategic Approach to Maternity Services (NSAMS). This clearly indicates a demand for midwifery continuity of care, and that access is limited through the public hospital system for women with pregnancies at all levels of risk. Consultation feedback also indicated the need to make changes to MBS midwifery items to improve access for women (10; 11)<sup>1</sup>.

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<sup>1</sup> Three members sit on both the Advisory Group to NSAMS and this group. The chief nursing and midwifery officer sits on both.



- The 2009 Report of the Maternity Services Review (*the Report*) noted that consumer submissions demonstrated a clear preference for care by midwives, either in birthing centres or in the home setting. Overall, the Report recommended changes to improve choice and the availability of a range of models of maternity care for Australian mothers by supporting an expanded role for midwives (12).
- 2. Across Australia, less than 10 per cent of women can access continuity of midwifery care, despite strong demand. (13)**
- Significant barriers currently prevent consumer access to MBS-rebated midwifery continuity of care in Australia, despite the benefits associated with the model, including:
    - **Legislative barriers:** The implementation of MBS-rebated midwifery continuity of care has been limited by requirements for midwives to enter into collaborative arrangements, and by the lack of public hospitals offering “access agreements” to participating midwives to enable the admission of a woman to hospital under the continuing care of the midwife.
    - **Regulatory barriers:** Midwives are required to have amassed 5000 hours of direct clinical care in six years prior to obtaining an MBS provider number. This requirement, coupled with a requirement for postgraduate qualifications in prescribing and diagnostics (rather than recognition of undergraduate qualifications), has limited access for women to MBS-rebated midwives.
    - **Insurance barriers:** Complex insurance legislation requires midwives to be sole traders or directors of the company that employs them. This means that participating midwives are restricted from working in a midwifery practice unless they are the director. This limits women’s access to midwives with appropriate insurance. In addition, there is no insurance product available for participating midwives attending homebirths, and no affordable insurance product for Aboriginal Community Controlled Health Organisations to employ midwives to provide intrapartum care.
- 3. “Bundled payment” funding models may more appropriately reflect the model and increase the uptake of midwifery continuity of care in Australia.**
- Bundled payments for health care have been implemented internationally, leading to improvements in quality of care. (14; 15) The Reference Group contends that the clearly delineated components of maternity care (antenatal, intrapartum, postnatal) make this model appropriate for further exploration. This funding model would also be simpler for consumers, as would a single rebate provided for their maternity care.



#### **4. Optimal maternity care requires cooperation between care providers.**

- The Reference Group understand the importance of collaboration between clinicians to ensure the best outcome. When a normal pregnancy becomes complex then a midwife will collaborate with an obstetrician, in the same vein when a pregnancy is complicated for example by cardiomyopathy or renal disease the obstetrician will collaborate with the relevant physician. Clear guidance is provided through the Australian College of Midwives developed and RANZCOG endorsed Consultation and Referral Guidelines regarding appropriate collaboration.
- The MBS and any future funding models need to facilitate cooperation between maternity care providers (including obstetricians, midwives, GPs, Aboriginal and Torres Strait Islander health workers and nurse practitioners). Circumstances that necessitate the transfer of care or collaboration with another clinician in the antenatal, intrapartum and postpartum period need to be reflected in the MBS, ensuring that the entirety of the professional input is recognised and valued appropriately and neither party is disadvantaged.



## 5. Recommendations

### 5.1 Antenatal attendances

**Table 2: Items 82100, 82105, 82110 and 82115**

Item	Descriptor	Schedule fee (AUD)	Services FY2016/17	Benefits FY2016/17 (AUD)	Services 5-year annual avg. growth
82100	Initial antenatal professional attendance by a participating midwife, lasting at least 40 minutes	53.40	3,883	177,829	30.0%
82105	Short antenatal professional attendance by a participating midwife, lasting up to 40 minutes.	32.30	12,154	349,024	21.5%
82110	Long antenatal professional attendance by a participating midwife, lasting at least 40 minutes.	53.40	24,209	1,156,532	36.2%
82115	Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks	319.00	6,235	1,706,909	49.3%

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

The Reference Group recommends:

- a. amending the item 82100 descriptor to increase the minimum time to 60 minutes as follows (changes in bold):

##### **Item 82100**

Initial antenatal professional attendance by a participating midwife, lasting at least **60 minutes**.

and



- b. increasing the schedule fee to better reflect the average duration of an initial antenatal attendance (approximately 90 minutes).

### 5.1.2 Rationale 1

This recommendation focuses on ensuring that the MBS reflects professional standards and high-quality care for consumers. It is based on the following:

- The Reference Group agreed that best practice requires an initial attendance of at least 60 minutes (most take more than 90 minutes). Initial antenatal consultations involve standard clinical care requirements, including physical assessment of mother and foetus; completion of ongoing screening, including ordering, undertaking and reviewing pathology and radiology investigations; and ongoing assessment of psychosocial wellbeing. Pregnancy care guidelines, endorsed by the National Health and Medical Research Council (NHMRC), outline the activities that should occur in an initial antenatal attendance to ensure high-quality clinical care (16). The Reference Group agreed that these activities cannot be undertaken to a high standard in under 60 minutes.
- The Reference Group agreed that although a midwife could feasibly complete high-quality initial antenatal attendances in 60 minutes for women with low-risk pregnancies, without complications, who are having their second or subsequent baby, the attendances take an average of 90 minutes.
- The Reference Group conducted a survey of 115 midwives across private and public settings. The average reported initial antenatal attendance duration was 91 minutes.
- Birthrate Plus (BRP) is a midwifery staffing tool used throughout the United Kingdom and adopted by NSW Health to measure workload requirements for midwives. BRP allocates 90 minutes for initial antenatal attendances for women planning to birth at home or in hospital (17).

*Note: BRP licensing agreements have also progressed in the Australian Capital Territory [ACT] and Tasmania.*

- The Reference Group agreed that a schedule fee increase congruent with the time required to complete a high-quality initial antenatal attendance would more accurately reflect the work involved and would increase access for consumers.



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

The Reference Group recommends:

- a. amending the item 82105 descriptor to specify a minimum duration of 10 minutes and removing the maximum duration of 40 minutes as follows (changes in bold):

#### **Item 82105**

Short antenatal professional attendance by a participating midwife, lasting at least 10 minutes.

- b. amending the item descriptor to describe the attendance as “routine” rather than “long”. The proposed item descriptor is as follows:

#### **Item 82110**

Routine antenatal professional attendance by a participating midwife, lasting at least 40 minutes.

- c. increasing the schedule fee to better reflect the average duration of a routine antenatal attendance of approximately 60 minutes
- d. creating a new item for a long antenatal attendance of at least 90 minutes as follows:

#### **New Item 821AA**

Long antenatal professional attendance by a participating midwife, lasting at least 90 minutes.

and

- e. setting a schedule fee for item 821AA that is higher than the schedule fee for item 82110 to account for the increased duration.



#### 5.1.4 Rationale 2

This recommendation focuses on ensuring that item time tiers accurately reflect the activities required to provide high-value care, and are appropriately rebated. It is based on the following:

- **Item 82105:** The Reference Group agreed that there are instances where short antenatal attendances (10–30 minutes) are appropriate. These visits would most frequently occur in between routine visits, or as a follow-up to a routine visit. For example:
  - A midwife may undertake a basic clinical examination, order pathology tests and explain their purpose to the woman. In a woman with a low-risk pregnancy, this will usually take 10 to 20 minutes.
  - A woman's blood pressure may be "borderline" at the routine visit. The midwife may return later that day or the next day to repeat the blood pressure, perform a urinalysis and physical exam, and discuss signs and symptoms that are important to monitor. This will usually take 10 to 20 minutes.
  - A midwife may need to consult with a woman to explain the outcome of a pathology or diagnostic screening test without further clinical examination. This will usually take 10 to 20 minutes.
- The Reference Group agreed that there are no circumstances in which antenatal attendances under 10 minutes provide high-value care to women.
- **Item 82110:** The descriptor has been amended to describe this attendance as "routine", rather than "long". The Reference Group agreed that a minimum duration of 40 minutes is appropriate for a routine antenatal attendance. NHMRC-endorsed Pregnancy Care Guidelines (16) outline the activities that should occur at a routine antenatal attendance to ensure high-quality clinical care. The Reference Group agreed that these activities cannot be undertaken to a high standard in under 40 minutes.
- It is a standard consumer expectation that a routine professional attendance by a participating midwife lasts at least 40 minutes in order to develop the necessary relationship for a partnership between mother and midwife.
- MBS data indicates that more than two-thirds of standard (i.e. not initial) participating midwife antenatal attendances are claimed under item 82110 (based on 2017/2018 data). The Reference Group agreed that this is likely to remain the "routine" antenatal time tier, even after introducing a long attendance (more than 90 minutes).



- The Reference Group agreed that although a midwife could feasibly complete high-quality routine antenatal attendances in 40 minutes for women with no complications, the attendances take an average of approximately 60 minutes. NHMRC-endorsed Pregnancy Care Guidelines outline the activities that should occur in a routine antenatal attendance to ensure high-quality clinical care. The Reference Group agreed that these take 60 minutes on average (16).
- The Reference Group conducted a survey of 115 midwives which indicated that the average routine antenatal visit takes approximately 52 minutes.
- The Reference Group agreed that a schedule fee increase would promote high-quality routine antenatal attendances, more accurately reflect the work involved, and increase access for consumers.
- **New item 821AA:** A new item is recommended for a long antenatal attendance of at least 90 minutes. The Reference Group agreed that there are many instances where antenatal attendances of over 90 minutes provide high-value care. For example:
  - For women who report domestic violence, midwives must undertake several steps to provide high-value care, including counselling, potential referral or admission, education about available services, ensuring the safety of the mother and any existing children, and developing a safety plan. These steps often take over 90 minutes.
  - For women with a disability or significant medical condition, planning many aspects of care requires longer than 90 minutes to ensure that all tests are considered, the woman and partner are counselled, and an appropriately detailed clinical examination is conducted.
  - For women with significant mental health issues, midwives often provide additional support and counselling during pregnancy, which may take over 90 minutes.
  - For women in families with a history of engagement with child safety bodies, each antenatal visit can be complex. Plans are made to refer and support women in preparation for keeping their baby and enabling positive, supportive parenting. These attendances often take over 90 minutes.
- The Reference Group noted that in cases of domestic violence and depression, longer antenatal attendances promote a close relationship between a woman and her midwife. This relationship with her “known midwife” contributes to the woman’s



likelihood to “disclose” modifiable health risks—for example, risk of future domestic violence (to mother, baby or both).

- The Reference Group considered introducing a cap on the number of long antenatal attendances that are claimable per pregnancy to prevent low-value use of item 821AA. However, it agreed that this would inadvertently restrict access for complex patients who require more care. The Reference Group noted multiple examples of clinical circumstances where more than three antenatal attendances would be required (see the examples listed above).
- The Reference Group agreed that use of this item should be reviewed in 12–24 months. The Reference Group agreed that patients with high volumes of item 821AA claims would likely be those with mental health conditions or chronic medical conditions. It noted that analysis of 821AA claims across patients with Mental Health Treatment Plans and/or GP Management Plans may provide a basis upon which to assess appropriate use of item 821AA.

### **5.1.5 Recommendation 3 – Introduce a new item for a complex antenatal attendance leading to a hospital admission**

The Reference Group recommends:

- a. creating a new item for a complex antenatal attendance leading to a hospital admission, as follows:

#### **New Item 821BB**

Complex antenatal attendance leading to a hospital admission—each professional attendance lasting at least 3 hours, to a maximum of 3 services per pregnancy.

- b. capping the number of times item 821BB can be claimed at three services per pregnancy
- c. creating a minimum duration of three hours for this item, and
- d. restricting co-claiming with all other antenatal attendances.

### **5.1.6 Rationale 3**

This recommendation focuses on ensuring that women can continue to receive care from their primary carer (participating midwife) when being admitted to hospital. It is based on the following:



- While the availability of access arrangements remains challenging for participating midwives, there has been some improvement. Public health organisations throughout Australia are now offering participating midwives access agreements to enable the admission of women under private midwifery care. Women are not only admitted for labour and birth, but also for complications during the antenatal period.
- This development has resulted in the need to develop a new MBS item for hospital admission during the antenatal period.
- In a midwifery continuity of care model, the midwife is the primary carer for the woman. Regardless of complexity, or the need to collaborate with an obstetrician, the midwife is required to complete the admission procedure, clinical assessment, testing, care planning and any foetal monitoring during and following admission.
- The work involved in these instances can be complex and prolonged, especially in the case of unplanned hospital admissions. The Reference Group agreed that a new item would more accurately reflect the work involved in these scenarios, and ensure that women have access to higher rebates when admitted to hospital.
- A minimum duration of three hours attendance has been set for this item. The Reference Group agreed that this is an appropriate caveat, as under a midwifery continuity of care model, the woman requires continuous attendance from the participating midwife from presentation to hospital through to the finalisation of admission and stabilisation of the woman. In contrast, obstetrician models focus on intermittent attendance for a shorter duration at key points, during which care is often directed over the phone.
- The Reference Group agreed that in the case of hospital admissions, the participating midwife may be with the woman for anywhere from two to six hours.
- The Reference Group agreed that item 821BB should be used in cases where women are admitted to hospital for which intrapartum items (82120, 82125, 821CC and 821DD) do not apply. The Reference Group identified several examples where this may occur, including:
  - Women admitted with symptoms of pre-eclampsia (headache, blurred vision) require a full clinical assessment; blood and urine testing; cardiotocography (CTG) monitoring; potentially an ultrasound scan; potentially medication provision, including steroid loading; education of the woman and family; collaboration with the obstetric team; and ongoing planning.



- Women admitted with antepartum haemorrhage require a full clinical assessment, blood testing, IV fluids, CTG monitoring, ultrasound scanning, education of the woman and family, collaboration with the obstetric team and ongoing planning.
- Women admitted with decreased foetal movements require a full clinical assessment, CTG monitoring, ultrasound scan, potentially an assessment for induction of labour or ongoing monitoring, collaboration with the obstetric team and ongoing planning.
- A cap of three claims per pregnancy has been set for item 821BB. The Reference Group agreed that the cap applied to MBS obstetric items 16533 and 16534—which can both be claimed a maximum of three times per pregnancy—is appropriate for item 821BB.
- The Reference Group agreed that use of this item should be reviewed in 12 to 24 months.

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

The Reference Group recommends:

- a. restricting claims of item 82115 to instances where the woman has had at least two prior antenatal attendances with the claiming participating midwife in the preceding six months, as follows (changes in bold):

##### Item 82115

Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks, **where the participating midwife has had at least 2 antenatal attendances with the patient in the preceding 6 months.**

- b. defining “two prior antenatal attendances” as claims for any of the following:
  - (i) Face-to-face antenatal attendances (items 82100, 82105 and 82110), and
  - (ii) Telehealth antenatal attendances (items 821FF, 821GG and 821HH).
- c. restricting co-claiming with corresponding GP/obstetric items for maternity care plans, so that only one care plan (independent of provider) can be claimed per pregnancy with the items for co-claim restrictions to include:



- (i) Item 16590: Planning and management of a pregnancy where the doctor intends to attend the birth.
- (ii) Item 16591: Planning and management of a pregnancy where the doctor does not intend to attend the birth.

and

- d. redistributing savings from reductions in the volume of item 82115 claims into participating midwife items 82110, 82135, 82120, 82125, 821CC and 821DD.

#### 5.1.8 Rationale 4

This recommendation focuses on ensuring that the MBS provides high-quality maternity care to women, based on a midwifery continuity of care model. It is based on the following:

- MBS data (2017) shows that 35 per cent of maternity care plans (item 82115) are claimed without antenatal care claims (items 82100, 82105, 82110) with a private midwife in the preceding 12 months, and 58 per cent are claimed with one or no previous antenatal care claims with a private midwife.
- The Reference Group agreed that completing a maternity care plan with one or no prior antenatal attendances does not provide high-value care to consumers.
- The Reference Group agreed that although there may be cases where women present late for maternity care, or have attended antenatal attendances with another provider or in the public hospital system, item 82115 should promote a midwifery continuity of care model, which provides high-value care to women.
- The Reference Group agreed that introducing a co-claiming restriction would limit use of item 82115 to instances that are high value for patients.
- The Reference Group agreed that both telehealth and face-to-face consultations should be considered antenatal attendances when defining this restriction, as its purpose is to promote continuity of care with a given midwife, regardless of how an attendance is undertaken.
- The Reference Group agreed that the creation of more than two maternity care plans for a patient, regardless of provider, would be unlikely to provide high-quality care to consumers. To mitigate this, the Reference Group agreed that item 82115 should not be co-claimed with item 16590 or 16591 in the same pregnancy.
- Schedule fee increases for items 82110, 82125, 82120 and 82135 and new schedule fees for items 821CC and 821DD are noted throughout this report. The Reference



Group agreed that savings accrued from changes to item 82115 should be reinvested into these items.

## 5.2 Intrapartum care

**Table 3: Items 82120 and 82125**

Item	Descriptor	Schedule fee (AUD)	Services FY2016/17	Benefits FY2016/17 (AUD)	Services 5-year annual avg. growth
82120	Management of confinement for up to 12 hours, including delivery (if undertaken)	753.30	530	299,405	61.7%
82125	Management of confinement for in excess of 12 hours, including delivery where performed; when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife)	753.30	137	77,405	114.7%

### 5.2.1 Recommendation 5 – Amend time tiering of intrapartum items

The Reference Group recommends:

- a. amending the descriptors of items 82120 and 82125 intrapartum time-tiers as follows (changes in bold):

#### Item 82120

Management of labour for **between 6 and 12** hours, including **birth where performed**.

#### Item 82125

Management of labour for **between 6 and 12 hours**, including **birth where performed**, when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife).

- b. creating two new items mirroring items 82120 and 82125, time tiered at six hours (where time is measured as midwife attendance duration, not labour duration), as follows:

**New Item 821CC**

Management of labour for up to 6 hours, including birth where performed OR attendance and immediate post-birth care at an elective caesarean section.

**New Item 821DD**

Management of labour for up to 6 hours, including birth where performed, when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife).

- c. ensuring the explanatory notes for items 82120, 82125, 821CC and 821DD clarify that time should be measured as duration of midwife attendance, not duration of labour
- d. allowing items 82120 and 82125 and the new intrapartum items (821CC and 821DD; see below) to be claimed up to a total of 30 hours attendance by up to two participating midwives (Claiming a 2<sup>nd</sup> or 3<sup>rd</sup> intrapartum item should reflect the handover of care between the primary and second midwife or vice versa. A second intrapartum item should not be claimed by either midwife unless care has been provided in the interim by the alternative midwife to ensure safe work conditions)
- e. allowing co-claiming with existing intrapartum items 82125 and 82120 to account for two or more midwives attending a labour, and
- f. allowing item 821CC to be claimed for a participating midwife's attendance at an elective caesarean section to ensure skin-to-skin contact of mother and baby immediately following birth and initiation of infant feeding in theatre and the recovery unit, until transfer of care to postnatal staff.

*Note: This recommendation should be considered alongside Recommendation 6.*

**5.2.2 Rationale 5**

This recommendation focuses on ensuring that the MBS promotes safe clinical practice, in line with professional standards. It is based on the following:

- The existing intrapartum items do not reflect the model of care that participating midwives operate within, and they inadvertently promote unsafe working conditions for midwives and possibly unsafe clinical practice. The current items promote long



working sessions and fatigue and restrict the safe handover of care between midwives.

- The current MBS item structure promotes working hours over 12 hours. When a midwife transfers care to a second midwife, rebates are only payable if this occurs more than 12 hours after the woman has been admitted to hospital.
- Participating midwives may have worked long hours providing antenatal care or attending other births prior to arriving at hospital to manage a woman's labour. In addition, midwifery support for labour is often provided at home, with the aim of delaying hospital admission until the woman feels ready to transfer. (18; 19) This means that a participating midwife admitting a woman for birth may have already worked prolonged hours in preceding days.
- These long hours put midwives at risk of fatigue and impaired performance, as detailed in multiple government-endorsed guidelines and professional standard documents highlighting occupational health and safety best practice, including:
  - Safe Work Australia's Guide for Managing the Risk of Fatigue at Work highlights three fatigue risks especially applicable to midwives: regular work over 12 hours, less than 10 hours between periods of work, and work often performed between 2 am and 6 am (20).
  - The Australian Medical Association's National Code of Practice: Hours of Work, Shiftwork and Rostering for Hospital Doctors highlights the increased risk of fatigue and decreased performance associated with working more than 10-hour shifts, having inadequate rest between shifts, and working more than two 14-hour shifts in a given week (21).
  - The Australian Nursing and Midwifery Federation's position on fatigue prevention highlights that midwives should be able to control their risk of fatigue, and that there should be adequate rest between working periods (22).
  - A statement by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) titled Fatigue and the Obstetrician Gynaecologist highlights the difficulty of predicting when women will go into spontaneous labour, and the importance of having colleagues to hand over care to, in order to prevent fatigue (23). This is equally relevant to midwives.
- To manage working hours during birth and labour, participating midwives must be able to flexibly transfer care to a second participating midwife when they deem it appropriate to do so. This is currently not well facilitated by the MBS items.



- Two new items mirroring items 82120 and 82125 have been recommended, each time tiered at up to six hours. The Reference Group agreed that two additional items mirroring items 82120 and 82125 but time tiered up to six hours (rather than 12) would enable midwives to hand over care earlier during the intrapartum period.
- The Reference Group also agreed that retaining items for longer attendances would allow for situations where a midwife is not fatigued and therefore chooses to remain at a birth for 12 hours as required.
- The descriptor has been updated to reflect modern language. The Reference Group agreed that the word “confinement” is rarely used in clinical practice, and that “birth” is a more acceptable term for consumers.
- Items 82125, 82120, 821CC and 821DD are claimable in any configuration up to a maximum of 30 hours. The Reference Group agreed that this would provide flexibility to practitioners, and access to high-value care and appropriate rebates for patients.
- It also agreed that in long labours, the primary midwife would hand over to a second midwife to negate any impacts as a result of fatigue, and may return after a rest to resume caring for the woman in labour.
- Appendix D maps the proposed item numbers against a number of intrapartum case studies to demonstrate the flexibility required and the need for this solution.
- The explanatory notes are recommended to be amended to clarify that time should be measured as duration of midwife attendance, not duration of labour. The Reference Group agreed that this would more accurately reflect the care that is provided to a woman to ensure optimal quality outcomes.

### **5.2.3 Recommendation 6 – Increase the per-minute schedule fee for intrapartum care**

The Reference Group recommends increasing the per-minute schedule fee for intrapartum care, as follows:

- a. for items 82120 and 82125, a MBS schedule fee that is 100 per cent higher than the current schedule fee for items 82120 and 82125, and
- b. for items 821CC and 821DD, a MBS schedule fee at the same per-minute rate as the existing schedule fee for items 82120 and 82125.



### 5.2.4 Rationale 6

This recommendation focuses on ensuring that women have adequate access to high-quality intrapartum care, and ensuring cost-effectiveness for the health care system. It is based on the following:

- Midwifery care has been demonstrated to provide high-value care to patients by significantly reducing intervention rates, and to provide value to the health care system by lowering costs (5; 8).
- Under the current MBS structure, there are differences in the rebates available to patients during the intrapartum period, depending on whether they access midwife-led or obstetrician-led care.
- Midwifery and obstetric birth items have equal schedule fees despite requiring different durations of attendance. Obstetric care and midwifery care for “normal” birth is rebated at a similar level (obstetric care item 16519, benefit \$525.50; midwifery care item 82120, \$565). However, the midwifery items are for 12 hours’ attendance, while obstetricians are likely to attend for short and/or intermittent periods during labour. An overview of the different working models between obstetricians and midwives is presented in Appendix E.
- The Reference Group’s recommendation to attach the \$565 rebate to a shorter time-tiered item (up to six hours) more accurately reflects the clinical care and attendance requirements for this item.
- Obstetric items include an item for “complex” births, whereas participating midwifery items do not. Obstetric care has a “complex” item (item 16522), which is claimed in nearly 50 per cent of births (MBS statistics 2017/18). Many of the conditions listed, including Mental Health Care Plans, are equally cared for by midwives and obstetricians.
- The recommendation to increase the schedule fee for up to 12 hours of care so that it is similar to the schedule fee for item 16522 is intended to more accurately represent the clinical care requirements and attendance for this item.
- Obstetric items include a series of items covering specific elements of intrapartum care. Participating midwife intrapartum items must cover all elements undertaken by the midwife during the intrapartum period.
- The Reference Group agreed that increasing the per-minute rebate rate for intrapartum items would enable more consumers to birth under a midwifery-led



continuity of care model, leading to potentially improved outcomes (5), high satisfaction for consumers and lower overall costs for the health care system.

### **5.2.5 Recommendation 7 – Enable intrapartum items to be claimed from the time the midwife attends the woman for labour care**

The Reference Group recommends enabling intrapartum items to be claimed from the time the midwife attends the woman for labour care (i.e. including outside of hospital), by:

- a. amending the intrapartum item descriptors (items 82120, 82125, 821CC and 821DD) to include the word “attendance” (“up to 6 hours attendance” or “between 6 and 12 hours attendance”) to ensure that the billing periods start whenever the midwife is in attendance for the labour and birth (including out of hospital), and
- b. amending the explanatory notes for items 82120, 82125, 821CC and 821DD to explain that the attendance time relating to these items is measured from when attendance starts, including if outside the hospital.

### **5.2.6 Rationale 7**

This recommendation focuses on ensuring that the MBS reflects the activities required to deliver high-value care to patients. It is based on the following:

- Currently, duration of care for items 82120 and 82125 is measured from when the woman is admitted to hospital. The Reference Group has recommended changing the explanatory notes to clarify that time should be measured based on the duration of attendance. This would allow the attendance to be claimable out of hospital.
- The need for midwifery support in labour begins at different times for different women. This support is often provided at home, with the aim of delaying hospital admission for as long as possible and providing care in a familiar environment. Measuring the provision of care from admission to hospital does not acknowledge the time that a midwife spends with a woman monitoring her at home in labour. The literature demonstrates that the earlier a woman presents to hospital in labour, the more likely she is to undergo unnecessary interventions (19; 18). Rebating midwifery care provided only in hospital creates an incentive for early presentation, poorer outcomes and low-value care.
- The Reference Group agreed that including the word “attendance” in the item descriptor would be an appropriate way to ensure that midwifery support in the home is included in the intrapartum items.



### 5.2.7 Recommendation 8 – Include home birthing in intrapartum items

The Reference Group recommends:

- a. including birth at home in the intrapartum items, and
- b. That medical indemnity insurance, for privately practicing midwives be expanded to support a mother's choice regarding place of birth, including birth at home.

### 5.2.8 Rationale 8

This recommendation responds to consumer demand and facilitates safe, high-quality care. It is based on the following.

- Every year, families choose to birth their baby at home, some with the care of a participating midwife, some with a non-regulated midwife, some through a public hospital program, and some with no professional care or support (freebirth). Families generally birth at home to be in a familiar place of comfort and control, surrounded and supported by loved ones, without the restrictions and impersonality of a hospital system; or because they have had a previous negative experience with hospital birth.
- For families choosing to birth at home, the MBS needs to facilitate a safe model of care by facilitating access to a participating midwife. There is currently no rebate for this, which means that many families cannot afford the care of a participating midwife.
- Multiple studies have demonstrated that homebirths are safe and lead to less birth intervention and high consumer satisfaction. A recent systematic review and meta-analysis of 25 studies evaluated the impact of place of birth on perinatal and maternal outcomes. Authors concluded that high-quality evidence about low-risk pregnancies indicates that place of birth has no statistically significant impact on infant mortality. Women experienced lower rates of perineal trauma and haemorrhage, and higher rates of normal vaginal birth, when undertaking a planned homebirth. The lower odds of maternal morbidity and obstetric intervention support the expansion of birth centre and homebirth options for women with low-risk pregnancies. The authors further noted that, based on the results, they support the expansion of birth centres and homebirth options, as well as systems to support them (24).
- The Reference Group noted that there is a robust governance framework to ensure that participating midwives work within an appropriate scope of practice when caring for women who choose to birth at home:



- Nurse & Midwives board of Australia (N&MBA) requires compliance with various standards and guidelines (midwife standards for practice)
- Australian Health Practitioner Regulation Agency at a higher level has a range of standards including around professional indemnity insurance for all health practitioners
- Midwives require an endorsement for scheduled medicines prior to obtaining a Medicare provider number – including 5000 hours of practice and completion of a midwifery professional review process
- Medicare requirements
- Medical Indemnity Group of Australia (provision professional indemnity) requirements which include communication of a care plan with a back-up booking hospital
- The 'National Midwifery Guidelines for Consultation and Referral' document (25)(endorsed by RANZCOG) which require consultation, referral and transfer for women who have or develop complexity during pregnancy or labour
- The 'Safety and Quality Framework for Privately Practising Midwives attending Homebirths' document (26) which regulates compliance with the above guidelines
- Various hospital guidelines where midwives have visiting access also require a level of consultation, referral and transfer. Non-compliance with these guidelines would result in visiting access for the midwife being withdrawn. This would then have a flow on as regulation asks whether a midwife has had credentialing removed and why.

Additionally the various health care complaints commissions of each state are active in addressing reports of inappropriate care by all health practitioners.

- The Reference Group agreed that maternity services consumer representatives have clearly communicated the need for birth options, including homebirth.
  - A review of the 832 submissions to the maternity services review in 2009 indicated strong support for home birthing (27).
  - More than 300 public submissions have been received in the PMRG public consultation period requesting access to MBS rebates for homebirth. Consumers reported that access to an MBS rebate for a hospital birth but not a



homebirth is discriminatory as the place of birth is the choice of a mother/couple.

- Reference Group members agreed that their clinical experience indicates that more women will choose to birth at home if this option is more readily available.
- The Reference Group noted that there are an increasing number of publicly funded homebirth programs throughout Australia, demonstrating state and territory governments' acknowledgement of consumer demand and willingness to support this birth option.
- The Reference Group agreed that including homebirth in current MBS items may make freebirths without medical support less likely to occur in the community. The Reference Group agreed that there is anecdotal evidence that freebirth rates are increasing in Australia, although formal statistics are lacking.
- The Reference Group agreed that access to home birth would support Aboriginal and Torres Strait Islander women to "Birth on Country", contributing to the preservation of their cultural identity and in line with their expressed wishes (28) and national documents endorsed by the Australian Health Ministers Advisory Committee (29).
- The Reference Group agreed that the lack of available indemnity insurance for birthing outside of hospital needs to be addressed to ensure successful and safe implementation of MBS-subsidised home birthing. The Commonwealth midwife indemnity support schemes are crucial for participating midwives providing Medicare rebated care including homebirth. The lack of insurance for intrapartum care is a large barrier to participating midwives providing homebirth services resulting in some women choosing unsupported options.
- 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 past 2019 and there are still many barriers that restrict access to the existing model. Many of these barriers fall outside of the MBS review remit but are discussed in detail under section 6 of this report. Highlighting the barriers to birthing options for the community offers an opportunity for escalation and influence to appropriate forums for prioritisation and resolution.



## 5.3 Postnatal attendances

Table 4: Items 82130, 82135 and 82140

Item	Descriptor	Schedule fee (AUD)	Services FY2016/17	Benefits FY2016/17 (AUD)	Services 5-year annual avg. growth
82130	Short postnatal professional attendance by a participating midwife, lasting up to 40 minutes, within 6 weeks after delivery	53.40	2,547	110,530	35.4%
82135	Long postnatal professional attendance by a participating midwife, lasting at least 40 minutes, within 6 weeks after delivery	78.50	28,844	2,004,481	48.3%
82140	Postnatal professional attendance by a participating midwife on a patient not less than 6 weeks but not more than 7 weeks after delivery of a baby	53.40	989	48,100	33.2%

### 5.3.1 Recommendation 9 – Amend the postnatal attendance items and introduce a new item for a long postnatal attendance

The Reference Group recommends aligning the time-tiered structure to provide improved health outcomes, by:

- amending the item 82130 descriptor to set a minimum duration of 20 minutes and remove the maximum duration of 40 minutes, as follows (changes in bold):

#### Item 82130

Short postnatal professional attendance by a participating midwife, **lasting at least 20 minutes**, within 6 weeks after birth.

- amending the item 82135 descriptor to describe the attendance as “routine”, rather than “long”, as follows (changes in bold):

#### Item 82135

**Routine** postnatal professional attendance by a participating midwife, lasting at least 40 minutes, within 6 weeks after birth.



- c. increasing the schedule fee for item 82135 to better reflect the average duration of a routine postnatal attendance of approximately 60 minutes. This attendance includes care of both mother and baby, and
- d. creating a new item (821EE) for a long postnatal attendance of at least 90 minutes, as follows:

**New Item 821EE**

Long postnatal professional attendance by a participating midwife, lasting at least 90 minutes.

### 5.3.2 Rationale 9

This recommendation creates a time-tiered structure that aligns items and rebates more closely with the work required to provide high-value care. It is based on the following.

- **Item 82130:** This recommendation recognises that the midwife is caring for both a mother and a new born infant in the postnatal period, both of whom have distinctive needs.
- The descriptor has been recommended for amendment to specify a minimum duration of 20 minutes. The Reference Group agreed that there are instances where short postnatal attendances (20 to 30 minutes) provide high-value care to women. These visits typically occur in between routine visits, or as a follow-up to a routine visit. For example:
  - A midwife may need to conduct a focused examination of a woman or baby, rather than a comprehensive examination. This may include checking breast engorgement, temperature or blood pressure, or checking for infection. This will also involve discussion with the woman and her partner. This would usually take 20 to 30 minutes.
  - A midwife may need to review pathology and/or administer medication such as vitamin K or anti-D, or repeat blood tests such as new born screening. Again, these will also involve discussion with the woman and potentially education of the woman and her partner. This would usually take 20 to 30 minutes.
- The Reference Group agreed that there are no circumstances in which postnatal attendances under 20 minutes would provide high-value care to women.
- **Item 82135:** The descriptor has been amended to describe this attendance as “routine”. The National Institute for Care Excellence (NICE) guidelines for postnatal



care list the activities that should occur at a routine postnatal visit to ensure high-quality care for both the mother and her infant **(27)**. The Reference Group agreed that these activities cannot be undertaken to a high standard in under 40 minutes.

- The Reference Group agreed that although a midwife could feasibly complete high-quality routine postnatal attendances in 40 minutes for women with no complications, the attendances take an average of approximately 60 minutes.
- The Reference Group conducted a survey of 115 midwives which showed that routine postnatal attendances take an average of 63 minutes. The Reference Group noted that postnatal attendances often occur at the woman's home, meaning that midwives must travel (sometimes significant distances) between appointments. The Reference Group agreed that this additional time requirement (not counted in the above survey) further supports the recommendation to increase the schedule fee for this item.
- The Reference Group agreed that a schedule fee increase would promote high-quality routine postnatal attendances, more accurately reflect the work involved for both the mother and the baby, and increase access for consumers.
- **New item 821EE:** A new item has been recommended for a long postnatal attendance of at least 90 minutes. The Reference Group agreed that there are numerous instances where postnatal attendances of over 90 minutes provide high-value care for women. For example:
  - For women with significant breastfeeding issues, there is a need to observe a breastfeed and conduct a clinical assessment of mother and baby. The breastfeed and associated education and discussions will require longer than 90 minutes.
  - Many women are discharged from hospital within four to six hours of birth. The subsequent home visit will not only encompass all routine clinical checks and assessments, as per the NICE guidelines, but also a bath demonstration, feeding support and education. These activities take over 90 minutes.
- Given that item 821EE has particular relevance for breastfeeding, it is important to note the following:
  - There is high-quality evidence that breastfeeding to a minimum of six months of age protects infants from a variety of infections, enhances emotional and cognitive development, and reduces maternal risk of perinatal depression and breast and ovarian cancer later in life (28).



- In Australia, despite 92 per cent of women initiating breastfeeding, the proportion who continue to exclusively breastfeed falls to 80 per cent in the first week of a baby's life, then 56 per cent by three months. Only 14 per cent continue breastfeeding to six months. This means that Australia falls well below the WHO recommendation that women exclusively breastfeed to six months. (32) (33)
- The Reference Group agreed that enabling longer consultations through a new item would support women to breastfeed.

### 5.3.3 Recommendation 10 – Include mandatory clinical activities and increase the minimum time for a six-week postnatal attendance

The Reference Group recommends amending the item 82140 descriptor to introduce a minimum duration of 60 minutes, and to include a birth debrief and mental health screening, as follows (changes in bold):

#### Item 82140

Postnatal professional attendance by a participating midwife with a woman not less than 6 weeks but not more than 7 weeks after birth of a baby, **lasting at least 60 minutes, and including:**

- a) **a labour and birth debrief, and**
- b) **mental health screening.**

### 5.3.4 Rationale 10

This recommendation focuses on ensuring that the MBS promotes high-quality maternity care, in line with professional standards. It is based on the following:

- The Reference Group agreed that a postnatal attendance between six and seven weeks is of high value for women, ensuring adequate handover of care to primary care providers.
- The Pregnancy Care Guidelines outline the activities that should occur in a final postnatal attendance (16). The Reference Group agreed that these activities could not be completed to a high standard in less than one hour.
- The Reference Group agreed that birth debriefing and mental health screening should specifically be enshrined in the descriptor for item 82140 because they are essential components of finalising clinical care, and because they allow for the detection of



potential mental health issues prior to handover/return to the woman's primary care provider. If a condition remains unidentified and the woman does not receive support, there can be long-term consequences for her health and wellbeing, her relationship with her partner and the baby's wellbeing. Birth trauma and post-traumatic stress disorder are increasingly acknowledged and recognised in post-partum women. The final contact with a woman's "known" midwife is a vital opportunity to screen for risk and, if appropriate, refer to the best support mechanisms.

## 5.4 Telehealth attendances

**Table 5: Items 82150–82152**

Item	Descriptor	Schedule fee (AUD)	Services FY2016/17	Benefits FY2016/17 (AUD)	Services 5-year annual avg. growth
82150	A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	28.30	1	24	-24.2%
82151	A professional attendance lasting at least 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	53.70	2	91	-16.7%
82152	A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	78.95	15	1,007	NA

*Note: There were no claims for item 82152 in 2011/12 to calculate a growth rate*

### 5.4.1 Recommendation 11 – Include GPs as eligible specialists for existing telehealth items

The Reference Group recommends amending the item descriptors (items 82151 and 82152) to include GPs in the list of doctors who can participate in the video consultation, as follows (changes in bold):

**Item 82151**

A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics, obstetrics **or general practice**.

and

**Item 82152**

A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient participating in a video consultation with a specialist / consultant in paediatrics or obstetrics **or general practice**.

#### 5.4.2 Rationale 11

This recommendation focuses on ensuring that the MBS provides adequate access to high-quality clinical services for women. It is based on the following:

- The Reference Group agreed that there is a need to expand midwifery services to rural and remote populations. There is a clear relationship between distance to maternity services and poorer clinical and psychosocial outcomes (31; 32). Key Australian maternity documents cite rural and remote maternal location as a barrier to quality maternity care (16; 33). The Australian Rural Birth Index project found that maternity services in Australia do not match population need (34).
- The Reference Group agreed that telehealth items are one way to drive increased access to midwifery services for rural and remote populations.
- Current midwifery telehealth items are underutilised. MBS data shows that items 82150–82152 were claimed a total of 18 times in 2016/17. The Reference Group proposed two reasons for this low service volume:
  - Telehealth attendances must include a specialist obstetrician or paediatrician, who often does not have the time to undertake telehealth consultations on an ad-hoc basis.
  - Claims for items 82150–82152 require the participating paediatrician or obstetrician to have submitted an MBS claim for their participation in the teleconference. Reference Group members with experience using these items



highlighted that specialist practitioners do not always bill for these attendances as they are a small part of their scope of practice. As such, MBS service volumes may be artificially low.

- The Reference Group agreed that including GPs in the descriptors for current telehealth items would be beneficial to women accessing midwifery care. GPs (especially those with a sub-specialisation in obstetrics) are well placed to deliver medical advice to women and their caring midwives during pregnancy. The Reference Group identified two potential use cases for this:
  - Women who live in rural or remote regions may have their early antenatal care primarily with their GP and may plan to birth in the city with midwifery continuity of care. There may be occasions when a telehealth consult will occur between the woman, the GP who is providing her antenatal care and the intended midwife for intrapartum and birth care.
  - There may be occasions when the women and her primary midwife will benefit from access to their regular GP for a team discussion. This discussion may include the results and implications of recent tests or detail on the ongoing management of chronic conditions. Ensuring key clinicians such as the woman's GP are actively involved in her pregnancy will optimise outcomes.
- GPs are better dispersed across Australian rural and remote areas than obstetricians and paediatricians. As such, women and their midwives may be able to undertake telehealth consultations with GPs more proximal to women's homes. The Reference Group agreed that this may drive more local continuity of care for women and these practitioners. The number of practitioners eligible to deliver these services will increase, driving increased access and overcoming the time constraints of specialists.
- The Reference Group agreed that use of this item should be reviewed in 12 to 24 months.

#### **5.4.3 Recommendation 12 – Facilitate telehealth consultations between women and midwives in the antenatal and postnatal period**

The Reference Group recommends:

- a. creating three new telehealth items (821FF, 821GG and 821HH) for women consulting with a midwife via teleconference, with a nurse, Aboriginal and Torres Strait Islander health worker or professional, or another midwife on the patient side
- b. creating time tiers for these new items in line with items 82150–82152, and
- c. that proposed new item descriptors be as follows:

**New Item 821FF – example text**

A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient, supported by a nurse, Aboriginal Health Worker/Professional or midwife, who is participating in a video consultation with a participating midwife.

**New Item 821GG**

A professional attendance lasting at least 20 minutes (whether or not continuous) to a patient, supported by a nurse, Aboriginal Health Worker/Professional or midwife, who is participating in a video consultation with a participating midwife.

**New Item 821HH**

A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient, supported by a nurse, Aboriginal Health Worker/Professional or midwife, who is participating in a video consultation with a participating midwife.

and

- d. adding the following restrictions, in line with items 82150–82152:
- (i) The woman must not be an admitted patient.
  - (ii) The woman must be located both within a telehealth-eligible area, and at least 35 kilometres by road from the participating midwife mentioned in the above descriptors.
  - (iii) The woman must reside in a rural or remote region (defined as Modified Monash Model areas 4–7).
  - (iv) The midwife must be intending to undertake the woman's birth, or in the case of postnatal care, be the primary provider of postnatal care or breastfeeding support for the woman.

**5.4.4 Rationale 12**

This recommendation focuses on ensuring that consumers in remote and rural areas can access high-quality, cost-effective maternity care. It is based on the following.

- As noted in Recommendation 9, the Reference Group agreed that there is a need to expand midwifery services to rural and remote populations.



- Members of the Reference Group who work primarily with Indigenous women or remote/rural services report that most of these women have access to a health worker such as a nurse. The identified telehealth need is for that worker and the women to be able to consult with a midwife.
- The Reference Group agreed that there are multiple instances where a participating midwife could provide high-value care to a woman via telehealth without the participation of a medical professional. For example:
  - Women who live or work in rural or remote areas (for example, Anangu Pitjantjatjara Yankunytjatjara [APY] lands) but are planning to come to the city to birth can access midwife care regularly throughout their pregnancy and build rapport with their midwife before seeing them face to face. This provides opportunities for explanation and education.
  - A woman residing in a remote area might attend a number of antenatal consultations via telehealth with a participating midwife who is her intended midwife for labour and birth. Due to the remote location, all antenatal consults cannot be attended face to face.
  - Women returning to remote areas after birth can consult via telehealth with the known birthing midwife, providing continuity of care.
  - Women who live several hours away from their midwife can check in for antenatal discussion and education. A local health worker can perform a basic clinical examination.
- The Reference Group agreed that having practitioners on the patient side during these consultations is important to enable appropriate observations and basic examinations during the attendance.
- The Reference Group agreed to include midwives in the list of eligible practitioners on the patient side under this item. The Reference Group agreed that a participating midwife consulting with another midwife via teleconference would be particularly useful when women are planning on moving to a metropolitan area to give birth. For example:
  - Women may move from a rural/remote area to the city for birth. Telehealth offers the opportunity for midwives to introduce rural and remote women to the participating midwife who will be undertaking their birth in a metropolitan region. This allows familiarity for those who are unable to meet their participating midwife face to face.



- Women who live in rural or remote regions may be experiencing breastfeeding challenges. The remote area midwife may not have any additional training in this area and may request help from a specialised midwife in the city. Together with the woman, they may be able to provide an assessment of attachment, remedial assistance and support to enable ongoing breastfeeding.
- The Reference Group noted the importance of continuity of care in ensuring high-value use of telehealth items in a fee-for-service system and has targeted its recommendations to promote this.

## 5.5 Enhance access to lactation support

### 5.5.1 Problem identified

The short and long-term benefits of breastfeeding are widely known and well understood. The WHO recommends breastfeeding to a minimum of 6 months and into the second year of life (32)

Australia has a high initiation rate for breastfeeding at 92-98% of women, but this drops off rapidly to 80% fully breastfed (no other food or fluid) by the end of the first week. At one month this figure declines to 71%; at three months 56%; and down to 14% at six months post birth (29).

One of the most significant causes of the reduction in breastfeeding rates in the postnatal period and the following 12 – 24 months is a lack of support and understanding around breastfeeding.

While midwives have a good understanding of lactation there are complex scenarios that midwives with specialty education and expertise can address.

The Reference Group noted a number of breastfeeding trends in Australia:

- In Australia women are not exposed to breastfeeding as much as other countries for cultural reasons.
- The fragmentation of care typically received around pregnancy and birth further erodes the opportunity to educate and inform women and their families about the benefits of breastfeeding.

### 5.5.2 Recommendation 13 Add a new item to the MBS for claiming for participating midwives to conduct ongoing lactation support

The Reference Group recommends:



- a. the addition of a new item to the MBS for claiming for participating midwives to conduct ongoing lactation support
- a. That the proposed new item descriptor be as follows:

**New Item XXXX– example text**

Professional attendance by a participating midwife with a woman during postnatal period until no more than 2 years after birth of a baby for the purpose of lactation support, **lasting at least 60 minutes.**

The Reference Group suggests that items could be restricted to 6 consults per 2- year period, except where a second pregnancy occurs in this 2 year period. This suggestion focusses on providing relevant and high value support for new mothers.

### 5.5.3 Rationale 13

- The Reference Group agreed that based on clinical experience it takes at least 60 minutes to deliver high value lactation support.
- The Reference Group agreed that breastfeeding should be promoted until at least 2 years of age, in line with WHO recommendations that promote. (32):
  - early initiation of breastfeeding within 1 hour of birth;
  - exclusive breastfeeding for the first 6 months of life; and
  - introduction of nutritionally-adequate and safe complementary (solid) foods at 6 months together with continued breastfeeding up to 2 years of age or beyond.
- The Reference Group noted that there is sound evidence regarding the health benefits of breast feeding in addition to the indirect cost savings to the health system. 'For the child who is not breastfed, or is breast fed for shorter lengths of time, there is an increased risk of:
  - SIDS
  - gastrointestinal infections
  - respiratory infections
  - ear infections
  - necrotising enterocolitis in premature babies
  - sepsis in premature babies



- dental malocclusions
- overweight and obesity
- lower IQ.

For the mother, not breastfeeding increases the risk of:

- breast cancer
- ovarian cancer (38)
- The Reference Group agreed that participating midwives are well equipped to provide continuing lactation support after the 6 weeks post-partum period is completed.
- The Reference Group identified a number of examples where a lactation consultation up until a child is 2 years of age would be beneficial and facilitate ongoing lactation:
  - Mastitis/breast abscess after the first 6 weeks
  - Breast refusal
  - Maternal return to work
  - Issues with maintaining supply, dysmorphic milk ejection reflex, nipple vasospasm
  - Slow weight gain/failure to thrive
  - Oro-facial/developmental issues
  - Breastfeeding through pregnancy/tandem feeding
  - Post maternal surgery or medical treatment for an acute or chronic condition.
  - Inducing lactation in the case of adoption or same sex couple.
  - Re-lactation-where the woman may change her mind or breast milk may be considered part of the child's medical management (For example leukaemia).
  - Counselling during pregnancy after a lactation failure with previous child.
- The Reference Group notes the following evidence in support of the effectiveness of continuing lactation support:
  - A randomised controlled trial investigating the impact of prenatal and postnatal lactation consultant interventions found that the intervention was effective in increasing breastfeeding duration and intensity (39).



## 5.6 Facilitating the Consumer Journey – expanding midwife access to pathology and diagnostic investigations

### 5.6.1 Problem identified

The MBS does not allow participating midwives to claim a number of items for standard and regularly required pathology and diagnostic/screening tests. These tests are necessary to provide high quality maternity care, and most are specifically outlined in the NHMRC endorsed Pregnancy Care guidelines (16).

The omission of these investigations causes inefficiencies in the MBS. Women often attend a consultation with their participating midwife, where the need for a specific test is determined. If the Midwife is unauthorised to order the test, the woman must attend an MBS-rebatable GP consultation for a second MBS consult to gain access to MBS rebates for the test. This process introduces additional cost into the MBS, with no added benefit.

### 5.6.2 Recommendation 14 - Addition of a small number of pathology and diagnostic investigation to the MBS rebate schedule for participating midwives as recommended by professional clinical guidelines

- Below is the list of pathology and diagnostic investigations the PMRG recommend should be added to the MBS rebate schedule for participating midwives:

**Table 6: Pathology and diagnostic investigations that the PMRG recommends should be available for participating midwives**

Test	Proposed Rationale
Thyroid function test/Thyroid antibodies	Thyroid testing is recommended for pregnant women who are at increased risk of thyroid dysfunction because of the range of adverse maternal and neonatal outcomes associated with overt hypothyroidism and hyperthyroidism (40).
Iron studies/Ferritin/ B12/Folate	Routinely testing pregnant women for haemoglobin concentration in early pregnancy and at 28 weeks gestation is recommended. Pending the haemoglobin results further diagnostic tests including serum ferritin, folate and B12 are required in order to diagnose anaemia.  In areas where prevalence of iron-deficiency anaemia are high Ferritin testing should be considered at the first antenatal visit (40).
Fasting bile acids	The collection of liver function tests and fasting bile acids is recommended to diagnose Obstetric Cholestasis when otherwise unexplained pruritus of pregnancy occurs (41).



Test	Proposed Rationale
Kleihauer	It is recommended that all women with a Rhesus (D) negative blood group who deliver an Rh (D) - positive baby should have quantification of feto-maternal haemorrhage to guide the appropriate dose of anti-D prophylaxis. All women who are given Anti-D in response to a potentially sensitizing event should also have the magnitude of potential feto-maternal haemorrhage assessed. (42)
Varicella	It is recommended that serology be attended when a pregnant woman with unknown immune status is exposed to the Varicella Zoster infection, in order to determine if the woman is eligible to receive Varicella Zoster immunoglobulin. (43)
Parvovirus	It is recommended that pregnant women who have been exposed to parvovirus infection should be offered serological testing for parvovirus-specific IgG to determine their susceptibility. The diagnosis of parvovirus infection is usually made, serologically and is usually detectable within 1-3 weeks of exposure and lasts for 2-3 months. (43)
Cytomegalovirus	Serology testing for CMV should be offered to women who come in to frequent contact with large numbers of very young children (e.g. child care workers). CMV testing should also be offered to pregnant women if they have symptoms suggestive of CMV that are not attributable to another specific infection or when imaging findings suggest fetal infection. (40).
Herpes virus swab	Collection of a HSV PCR from the genital tract is recommended for a pregnant woman with a suspected first episode of genital herpes. Serology for HSV-1 and 2 is also attended.  (Ref. Management of Perinatal Infections, Australian Society of Infectious Diseases 2014)
Vitamin D	It is recommended that serology be considered for women at high risk of suboptimal Vitamin D levels. (40)
HbA1c	It is recommended that 'women with risk factors for Diabetes be offered early testing.' While OGTT is the preferred screen clinical guidelines recommend HbA1c in the first trimester for those women who cannot tolerate the OGTT (e.g. due to nausea and vomiting). (40).
Postnatal abdominal scan	The use of ultrasound to diagnose retained products of conception (RPOC) in the postnatal period is associated with a significant 'false-positive rate'. However ultrasound examination is attended before considering a D&C due to the increased risk of uterine perforation with a surgical procedure in the postpartum period. Referring a woman to an Obstetrician for RPOC with the ultrasound findings already attended ensures that the collaborating medical officer has all available information with which to make a decision and prevents the woman attending a medical consult, being referred for an ultrasound and then returning for a follow-up consult.



Test	Proposed Rationale
Growth and wellbeing scans	Ultrasound assessment of fetal size should be attended when there are fundal height discrepancies and risk factors for a small for gestational age foetus. (40)

### 5.6.3 Rationale 14

- The omission of standard/regularly required pathology and diagnostic investigations from the Midwifery MBS rebate schedule results in increased costs to the MBS system (two MBS consultations), creates inconvenience for the consumer and could possibly lead to low value care.
- The NHMRC endorsed Pregnancy Care Guidelines (40) outline the requirements to perform many of the above pathology and diagnostic investigations. Other investigations listed are clearly best practice and will be performed upon referral to a GP or obstetrician under the current system. In the case of referral to another clinician it is best practice and time efficient to attend appropriate screening or diagnostics prior to referral in order that the receiving clinician has all of the relevant information.
- This recommendation supports technological progress such as patient diagnostic results being directly uploaded and available for all health practitioners to view on 'My Health Record'. Such strategies have already launched in Queensland and when more widely instituted will reduce the duplication that occurs with multiple providers ordering the same diagnostics for the same patients.

## 5.7 Improving Women's Access to Midwifery Care by Removal of Mandated Collaborative Agreements

### 5.7.1 Problem Identified

Mandated collaborative arrangements for endorsed midwives were introduced in 2010 as a prerequisite to an endorsed midwife providing health care services subsidised by the MBS. This was a ministerial determination made at the time of the legislative amendments to allow patient access to rebates through the MBS for eligible midwife services. The legislation dictates that an endorsed Midwife must have a formal collaborative agreement with an Obstetric medical practitioner or a Health Service with an Obstetric Service before they are eligible for an MBS provider number. The aim of the legislation was to avoid fragmented care.

The cost of private healthcare by a Midwife or Obstetrician can be a barrier to many families however an MBS rebate can make the care affordable and accessible. It has become evident



that rather than facilitating access to Midwifery care legislation has in fact restricted the capacity for endorsed Midwives to establish a private practice that offers MBS rebates.

No other profession is reliant on another single professional to determine whether they are able to establish a private practice. A GP is not reliant on a Psychiatrist signing a formal agreement before they can care for or refer complex mental health patients. An Obstetrician is not reliant on an Endocrinologist signing a formal agreement before they can care for or refer complex diabetic patients. And yet a Midwife is reliant on an individual Obstetric medical practitioner or healthcare organisation signing a formal collaborative agreement before they are eligible to apply for a Medicare Provider number and thus offer MBS rebates to families under their care.

The feedback from endorsed midwives in 2019 is that very few Obstetricians or health organisations when approached will agree to formal collaborative agreements and this is evidenced by the minimal number of health organisations throughout Australia offering access agreements to endorsed Midwives.

Endorsed Midwives need capacity to freely collaborate and refer as other professionals are permitted to do. Midwives who have fulfilled the multitude of compliance items to achieve endorsement should be eligible to apply for a Medicare Provider number without being reliant on the signed endorsement of another individual clinician or health care organisation.

### **5.7.2 Recommendation 15 - Removal of the need for mandated formal collaborative agreements**

The Reference Group recommends that the legislation requiring a collaborative arrangement be rescinded for endorsed midwives. This would require legislative amendment and alteration to the MBS item descriptors.

### **5.7.3 Rationale**

This recommendation focuses on the provision of affordable, universal and high-value care for women in line with the recommendation to increase access to midwifery continuity of care as a priority. It is based on the following:

- The Reference Group noted that this recommendation would enable more Participating Midwives to access MBS rebates thus increasing the affordability and access for women to midwifery care.
- The Reference Group noted that a majority of the submissions received from consumers and stakeholders during the public consultation period, raised concerns regarding the barriers caused by mandated collaborative agreements. These



submissions requested removal of this mandated requirement from legislation and Medicare.

- Endorsed midwives reported during the consultation period that formal collaborative agreements were difficult to source and are an impediment to the establishment of an affordable private practice and development of this model.
- Some of the reasons for this are:
  - Collaborative arrangements can be difficult to develop, particularly in rural and remote areas. (44) (45) The availability and accessibility of medical practitioners with whom an endorsed midwife can establish the mandated collaborative arrangement remains a challenge in some rural and remote locations, reducing patient access to endorsed midwife care. In addition, difficulty engaging a medical practitioner to collaborate with and resistance to endorsed midwife referrals has been reported by some endorsed midwives.
  - Requiring an endorsed midwife to establish a formal collaborative agreement makes them dependent on the willingness and availability of individual medical practitioners to participate. (46) In turn there is no mandate that medical practitioners must collaborate.
  - Collaborative arrangements can affect perceptions of the autonomy of an endorsed midwife, including their professional recognition and sense of control as legitimate health care providers (47) and leads to perception of medical control over the woman's care
- The original reasons behind establishing collaborative arrangements, such as avoiding fragmented care (48) (49), do not justify the continued requirement for these arrangements as there is no evidence that collaborative arrangements have significantly contributed to a reduction in fragmented care. Neither the presence nor the effectiveness of collaborative arrangements has been monitored by the Department since implementation of the determination in 2010.
  - Experience demonstrates that eligible midwives effectively collaborate without formal agreements. The National Health and Medical Research Council developed a guidance document for endorsed midwives based on the evidence surrounding midwifery collaborative practice (50).
  - Collaboration is ingrained in midwifery philosophy and is represented in the NMBA standards for practice and the professional guidelines (Australian



College of Midwives National Midwifery Guidelines for Consultation and referral). These standards are grounded in actual (as opposed to aspirational) practice and are evidence-based (51). To meet the standards of practice (against which midwives are audited), collaborative practice must occur. A separate mandated collaborative arrangement is not required.

- There is no evidence to indicate that formal collaboration improves safety.
- There is no evidence to suggest that formal collaborative arrangements increase collaboration between midwives and medical practitioners and there is evidence that it has led to further cultural breakdown between the midwifery and medical profession (52)
- Formal collaborative arrangements are not required in comparable countries. For example, mandated collaborative arrangements are not required for midwives practising in New Zealand. Nurses and midwives are the only health professionals required by law to establish an arrangement with a medical officer in order to participate in the MBS.



## 6. Access to midwifery care

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### 6.1 Consumer access to midwifery continuity of care

Women value supportive, respectful and relational care such as that provided by the continuity of caregiver. Additionally, women wanting to birth safely and naturally, with lower intervention approaches consider Midwifery care as essential to achieving these objectives (12). Improving access to high-value care and removing financial and structural barriers to midwifery services has been a focus of the PMRG. 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 (37) (29).

The barriers to MBS-rebateable midwifery care fall into two main categories: financial and structural. These barriers presented a range of issues for the PMRG which were outside of the scope of the review process. Therefore due to the demand from consumers, efficacy of midwifery continuity of care and the evidence based benefits of this model, it is the overall recommendation of the Reference Group that a further process utilising a similar methodology to the MBS review be established as a matter of priority, reporting to the Health Minister to examine more fulsomely the barriers and solutions to the expansion of Medicare rebated midwifery care.

#### 6.1.1 Structural barriers

Midwives working in an MBS eligible model are absolutely held to account with regards to their professional practice through a myriad of compliance items they must fulfil for the Nurse & Midwives Board of Australia, Medicare, Federal legislation, State policy, professional guidelines in addition to the credentialing organisation requirements of which many of these are required to be demonstrated every 1 to 3 years. The Reference Group are in agreement that robust requirements should exist to ensure quality and safe care. However, it is evident that some of the current requirements for midwives to enter private practice may be onerous as compared to other professions. The following regulatory barriers are additional to those already addressed earlier in this report and the PMRG recommends that government consider how they can be addressed.



### **6.1.2 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. To be eligible for this indemnity coverage Participating Midwives are first required to: meet national registration requirements; 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. Midwives are then required to purchase individual professional indemnity insurance with payment of five years of run-off cover. This can be prohibitive to entering private practice.

The Commonwealth midwife indemnity support schemes are crucial for participating midwives providing Medicare rebated care, including homebirth care. 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.

### **6.1.3 Recency of practice**

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.

### **6.1.4 Midwifery Prescribing Pathway**

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 in addition to their original scope of



practice. Midwives require a limited prescribing formulary that supports the scope of practice they originally studied. Prescribing for Midwives should be included in Midwifery undergraduate education programs.

### **6.1.5 Early career Pathway to Midwifery Private Practice**

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.

## **6.2 Financial barriers**

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

- Rebates do not align with the cost of service provision, particularly for intrapartum items. Like other clinical professions, participating midwives have a full set of practice overheads, including practice accommodation, insurance, motor vehicle costs, administration overheads and more.
- Low rebates mean that out-of-pocket payments are high, restricting access to a small number of women.

There are additional financial barriers that require consideration which were outside the scope of this review:

- Private health insurers will not enter into agreements with midwives for "no gap" or "known gap" arrangements, limiting the private health rebates available to women.
- The fee-for-service model is not well aligned to reflect continuity of care.



### 6.2.1 Bundled payment funding model

Bundled payment funding for midwifery care should be explored. 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:

- There is potential to better align pricing incentives across settings by introducing bundled pricing approaches.
- Uncomplicated maternity care services are potentially amenable to bundled pricing as they follow a relatively predictable care pathway.
- 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:

- 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).
- Labour and birth:
  - All attendances relating to labour and birth, labour management up to 30 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.



- 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, including:

- 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.
- 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).
- 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) and 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:

- Bundled payments may increase complexity for women choosing or needing to change care provider.
- Bundled payments would be a departure from the fee-for-service nature of the MBS to date.
- 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.
- 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.

### 6.3 Summary

In summary, there are a number of benefits to be realised by negating the remaining structural and financial barriers to Medicare rebated midwifery care, 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. Women value supportive, respectful and relational care such as that provided by continuity of caregiver. Additionally women wanting to birth safely and naturally, with lower intervention approaches consider Midwifery care as essential to achieving these objectives (12). Removal of the barriers to Midwifery continuity of care would enable an increase in uptake by women. There would be a reduction in interventions (fewer inductions of labour, pharmacological pain relief used during labour, decreased time in hospital) (5) and an increase in the proven health outcome benefits including 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 covered below.

## 7. Impact statement

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Both consumers and participating midwives are expected to benefit from the recommendations in this report. In making its recommendations, the Reference Group's primary focus was ensuring consumer access to high-quality maternity services. The Reference Group also considered each recommendation's impact on participating midwives to ensure that it was fair and reasonable.



Consumers will benefit from the Reference Group's recommendations through improved access to midwifery continuity of care models, higher quality of clinical services and increased choice, including:

- **Improved access to midwifery continuity of care:** The Reference Group has recommended a series of schedule fee changes throughout the report. These will benefit consumers by reducing the currently high out-of-pocket fees incurred when accessing private midwifery care. The Reference Group's recommendation to remove structural barriers limiting the number of participating midwives across Australia will facilitate increased access for consumers by building a workforce for this model. The Reference Group's telehealth recommendations aim to increase access for rural and remote populations. The Reference Group's recommendations will also increase the ability of Aboriginal Community Controlled Health Organisations to employ midwives across this sector and consider establishing birthing on country services in line with national guidelines. (45) This is crucial to providing a healthy start to life for mothers and babies and will help to close the gap in maternal and perinatal outcomes for Aboriginal and Torres Strait Islander families.
- **Higher quality clinical services:** The Reference Group's recommendations on time-tiers for intrapartum items will reduce the risk of fatigue for participating midwives, increasing the quality of clinical services provided to consumers. The Reference Group's recommendation restricting the use of maternity care plans will ensure that continuity of care is promoted.
- **Increased choice:** The Reference Group's recommendation to facilitate home birthing under the MBS will benefit consumers by providing increased choice in the face of strong demand. These choices will provide safe birth options in line with clinical best-practice guidelines.

The Reference Group's recommendations will benefit participating midwives by enshrining a more accurate representation of their work in the MBS, and increasing the financial viability of private midwifery care. More broadly, the recommendations will benefit midwives by providing increased choice in working models as private midwifery care becomes a financially and structurally viable option.

Consumers, midwives and the Australian health care system will benefit from overall increased investment in private midwifery continuity of care. These benefits will accrue from high-quality, cost-effective maternity outcomes that benefit families and the community.



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## 9. Glossary

Term	Description
ACM	Australian College of Midwives
CAGR	Compound annual growth rate or the average annual growth rate over a specified time period.
Change	When referring to an item, “change” describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes; (ii) the consolidation of item numbers; and (iii) splitting item numbers (for example, splitting the current services provided across two or more items).
CTG	Cardiotocography
Delete	Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS.
Department, The	Australian Government Department of Health
DHS	Australian Government Department of Human Services
GP	General practitioner
GPPCCC	General Practice and Primary Care Clinical Committee
High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.
Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
Low-value care	Services that evidence suggests confer no or very little benefit to consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits.



MBS	Medicare Benefits Schedule
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure or test to which the relevant MBS item refers.
Minister, The	Minister for Health
Misuse (of MBS item)	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
MSAC	Medical Services Advisory Committee
New item/service	Describes when a new service has been recommended, with a new item number. In most circumstances, new services will need to go through the MSAC. It is worth noting that implementation of the recommendation may result in more or fewer item numbers than specifically stated.
NHMRC	National Health and Medical Research Council
NICE	National Institute for Health and Care Excellence
NMBA	Nursing and Midwifery Board of Australia
No change or leave unchanged	Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (for example, references to other items, which may have changed as a result of the MBS Review or prior reviews).
NSAMS	National Strategic Approach to Maternity Services
Obsolete services / items	Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.
PBS	Pharmaceutical Benefits Scheme
PCRG	Primary care reference group
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Reference Group, The	Participating midwife Reference Group of the MBS Review



Services average annual growth	The average growth per year, over five years to 2014/15, in utilisation of services. Also known as the compound annual growth rate (CAGR).
Taskforce, The	8MBS Review Taskforce
Total benefits	Total benefits paid in 2014/15 unless otherwise specified
WHO	World Health Organization



## Appendix A Full list of in-scope items

### Antenatal attendances: Items 82100, 82105, 82110 and 82115

Item	Descriptor	Schedule fee (AUD)	Services FY2016/17	Benefits FY2016/17 (AUD)	Services 5-year annual avg. growth
82100	Initial antenatal professional attendance by a participating midwife, lasting at least 40 minutes	53.40	3,883	177,829	30.0%
82105	Short antenatal professional attendance by a participating midwife, lasting up to 40 minutes.	32.30	12,154	349,024	21.5%
82110	Long antenatal professional attendance by a participating midwife, lasting at least 40 minutes.	53.40	24,209	1,156,532	36.2%
82115	Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks	319.00	6,235	1,706,909	49.3%

### Intrapartum care: Items 82120, 82125, 82130, 82135 and 82140

Item	Descriptor	Schedule fee (AUD)	Services FY2016/17	Benefits FY2016/17 (AUD)	Services 5-year annual avg. growth
82120	Management of confinement for up to 12 hours, including delivery (if undertaken)	753.30	530	299,405	61.7%
82125	Management of confinement for in excess of 12 hours, including delivery where performed; when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife)	753.30	137	77,405	114.7%



### Postnatal attendances: Items 82130, 82135 and 82140

Item	Descriptor	Schedule fee (AUD)	Services FY2016/17	Benefits FY2016/17 (AUD)	Services 5-year annual avg. growth
82130	Short postnatal professional attendance by a participating midwife, lasting up to 40 minutes, within 6 weeks after delivery	53.40	2,547	110,530	35.4%
82135	Long postnatal professional attendance by a participating midwife, lasting at least 40 minutes, within 6 weeks after delivery	78.50	28,844	2,004,481	48.3%
82140	Postnatal professional attendance by a participating midwife on a patient not less than 6 weeks but not more than 7 weeks after delivery of a baby	53.40	989	48,100	33.2%

### Telehealth attendances: Items 82150–82152

Item	Descriptor	Schedule fee (AUD)	Services FY2016/17	Benefits FY2016/17 (AUD)	Services 5-year annual avg. growth
82150	A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	28.30	1	24	-24.2%
82151	A professional attendance lasting at least 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	53.70	2	91	-16.7%
82152	A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	78.95	15	1,007	N/A



## Appendix B Full list of recommendations

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

The Reference Group recommends:

- a. amending the item 82100 descriptor to increase the minimum time to 60 minutes as follows (changes in bold):

#### **Item 82100**

Initial antenatal professional attendance by a participating midwife, lasting at least **60 minutes**.

and

- b. increasing the schedule fee to better reflect the average duration of an initial antenatal attendance (approximately 90 minutes).

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

The Reference Group recommends:

- a. amending the item 82105 descriptor to specify a minimum duration of 10 minutes and removing the maximum duration of 40 minutes as follows (changes in bold):

#### **Item 82105**

Short antenatal professional attendance by a participating midwife, lasting at least **10 minutes**.

- b. amending the item descriptor to describe the attendance as “routine” rather than “long”. The proposed item descriptor is as follows:

#### **Item 82110**

Routine antenatal professional attendance by a participating midwife, lasting at least 40 minutes.



- c. increasing the schedule fee to better reflect the average duration of a routine antenatal attendance of approximately 60 minutes
- d. creating a new item for a long antenatal attendance of at least 90 minutes as follows:

**New Item 821AA**

Long antenatal professional attendance by a participating midwife, lasting at least 90 minutes.

and

- e. setting a schedule fee for item 821AA that is higher than the schedule fee for item 82110 to account for the increased duration.

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

The Reference Group recommends:

- a. creating a new item for a complex antenatal attendance leading to a hospital admission, as follows:

**New Item 821BB**

Complex antenatal attendance leading to a hospital admission—each professional attendance lasting at least 3 hours, to a maximum of 3 services per pregnancy.

- b. capping the number of times item 821BB can be claimed at three services per pregnancy
- c. creating a minimum duration of three hours for this item, and
- d. restricting co-claiming with all other antenatal attendances.

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

The Reference Group recommends:

- a. restricting claims of item 82115 to instances where the woman has had at least two prior antenatal attendances with the claiming participating midwife in the preceding six months, as follows (changes in bold):

**Item 82115**

Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks, **where the participating midwife has had at least 2 antenatal attendances with the patient in the preceding 6 months.**

- b. defining “two prior antenatal attendances” as claims for any of the following:
    - (i) Face-to-face antenatal attendances (items 82100, 82105 and 82110), and
    - (ii) Telehealth antenatal attendances (items 821FF, 821GG and 821HH).
  - c. restricting co-claiming with corresponding GP/obstetric items for maternity care plans, so that only one care plan (independent of provider) can be claimed per pregnancy with the items for co-claim restrictions to include:
    - (i) Item 16590: Planning and management of a pregnancy where the doctor intends to attend the birth.
    - (ii) Item 16591: Planning and management of a pregnancy where the doctor does not intend to attend the birth.
- and
- d. redistributing savings from reductions in the volume of item 82115 claims into participating midwife items 82110, 82135, 82120, 82125, 821CC and 821DD.

**Recommendation 5 – Amend time tiering of intrapartum items**

The Reference Group recommends:

- a. amending the descriptors of items 82120 and 82125 intrapartum time-tiers as follows (changes in bold):

**Item 82120**

Management of labour for **between 6 and 12** hours, including **birth where performed.**

**Item 82125**

Management of labour for **between 6 and 12 hours**, including **birth where performed**, when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife).

- b. creating two new items mirroring items 82120 and 82125, time tiered at six hours (where time is measured as midwife attendance duration, not labour duration), as follows:

**New Item 821CC**

Management of labour for up to 6 hours, including birth where performed OR attendance and immediate post-birth care at an elective caesarean section.

**New Item 821DD**

Management of labour for up to 6 hours, including birth where performed, when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife).

- c. ensuring the explanatory notes for items 82120, 82125, 821CC and 821DD clarify that time should be measured as duration of midwife attendance, not duration of labour
- d. allowing items 82120 and 82125 and the new intrapartum items (821CC and 821DD; see below) to be claimed up to a total of 30 hours attendance by up to two participating midwives (Claiming a 2<sup>nd</sup> or 3<sup>rd</sup> intrapartum item should reflect the handover of care between the primary and second midwife or vice versa. A second intrapartum item should not be claimed by either midwife unless care has been provided in the interim by the alternative midwife to ensure safe work conditions)
- e. allowing co-claiming with existing intrapartum items 82125 and 82120 to account for two or more midwives attending a labour, and
- f. allowing item 821CC to be claimed for a participating midwife's attendance at an elective caesarean section to ensure skin-to-skin contact of mother and baby immediately following birth and initiation of infant feeding in theatre and the recovery unit, until transfer of care to postnatal staff.

*Note: This recommendation should be considered alongside Recommendation 6.*

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

The Reference Group recommends increasing the per-minute schedule fee for intrapartum care, as follows:

- a. for items 82120 and 82125, a MBS schedule fee that is 100 per cent higher than the current schedule fee for items 82120 and 82125, and
- b. for items 821CC and 821DD, a MBS schedule fee at the same per-minute rate as the existing schedule fee for items 82120 and 82125.

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

The Reference Group recommends enabling intrapartum items to be claimed from the time the midwife attends the woman for labour care (i.e. including outside of hospital), by:

- a. amending the intrapartum item descriptors (items 82120, 82125, 821CC and 821DD) to include the word “attendance” (“up to 6 hours attendance” or “between 6 and 12 hours attendance”) to ensure that the billing periods start whenever the midwife is in attendance for the labour and birth (including out of hospital), and
- b. amending the explanatory notes for items 82120, 82125, 821CC and 821DD to explain that the attendance time relating to these items is measured from when attendance starts, including if outside the hospital.

**Recommendation 8 – Include home birthing in intrapartum**

The Reference Group recommends:

- a. including birth at home in the intrapartum
- b. That medical indemnity insurance, for privately practicing midwives be expanded to support a mother’s choice regarding place of birth, including birth at home.

**Recommendation 9 – Amend the postnatal attendance items and introduce a new item for a long postnatal attendance**

The Reference Group recommends aligning the time-tiered structure to provide improved health outcomes, by:

- b. amending the item 82130 descriptor to set a minimum duration of 20 minutes and remove the maximum duration of 40 minutes, as follows (changes in bold):

**Item 82130**

Short postnatal professional attendance by a participating midwife, **lasting at least 20 minutes**, within 6 weeks after birth.

- c. amending the item 82135 descriptor to describe the attendance as “routine”, rather than “long”, as follows (changes in bold):

**Item 82135**

**Routine** antenatal professional attendance by a participating midwife, lasting at least 40 minutes, within 6 weeks after birth.

- c. increasing the schedule fee for item 82135 to better reflect the average duration of a routine postnatal attendance of approximately 60 minutes. This attendance includes care of both mother and baby, and
- d. creating a new item (821EE) for a long postnatal attendance of at least 90 minutes, as follows:

**New Item 821EE**

Long postnatal professional attendance by a participating midwife, lasting at least 90 minutes.

**Recommendation 10 – Include mandatory clinical activities and increase the minimum time for a six-week postnatal attendance**

The Reference Group recommends amending the item 82140 descriptor to introduce a minimum duration of 60 minutes, and to include a birth debrief and mental health screening, as follows (changes in bold):

**Item 82140**

Postnatal professional attendance by a participating midwife with a woman not less than 6 weeks but not more than 7 weeks after birth of a baby, **lasting at least 60 minutes, and including:**

- c) a labour and birth debrief, and
- d) mental health screening.

**Recommendation 11 – Include GPs as eligible specialists for existing telehealth items**

The Reference Group recommends amending the item descriptors (items 82151 and 82152) to include GPs in the list of doctors who can participate in the video consultation, as follows (changes in bold):

**Item 82151**

A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics, obstetrics **or general practice**.

and

**Item 82152**

A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient participating in a video consultation with a specialist / consultant in paediatrics or obstetrics **or general practice**.

**Recommendation 12 – Facilitate telehealth consultations between women and midwives in the antenatal and postnatal period**

The Reference Group recommends:

- b. creating three new telehealth items (821FF, 821GG and 821HH) for women consulting with a midwife via teleconference, with a nurse, Aboriginal and Torres Strait Islander health worker or professional, or another midwife on the patient side
- c. creating time tiers for these new items in line with items 82150–82152, and



- d. that proposed new item descriptors be as follows:

**New Item 821FF – example text**

A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient, supported by a nurse, Aboriginal Health Worker/Professional or midwife, who is participating in a video consultation with a participating midwife.

**Recommendation 13 Add a new item to the MBS for claiming for participating midwives to conduct ongoing lactation support**

The Reference Group recommends:

- e. the addition of a new item to the MBS for claiming for participating midwives to conduct ongoing lactation support
- d. That the proposed new item descriptor be as follows:

**New Item XXXX– example text**

Professional attendance by a participating midwife with a woman during postnatal period until no more than 2 years after birth of a baby for the purpose of lactation support, **lasting at least 60 minutes.**

The Reference Group suggests that items could be restricted to 6 consults per 2- year period, except where a second pregnancy occurs in this 2 year period. This suggestion focusses on providing relevant and high value support for new mothers.

**Recommendation 14 - Addition of a small number of pathology and diagnostic investigation to the MBS rebate schedule for participating midwives as recommended by professional clinical guidelines**

- Below is the list of pathology and diagnostic investigations the PMRG recommend should be added to the MBS rebate schedule for participating midwives:



**Table 7: Pathology and diagnostic investigations that the PMRG recommends should be available for participating midwives**

Test	Proposed Rationale
Thyroid function test/Thyroid antibodies	Thyroid testing is recommended for pregnant women who are at increased risk of thyroid dysfunction because of the range of adverse maternal and neonatal outcomes associated with overt hypothyroidism and hyperthyroidism (40).
Iron studies/Ferritin/ B12/Folate	Routinely testing pregnant women for haemoglobin concentration in early pregnancy and at 28 weeks gestation is recommended. Pending the haemoglobin results further diagnostic tests including serum ferritin, folate and B12 are required in order to diagnose anaemia.  In areas where prevalence of iron-deficiency anaemia are high Ferritin testing should be considered at the first antenatal visit (40)
Fasting bile acids	The collection of liver function tests and fasting bile acids is recommended to diagnose Obstetric Cholestasis when otherwise unexplained pruritus of pregnancy occurs (41).
Kleihauer	It is recommended that all women with a Rhesus (D) negative blood group who deliver an Rh (D) - positive baby should have quantification of feto-maternal haemorrhage to guide the appropriate dose of anti-D prophylaxis. All women who are given Anti-D in response to a potentially sensitizing event should also have the magnitude of potential feto-maternal haemorrhage assessed. (42)
Varicella	It is recommended that serology be attended when a pregnant woman with unknown immune status is exposed to the Varicella Zoster infection, in order to determine if the woman is eligible to receive Varicella Zoster immunoglobulin. (43)
Parvovirus	It is recommended that pregnant women who have been exposed to parvovirus infection should be offered serological testing for parvovirus-specific IgG to determine their susceptibility. The diagnosis of parvovirus infection is usually made, serologically and is usually detectable within 1-3 weeks of exposure and lasts for 2-3 months. (43)
Cytomegalovirus	Serology testing for CMV should be offered to women who come in to frequent contact with large numbers of very young children (e.g. child care workers). CMV testing should also be offered to pregnant women if they have symptoms suggestive of CMV that are not attributable to another specific infection or when imaging findings suggest fetal infection. (40).
Herpes virus swab	Collection of a HSV PCR from the genital tract is recommended for a pregnant woman with a suspected first episode of genital herpes. Serology for HSV-1 and 2 is also attended.



Test	Proposed Rationale
	(Ref. Management of Perinatal Infections, Australian Society of Infectious Diseases 2014)
Vitamin D	It is recommended that serology be considered for women at high risk of suboptimal Vitamin D levels. (40)
HbA1c	It is recommended that 'women with risk factors for Diabetes be offered early testing.' While OGTT is the preferred screen clinical guidelines recommend HbA1c in the first trimester for those women who cannot tolerate the OGTT (e.g. due to nausea and vomiting). (40).
Postnatal abdominal scan	The use of ultrasound to diagnose retained products of conception (RPOC) in the postnatal period is associated with a significant 'false-positive rate'. However ultrasound examination is attended before considering a D&C due to the increased risk of uterine perforation with a surgical procedure in the postpartum period. Referring a woman to an Obstetrician for RPOC with the ultrasound findings already attended ensures that the collaborating medical officer has all available information with which to make a decision and prevents the woman attending a medical consult, being referred for an ultrasound and then returning for a follow-up consult.
Growth and wellbeing scans	Ultrasound assessment of fetal size should be attended when there are fundal height discrepancies and risk factors for a small for gestational age foetus. (40)

### Recommendation 15 - Removal of the need for mandated formal collaborative agreements

The Reference Group recommends that the legislation requiring a collaborative arrangement be rescinded for endorsed midwives. This would require legislative amendment and alteration to the MBS item descriptors.



## Appendix C Summary for consumers

This table describes the medical service, the recommendation(s) of the clinical experts and why the recommendation(s) has been made.

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

Item	What it does	Committee recommendation	What would be different	Why
82100	Initial antenatal professional attendance by a participating midwife, lasting at least 40 minutes.	Amend the minimum time for the attendance to at least 60 minutes and increase the schedule fee.	No initial antenatal attendance would be undertaken in less than 60 minutes.	Best-practice guidelines outline the activities that should occur in an initial antenatal attendance. The Reference Group agreed that these activities could not be undertaken to a high standard in less than 60 minutes and frequently take more than 90 minutes. This recommendation would prevent low-value use of item 82100.



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

Item	What it does	Committee recommendation	What would be different	Why
<b>82105</b>	Short antenatal professional attendance by a participating midwife, lasting up to 40 minutes.	Amend the descriptor to specify a minimum time of 10 minutes, and remove the maximum time.	No woman would receive antenatal attendances of less than 10 minutes.	There are instances where short antenatal attendances (10–30 minutes) provide high value for women, such as a basic clinical examination, or ordering a pathology test and explaining its purpose to the woman. There are no circumstances where antenatal attendances under 10 minutes provide high-value care to women.
<b>82110</b>	Long antenatal professional attendance by a participating midwife, lasting at least 40 minutes.	Amend the descriptor to rename the attendance as “routine” instead of “long” and increase the schedule fee.	Only routine antenatal attendances would be undertaken through this item.  Increasing the schedule fee would give women access to higher rebates for routine antenatal appointments.	Most routine antenatal attendances take approximately 60 minutes. For this reason, the item has been renamed as “routine” and the schedule fee has been amended to more accurately reflect its duration.
<b>821AA</b>	Long antenatal professional attendance by a participating midwife, lasting at least 90 minutes.	Create a new item.	Complex antenatal attendances that take a long time would be adequately rebated for women.	There are many instances where antenatal attendances of over 90 minutes provide high-value care—for example, when women with a disability or a significant medical condition require a longer amount of time to ensure all tests are considered and an appropriately detailed clinical examination is conducted.

**Recommendation 3: Introduce a new item (821BB) for a complex antenatal attendance leading to a hospital admission**

Item	What it does	Committee recommendation	What would be different	Why
<b>821BB</b>	Complex antenatal attendance leading to a hospital admission—each professional attendance lasting at least three hours, with a maximum of three services per pregnancy.	Create a new item.	A complex antenatal attendance leading to a hospital admission for complications during pregnancy would now be rebated for women.	Participating midwives are the primary carers of pregnant women under a midwifery continuity of care model. During this period, women may need to be admitted to hospital for complications during pregnancy. The midwife often undertakes this admission process. There is currently no MBS rebate available to the patient for the (substantial) time the midwife spends admitting them.


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

Item	What it does	Committee recommendation	What would be different	Why
<b>82115</b>	Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks.	<p>Restrict claims of item 82115 to instances where the woman has had at least two prior antenatal attendances with the claiming midwife during the pregnancy.</p> <p>Restrict co-claiming with GP/obstetrician maternity care plan items.</p>	<p>MBS rebates would not be available for a maternity care plan unless the woman has had at least two antenatal appointments with the participating midwife.</p> <p>MBS rebates would not be available for maternity care plans if the woman already has a maternity care plan with a GP or obstetrician.</p>	Maternity care plans should be used when there is an established relationship between a woman and a participating midwife. These restrictions would help to reduce low-value claims of this item and ensure that it promotes a continuity of care model.



### Recommendation 5: Amend time tiering of intrapartum items

Item	What it does	Committee recommendation	What would be different	Why
<b>82120</b>	Management of confinement for up to 12 hours, including delivery (if undertaken).	Update descriptors to reflect modern language: replace “delivery” with “birth”, and “confinement” with “labour”.	The new descriptor would include more modern language, with no substantial change in meaning.	The words birth and labour are used more commonly, and are more consumer friendly, than confinement and delivery.
<b>82125</b>	Management of confinement for in excess of 12 hours, including delivery where performed; when care is transferred from one participating midwife to another participating midwife (the second participating midwife).	Update descriptors to reflect modern language: replace “delivery” with “birth”, and replace “confinement” with “labour”.	The new descriptor would include more modern language, with no substantial change in meaning.	The words birth and labour are used more commonly, and are more consumer friendly, than confinement and delivery.
<b>821CC</b>	Management of labour for up to six hours, including birth (if undertaken), including attendance and immediate post-birth care at an elective caesarean section.	Create a new item.	A participating midwife would be able to hand over care to a second participating midwife after six hours if they are fatigued.	The current MBS structure promotes working hours over 12 hours. These long hours put midwives at risk of fatigue. A new item time tiered at six hours would enable participating midwives to hand over care earlier during the intrapartum period.
<b>821DD</b>	Management of labour for up to six hours when care is transferred from one participating midwife to another participating midwife (the second participating midwife).	Create a new item.	A second participating midwife would be able to claim for six hours of intrapartum care.	The current MBS structure promotes working hours over 12 hours. These long hours put midwives at risk of fatigue. A new item time tiered at six hours would enable participating midwives to hand over care earlier during the intrapartum period.


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

Item	What it does	Committee recommendation	What would be different	Why
<b>82120</b>	Management of confinement for up to 12 hours, including delivery (if undertaken).	Increase the per-minute schedule fee rate to be 100 per cent higher.	The consumer rebate for this item would be double the current rebate.	There are differences in the rebates available to women during the intrapartum period depending on whether they access midwife-led or obstetrician-led care. This recommendation would increase rebates available to women to ensure they can access continuity of midwifery care.
<b>82125</b>	Management of confinement for in excess of 12 hours, including delivery where performed; when care is transferred from one participating midwife to another participating midwife (the second participating midwife).	Increase the per-minute schedule fee rate to be 100 per cent higher.	The consumer rebate for this item would be double the current rebate.	There are differences in the rebates available to women during the intrapartum period depending on whether they access midwife-led or obstetrician-led care. This recommendation would increase rebates available to women to ensure they can access continuity of midwifery care.
<b>821CC</b>	Management of labour for up to six hours, including birth (if undertaken), including attendance and immediate post-birth care at an elective caesarean section.	Set schedule fees for items 821CC and 821DD at the same per-minute rate as the revised schedule fee for items 82120 and 82125.	The consumer rebate for this item would be equal to the per-minute rate for items 82120 and 82125.	There are differences in the rebates available to women during the intrapartum period depending on whether they access midwife-led or obstetrician-led care. This recommendation would increase rebates available to women to ensure they can access continuity of midwifery care.
<b>821DD</b>	Management of labour for up to six hours where care is transferred from one participating midwife to another participating midwife (the second participating midwife).	Set schedule fees for items 821CC and 821DD at the same per-minute rate as the revised schedule fee for items 82120 and 82125.	The consumer rebate for this item would be equal to the per-minute rate for items 82120 and 82125.	There are differences in the rebates available to women during the intrapartum period depending on whether they access midwife-led or obstetrician-led care. This recommendation would increase rebates available to women to ensure they can access continuity of midwifery care.


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

Item	What it does	Committee recommendation	What would be different	Why
<b>82120, 82125, 821CC, 821DD</b>	Management of labour, time tiered as in Recommendation 6.	Amend intrapartum item descriptors (items 82120, 82125, 821CC and 821DD) to include the word “attendance” (“up to 6 hours attendance” or “between 6 and 12 hours attendance”) to ensure that the billing periods start whenever the midwife is in attendance for the labour and birth (including out of hospital).	The billing periods for care provided under these items would start whenever the midwife is in attendance for the labour and birth (including out of hospital).	The duration of care for these items is currently measured from when the woman is admitted to hospital. Intrapartum care is often provided at home, with the aim of delaying hospital admission for as long as possible and providing care in a familiar environment. This recommendation would provide women with rebates for early labour care with a participating midwife in the home.



### Recommendation 8: Include home birthing in intrapartum items

Item	What it does	Committee recommendation	What would be different	Why
<b>82120, 82125, 821CC, 821DD</b>	Management of labour, time tiered as in Recommendation 6.	Allow intrapartum items to be claimable for women choosing to birth at home.	Women choosing to birth at home with a participating midwife would receive MBS rebates for labour care.	Evidence shows that homebirths are safe. Every year, families choose to birth their baby at home, some with the care of a participating midwife, some with a non-regulated midwife, some through a public hospital program, and some with no professional care or support (freebirth). Many families cannot afford the care of a participating midwife who can provide the option to birth at home. This recommendation would provide MBS rebates for births at home with a Participating Midwife, allowing women to choose the place of birth they feel most comfortable with.


**Recommendation 9: Amend the postnatal attendance items and introduce a new item (821EE) for a long postnatal attendance**

Item	What it does	Committee recommendation	What would be different	Why
<b>82130</b>	Short postnatal professional attendance by a participating midwife, lasting up to 40 minutes, within six weeks of delivery.	Amend the item descriptor to set a minimum time of 20 minutes and remove the maximum time of 40 minutes.	Postnatal attendances under 20 minutes would no longer be rebated under the MBS.	There are no circumstances in which postnatal attendances under 20 minutes would provide high-value care to women.
<b>82135</b>	Long postnatal professional attendance by a participating midwife, lasting at least 40 minutes, within six weeks of delivery.	Amend the item descriptor to rename the attendance as “routine” rather than “long”.  Increase the schedule fee to align with an average duration of 60 minutes.	Women would receive a higher rebate for this item.	Routine postnatal attendances take on average 60 minutes. A schedule fee increase would promote high-quality routine postnatal attendances, more accurately reflect the work involved for both mother and baby, and increase access for women.
<b>821EE</b>	Long postnatal professional attendance by a participating midwife, lasting at least 90 minutes.	Create a new item.	Women would receive higher rebates for long antenatal attendances lasting more than 90 minutes.	There are numerous instances where postnatal attendances of over 90 minutes provide high-value care for women. This recommendation would ensure that women receive appropriate rebates for these instances.


**Recommendation 10: Include mandatory clinical activities and increase the minimum time for a six-week postnatal attendance**

Item	What it does	Committee recommendation	What would be different	Why
<b>82140</b>	Postnatal professional attendance by a participating midwife on a patient not less than six weeks but not more than seven weeks after delivery of a baby.	<p>Amend the item descriptor to introduce a minimum time of 60 minutes.</p> <p>Amend the item descriptor to include a birth debrief and mental health screening.</p>	<p>Six-week postnatal attendances under 60 minutes would no longer be rebated under the MBS.</p> <p>Six-week postnatal attendances would have to include birth debriefing and mental health screening.</p>	<p>The Pregnancy Care Guidelines outline the activities that should occur in a six-week postnatal attendance. These cannot be completed to a high standard in under 60 minutes. Mental health screening and birth debriefing are important elements of this attendance and are specifically included in these care guidelines. This recommendation would ensure that care specified in best-practice guidelines occurs in practice.</p>

**Recommendation 11: Include GPs as eligible specialists for existing telehealth items**

Item	What it does	Committee recommendation	What would be different	Why
<b>82150, 82151, 82152</b>	A professional attendance to a patient who is participating in a video consultation with a specialist or consultant in paediatrics or obstetrics.	Adjust item descriptors to include GPs in the list of doctors who can participate in the video consultation.	Women would receive a rebate to cover the cost of a midwife participating in a video consultation with a GP (not just specialists).	Telehealth is one way to increase access to maternity services for those in rural and remote regions. GPs (especially those with a sub-specialisation in obstetrics) are well placed to deliver medical advice to women and their caring midwives during pregnancy.

**Recommendation 12: Facilitate telehealth consultations between women and midwives in the antenatal and postnatal period**

Item	What it does	Committee recommendation	What would be different	Why
<b>821FF, 821GG and 821HH</b>	A professional attendance to a patient, supported by a nurse, Aboriginal and Torres Strait Islander health worker/professional or midwife, who is participating in a video consultation with a participating midwife.	Create three new items.	Women would receive rebates to cover the cost of participating in a video consultation with a participating midwife.	Women in rural and remote regions cannot always access high-quality, cost-effective maternity care. This recommendation would allow more women to access maternity care via telehealth with a participating midwife.

**Recommendation 13: Recommendation 13 Add a new item to the MBS for claiming for participating midwives to conduct ongoing lactation support**

Item	What it does	Committee recommendation	What would be different	Why
	Professional attendance by a participating midwife with a woman during postnatal period no more than 2 years after birth of a baby for the purpose of lactation support, lasting at least 60 minutes.	Create one new item	Women would be able to access MBS rebateable lactation support from a participating Midwife from 6 weeks after the infant's birth until the infants 2 <sup>nd</sup> birthday. This support is currently only available until 6 weeks post birth.	Continued Breast feeding has innumerable benefits for both the infant and the mother. Australia is fortunate to have a high initiation rate for breastfeeding at 92-98% of women, however this drops off rapidly with only 14% Women breast feeding at 6 months post birth.



**Recommendation 14: Addition of a small number of pathology and diagnostic investigation to the MBS rebate schedule for participating midwives as recommended by professional clinical guidelines**

Item	What it does	Committee recommendation	What would be different	Why
	Order of a pathology or diagnostic investigation by a participating Midwife as recommended by professional clinical guidelines.	Addition of a small number of pathology and diagnostic investigation to the MBS rebate schedule for participating midwives as recommended by professional clinical guidelines	Women would have access to MBS rebates for an additional small number of pathology and diagnostic investigations that are recommended in professional clinical guidelines. When ordered by the primary caring Endorsed Midwife, women would no longer require an additional MBS GP appointment in order to have the investigation ordered.	The addition of these items to the MBS schedule provide a more consumer responsive model of care and will reduce the number of MBS visits required to order a single investigation.

**Recommendation 15: Removal of the need for mandated formal collaborative agreements**

Item	What it does	Committee recommendation	What would be different	Why
	Removes the need for a formal written collaborative agreement with another individual medical practitioner or health organisation prior to a Midwife being considered eligible for an MBS provider no.	The legislation requiring a collaborative arrangement be rescinded for endorsed midwives. This would require legislative amendment and alteration to the MBS item descriptors.	Endorsed Midwives would be eligible to apply for an MBS provider number without the 'prior consent' of another individual medical practitioner or health organisation. Participating Midwives would be free to refer and collaborate with all medical and allied health professionals to optimise the clinical care of any given woman.	The minimal number of medical practitioners and/or health organisations willing to participate in a formal collaborative agreement with a Midwife seeking endorsement is restricting consumer access to MBS rebatable Midwifery continuity of care. Certain states and jurisdictions appear to be less responsive than others.



## Appendix D Mapping new intrapartum items to clinical cases

Hours	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37
<p>Below are a number of actual intrapartum cases. Proposed MBS items have been mapped against these cases to demonstrate utilisation.</p> <p>The majority of intrapartum cases will be covered by item 82120 or a combination of 82120 and 821CC, however some of the more complex and lengthy cases have been included in this exercise to demonstrate the flexibility required by the item no.s.</p>																																					
Case 1	<div><div></div><div>821CC</div></div> <p>Case 1: Elective Caesarean Birth. Hr 1: The Midwife attends the ward to prepare the woman. Hr 2: The Midwife and Woman are transferred to the theatre for spinal and immediate surgery preparation Hr 3: Birth of the infant and Skin to Skin Hr 4-5: Skin to Skin, first infant feed and maternal &amp; neonatal care and observations in recovery Hr 5-6: Maternal &amp; neonatal transfer to ward. Orientation, observations, feeding and skin to skin.</p> <p>All care provided by primary Midwife</p>																																				
Case 2	<div><div></div><div>82120</div></div> <p>Case 2: 2nd Baby, 5 cm dilated on arrival to hospital, progressed to birth within 4 hours. Discharged home 5 hours after birth.</p> <p>All care provided by primary Midwife.</p>																																				
Labour RM 1	<div><div></div><div>82120: Management of labour for between 6 and 12 hours, including birth where performed</div></div>																																				
Labour RM 2	<div><div></div><div>82125: Management of labour for between 6 and 12 hours, including birth where performed; when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife)</div></div>																																				
Birth	<div><div></div><div>821CC: Management of labour for up to 6 hours, including birth where performed, including attendance and immediate post-birth care at an elective caesarean section</div></div>																																				
Postnatal	<div><div></div><div>821DD: Management of labour for up to 6 hours, including birth where performed when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife)</div></div>																																				
Caesarean	<div><div></div></div>																																				



Hours	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37
Case 3	<div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div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Labour RM 1  
Labour RM 2  
Birth  
Postnatal  
Caesarean



82120: Management of labour for between 6 and 12 hours, including birth where performed

82125: Management of labour for between 6 and 12 hours, including birth where performed; when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife)

821CC: Management of labour for up to 6 hours, including birth where performed, including attendance and immediate post-birth care at an elective caesarean section

821DD: Management of labour for up to 6 hours, including birth where performed when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife)



## Appendix E Comparison of obstetric and midwifery care during birth

Midwifery care	Obstetric care
<p>c. <b>Continuous attendance:</b> Women's expectations are that the participating midwife is available throughout labour and birth and continues to provide care through the first few hours following birth to monitor early attachment and the first breastfeed. This generally includes between two and six hours post-birth care, depending on whether the woman is remaining in hospital or going immediately home.</p> <p>d. Ongoing communication and education are a significant part of the midwife's role. This is also the case where a midwife is supporting an obstetrician in birth (i.e. in other models).</p> <p>e. The midwife admits the woman and checks her history, birth plan and plans for feeding a newborn; performs baseline observations; and develops a plan.</p> <p>f. Ongoing observations are taken every 15 minutes to half hour throughout labour. The foetal heart rate and pattern, and contractions (rate, length and intensity), require 10 minutes of continuous assessment every 15 minutes to half hour. Maternal blood pressure, maternal pulse, vaginal loss, maternal temperature and urinary output are also assessed. Labour progress is assessed throughout by abdominal palpation, observation of the woman and vaginal examination where appropriate.</p> <p>g. The midwife provides support and comfort, generally in a hands-on role, as well as pain relief (including pharmacological and non-pharmacological measures).</p> <p>h. The midwife provides ongoing documentation and reporting to any other staff as required.</p> <p>i. Depending on the labour and individual circumstances, the midwife can perform a range of procedures including commencement and management of induction of labour, cannulation, taking blood as required, performing CTG either intermittently or continuously, monitoring epidurals and recording clinical information.</p> <p>j. The midwife may need to pre-empt or coordinate operative birth, including all preparation for theatre.</p> <p>k. During the second stage of labour, observation frequency increases to five minutes and there is ongoing assessment of progress and conduct of birth; administration of any drugs required, or resus as required; management of complications, as required; and documentation.</p> <p>l. The third stage includes birth of the placenta (active or physiologic), facilitation of mother-baby attachment, the first breastfeed, observations of mother and baby, and a newborn check (including weight, length and all physical attributes).</p>	<p>m. <b>Intermittent attendance:</b> Women's expectations are that the obstetrician will assess them at key points during labour, will be there for birth, and for a short period after to suture and complete documentation.</p> <p>n. On admission or at some point after admission, the obstetrician reviews the information collected by the midwife, assesses the information, gathers further information as needed and develops a plan.</p> <p>o. The obstetrician communicates with the woman, her partner and the midwife.</p> <p>p. The obstetrician completes a review at various stages, which involves reviewing the information collected, performing vaginal examination and abdominal palpation.</p> <p>q. The obstetrician attends the birth and intervenes if clinically necessary.</p> <p>r. The obstetrician manages complications including resuscitation if needed.</p> <p>s. The obstetrician performs operative birth if required.</p> <p>t. The obstetrician manages the third stage of labour (usually active management).</p> <p>u. The obstetrician sutures if required.</p>



## Appendix F Response provided to GPPCCC referred questions

**Figure 3: Rebate attendance at a case conference by non-doctor health professionals**

### PARTICIPATING MIDWIVES REFERENCE GROUP

#### Rebate attendance at a case conference by non-doctor health professionals

Question	Response	Rationale and evidence
What does the evidence say about the benefit of midwives attending case conferences?	Attendance of midwives at case conferences improves coordination of care. From a consumer perspective it is a basic expectation that the midwife taking care of them during birth would attend their case conference.	<ul style="list-style-type: none"> <li>In a hospital setting, a patient would not consider having a case conference without her midwife. The same standards should apply in private settings. (Anecdotal)</li> <li>For a consumer, a close relationship with their midwife is crucial, and attendance at any case conference by the midwife is important to achieve this. (Anecdotal)</li> <li>Attendance at case conferences encourages coordination of care during pregnancy, or upon discharge from hospital. This translates to better outcomes for patients. (Anecdotal)</li> </ul>
To what extent do they currently attend case conferences? What are the main barriers to attendance?	<p>Some midwives currently attend case conferences, and often lead the conference when they do (where no GP is attending). Members often include a mental health worker, midwife and psychologist. However, case conferences are also commonly used to support women with gestational diabetes (and include dietitians, obstetricians, etc). Case conferences are usually face-to-face, and are convened to ensure all supports for a woman are 'on the same page'.</p> <p>Barriers to midwives attending case conferences include:</p> <ul style="list-style-type: none"> <li>Lack of funding: no item numbers exist for midwives, and clients do not pay out-of-pocket for these services, which poses a challenge for sustainability</li> <li>Informality: no item number means that practitioners may not always think to include midwives in case conferences</li> <li>Travel required: case conference teams are often not co-located, and midwives have to travel</li> <li>High administrative burden: Midwives often coordinate the case conference, and thus have to complete all minute-taking, communication and organisational activities</li> </ul>	<ul style="list-style-type: none"> <li>Formalisation of case conference attendance with an item number would increase awareness for both midwives and other health providers that including midwives is an option. This would encourage more case conferences involving midwives for complex care cases. (Anecdotal)</li> <li>Case conferences are infrequently used in general practice due to the difficulty of achieving the required of getting three people together i.e., rules may be too tight. (Anecdotal)</li> </ul>



## Appendix G Pathology and Diagnostic investigations currently omitted from the 2010 Midwifery approved MBS list.

Test	Rationale
Thyroid function test/Thyroid antibodies	NHMRC 'Clinical Practice Guidelines, Pregnancy Care Guidelines' 2019
Iron studies/Ferritin/B12/Folate	NHMRC 'Clinical Practice Guidelines, Pregnancy Care Guidelines' 2019
Fasting bile acids	RCOG Green Top Guideline No. 43, Endorsed by RANZCOG
Kleihauer	RANZCOG Guidelines for the Use of Rh (D) Immunoglobulin (Anti D) in obstetrics in Australia (2015)
Varicella/ /	NHMRC 'Clinical Practice Guidelines, Pregnancy Care Guidelines' 2019
Parvovirus	Management of Perinatal Infections, Australian Society of Infectious Diseases Management of Perinatal Infections 2014
CMV	NHMRC 'Clinical Practice Guidelines, Pregnancy Care Guidelines' 2019
Herpes virus swab	Management of Perinatal Infections, Australian Society of Infectious Diseases Management of Perinatal Infections 2014
Vitamin D	Listed in NHMRC 'Clinical Practice Guidelines, Pregnancy Care Guidelines' 2019
B12 and Folate	NHMRC 'Clinical Practice Guidelines, Pregnancy Care Guidelines' 2019



Test	Rationale
HbA1c	Australian clinical guidelines
Postnatal abdominal scan	Where there are symptoms or signs consistent with retained products and prior to considering a D&C
Growth and wellbeing scans	NHMRC 'Clinical Practice Guidelines, Pregnancy Care Guidelines' 2019