Changes to eligible midwifery status: new possibilities for rural maternity care?

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Current rural maternity care
Closure of maternity services has led to a near-halving of accessible rural maternity units within the last 20 years. These closures have exacerbated the workforce shortages that often cause them, and transfer the social, economic and psychological costs from health services to families, such that within the current Australian health system, only 12% of rural families feel they have good access to maternity services. Closure of local maternity care facilities on a cost basis fails to account for the costs to communities of inadequate access, which may include the economic losses suffered due to hospital closure, and the disincentive for families to move to these areas in their childbearing years—a substantial factor in the viability of rural communities.

Travelling to larger regional or metropolitan centres for antenatal and postnatal care is not subsidised for families, and for financial, logistical or social reasons (including transport, childcare, and employment, among others) many rural and remote families do not, or cannot access these services. Limited access to antenatal care alone is associated with significant increases in maternal and infant morbidity and mortality; can result in failure to detect serious complications for mothers and babies; and contributes to the underreporting and risk of conditions such as perinatal depression for rural and remote families, already significantly higher than in metropolitan areas. The stress associated with pregnancy for women travelling one hour or more to access maternity care is over eight times greater than for women who do not.

In terms of intra-partum care, these same difficulties, and the anxiety and stress associated with separation from family, friends and community leads many women to avoid transfer to metropolitan areas until birth is imminent, increasing the risks of delivery prior to reaching health care services and exposing women to the hazards of travel in labour. Travel is often at higher speeds than in metropolitan areas, over poorer roads, and with additional dangers like wildlife. For Aboriginal and Torres Strait Islander women, the separation from family, community and country has even greater physical, mental, and spiritual significance.

With increasing remoteness from capital cities, midwives form an increasing proportion of the maternity care workforce. However, the prevalence of maternity-trained health professionals declines with increasing distance, even though the birth rate rises. With the increasing age of the current health workforce it is crucial that midwives, particularly younger midwives, be appropriately trained and encouraged into rural maternity care, and allowed to work within their full scope of practice. The role and abilities of the eligible midwife as a capable, autonomous practitioner—either within health services, or as private practitioners, offer significant opportunities for improving rural maternity care, and fulfilling the vision of the National Maternity Services Plan to deliver, “High quality, evidence-based, culturally competent maternity care in a variety of settings close to where they live,” including continuity of chosen caregiver (p. iii). This paper will discuss eligible midwives (EMs) in both contexts, within health services and in private practice, and the ways in which they might be utilised—adaptable to local requirements.

What is an eligible midwife?
‘Eligible midwife’ is a new, legislated designation, administered by the Nursing and Midwifery Board as part of AHPRA, available to currently registered midwives in Australia with:

- no conditions on practice
- a minimum of three years full-time post-registration experience, or equivalent
• successful completion of an approved professional practice review program (the Midwifery Practice Review, or MPR) which demonstrates continuing competence in the full scope of midwifery care—provision of care antenatally, intra-partum, and post-partum for women and infants

• successful completion, or the formal undertaking to complete within 18 months of recognition as an eligible midwife: an Australian Nursing and Midwifery Accreditation Council (ANMAC) accredited and Board-approved program of study to develop midwives’ knowledge and skills in prescribing medicines, or a program that is substantially equivalent to such an approved program of study, as determined by the Board

• a signed collaborative arrangement with a named medical practitioner.11

Eligible midwives have the right to prescribe specific medications and access the PBS, to receive Medicare provider status and subsidised professional indemnity insurance.11 The reforms were designed to increase women’s equity of access to continuity of care by their chosen caregiver12, and reflected the assertion of the World Health Organisation (WHO) that midwives are the most appropriate health practitioners to provide care for women through pregnancy and birth, as these are not illnesses, but normal physiological processes that for most women will result in safe, successful outcomes with support, patience and skilled midwifery care.13

What are the changes to eligible midwifery status, and why were they made?

Discussion papers released by the Australian Health Minister’s Advisory Council and the Department of Health and Ageing (DHA) endorsed a multi-disciplinary collaborative framework that took into account the excellent economic and health outcomes for midwifery-led models of care.14 This was supported by both the Maternity Services Review12 and the Productivity Commission, and yet the original Determination enshrined a system of vertical ‘collaboration’ instead, requiring a signed arrangement with a named medical practitioner.14

In August 2012, it was announced that the wording would be formally changed from a, “Named Medical Practitioners,” to a, “Health Provider Organisation.”15 The changes recognise, belatedly, that most midwives work collaboratively without formal legislative requirement; operating under the Australian Nursing and Midwifery Council (ANMC) Code of Professional Conduct for Midwives, ANMC Code of Ethics and the ANMC Competency Standards, and subject to ongoing professional scrutiny and development through the Midwifery Practice Reviews required of eligible midwives.14 Formally enshrined unidirectional ‘collaboration’ was only required of midwives seeking access to the Medicare Benefits Scheme (MBS), Pharmaceutical Benefits Scheme (PBS) and Professional Indemnity Insurance (PII), despite working within their full scope of practice in similar ways to hospital-employed midwives in caseload models, for example.14

In 2010, prior to the original Determination, the Maternity Services Review had explicitly suggested that a, “Lack of unanimity,”12 should not be used as an excuse to neglect developing evidence-based best practice. Given that the evidence, including the largest randomised-controlled trial in the world of its kind, suggests that midwifery-led care produces reduced rates of intervention, high levels of satisfaction from both practitioners and women, and significant economic efficiencies16, it is long past time that midwives were given due recognition and an expanded role within the Australian maternity system. The National Maternity Services Plan required the, “[Development of] consistent approaches to the provision of clinical privileges within public maternity services to enable admitting and practice rates for eligible midwives and medical practitioners.”12

The changes will enable the registration of far greater numbers of eligible midwives, and improve the access to private admitting rights. Where these have been implemented so far in regional areas, such as in Toowoomba and Emerald, they have been highly successful in achieving safe outcomes and maternal satisfaction with care.17
What are the advantages of an EM for a rural community?

According to the United Nations Population Fund (UNFPA), "When they are properly trained, empowered and supported, midwives in the community offer the most cost-effective and high-quality path to universal access to maternal health care." Midwives are the best distributed maternity care workforce in Australia, with better distribution in rural and regional areas than GP obstetrician or specialist obstetricians. Midwives and nurses form 60% of the health workforce in Australia (many, though not all, with dual qualification), and their proportion of the workforce increases with increasing remoteness. Up-skilling midwives into the advanced practice role of eligible midwives in autonomous, collaborative rural practice therefore offers both the largest pool of the health workforce to draw upon, and the greatest number of experienced rural and remote practitioners.

Locally accessible care contributes to the minimisation of psychological, social and financial costs for families associated with travel for antenatal and postnatal appointments. This translates to not only happier, healthier and wealthier communities, benefiting from continuity of carer and understanding of local conditions, but increased attendance at ante- and post-natal care, with resultant improved maternal and neonatal outcomes.

Midwives working in a case-loading model—in which midwives work on the basis of scheduled appointments and when they are needed, rather than on strictly rostered shifts—requires reduced staffing numbers, and hence costs health services (or Medicare, as applicable) compared to continuously staffing a venue even when no women are in attendance for labour, birth or other care. This model also provides far greater job satisfaction for midwives. Not only are they able to practice solely in their chosen profession, rather than performing general nursing tasks, but they have the opportunity to better develop relationships with and care for women and families. EMs are perfectly placed to fulfil this role, as highly qualified autonomous practitioners, skilled in the full scope of midwifery practice, and able to prescribe and request diagnostic tests and refer as required. This prevents the need for duplication of effort, saving valuable time for GPs and other members of the health team, where their advanced or different skills are not required.

Research has indicated many women are happy to transfer to larger regional centres for birthing, when required, but the presence of local, accessible maternity care will enable women to remain longer in their communities, minimising the social and financial costs for communities, and maximising women’s access to antenatal and postnatal care. In the case of precipitant birth or spurious labour, or where low-risk women do not wish to transfer outside their community, skilled care would be on hand to assist with immediate care (including resuscitation if required), and assist with transfer to a larger facility if this is deemed necessary. As the NRHA rightly pointed out in its submission to the Maternity Services Review, “Babies sometimes do not wait and therefore cannot be transferred.”

For midwives, the opportunity to practice exclusively in their chosen profession (midwifery, as opposed to general nursing) is an extremely important recruitment and retention incentive. Many feel at present that dissatisfaction with their general nursing or dual role is a compromise they must make to live in their rural area of choice. It is entirely conceivable that the opportunity to practice solely midwifery could tempt many others to rural work, where dual role requirements have previously provided a disincentive. Case-loading also offers the opportunity to attract Bachelor of Midwifery graduates, who are often more experienced and better suited to rural midwifery practice than dual qualified or Graduate Diploma-qualified practitioners.

Section 19(2) of the Health Insurance Act 1973, enables eligible midwives employed by the Aboriginal and Torres Strait Islander Community-Controlled Health Services, including rural and remote communities, to claim Medicare benefits for bulk-billed services. Similarly, the COAG Improving Access to Primary Care in Rural and Remote Areas exemption allows midwives to provide bulk-billed services to rural and remote communities. These benefits are unaffected by the changes to the Determination, and provide an additional opportunity to maximise access in areas of workforce shortage.
Is this what rural communities want?

At the time of the original Determination, the Health Consumers of Rural and Remote Australia Inc urged the Government not to rule against private midwifery and community birthing services (including homebirth) for rural and remote families. This reflects the fact that continuity of care and locally accessible care are associated with the best outcomes for women and babies, and that women’s assessments of risk are different to obstetric assessment, in that it takes into account the psychological and economic costs of separation from family and community.

There is evidence that small rural maternity units are at least as safe for low risk women as larger city hospitals, even where there are limited numbers of births and/or onsite caesarean section is not available. These outcomes are strengthened where local maternity care is enhanced by continuing professional development, genuinely collaborative care and back-up systems and transfer for those families who do require additional services (such as Neo-natal Intensive Care.)

Rural maternity care has by necessity involved collaborative care, often between a midwife and a GP obstetrician. Small staffing numbers and facilities offer women the benefits of continuity of caregiver, which is associated with both increased safety and satisfaction. The best models of care include genuine collaboration for women-centred care, based on mutual trust, respect and open communication within clearly delineated roles and responsibilities. These may be encouraged and maintained through regular interdisciplinary meetings and case reviews; modelling of collaborative behaviour to new employees; and transparent ground rules encouraging critical reflection on personal practice by all disciplines; consensus decision-making and open communication.

Lessons from overseas

Peak maternity bodies in British Colombia, Canada, with similar factors of rural and remoteness, and Indigenous communities, suggest that even limited local maternity services provide far better outcomes than no local maternity services. Improved outcomes for local communities are observed even without local access to operative delivery. A five year study of births in the Zuni-Pueblo and Ramah Navaho communities in New Mexico demonstrated equivalent or better than national health outcomes, despite a higher-risk group for birthing in a rural community without onsite theatre facilities. In New Zealand, 15.6% of women birth in primary maternity units with no specialist facilities onsite, the majority of which are in rural or regional areas. Fewer than one in five women require transfer, and for those who remain, vaginal birth rates are dramatically higher, and caesarean section rates significantly lower. Similarly, Inuit and Canadian Aboriginal women have demonstrated high safety and satisfaction outcomes with midwifery-led maternity care in rural and remote communities, even where birth numbers are low.

How can we promote EMs and access to maternity care?

One of the more critical elements of providing safe rural maternity care is ensuring access to continuing professional development (CPD). It is vital that eligible midwives (and all health practitioners) are able to access education opportunities and study leave (with appropriate locum cover) to maintain current skills, particularly in areas with limited birthing numbers. This is essential to maintain competency in rarely-used techniques, including those employed, for example, in precipitant breech birth or shoulder dystocia. Support and/or subsidies for online education, and regular peer networking will limit the sense of professional isolation, and minimise the difficulties of achieving the required 20 hours of CPD each year where local education is not offered. Cover should be provided for short periods for eligible midwives to work within metropolitan hospitals to ensure currency of practice. Subsidised prescriber courses for registered midwives wishing to attain eligible midwifery status should be available to those either currently working, or willing to work in rural areas.

Case-loading models of care offer high levels of practitioners and consumer satisfaction, as well as high levels of cost-effectiveness. A large randomised-controlled trial of midwifery-led collaborative care demonstrated dramatically reduced levels of intervention— including a 22% reduction in the rate of...
caesarean section, producing its own cost savings in both primary care and referral centres. No neonatal outcomes in this trial favoured standard care. Health services should be encouraged and supported to incorporate case-loading into their maternity care, and develop (or customise) role modelling and interdisciplinary collaboration frameworks to enhance team approaches to care (for example, the 'Three Centres Consensus Guidelines').

Where local care cannot be staffed or is not practical (for instance, in a community with a very high proportion of older families), or as an interim measure, EMs’ skills should be utilised in outreach practitioner or locum support roles, including their incorporation into the existing Specialist Obstetrician Locum Service and/or Medical Specialist Outreach Access Program models. Medicare rebates for antenatal education sessions should be established, including those delivered by telehealth—allowing rural women to access the same level of information as those in metropolitan areas. Where provided in a group, antenatal education may assist to minimise social isolation for new mothers. Innovative use of technology, such as group Skype sessions for breastfeeding education, or use of mobile health technology to follow up on infancy vaccinations should be investigated.

Eligible midwifery access to the PBS should be expanded, such that it includes all medications likely to be required within midwifery scope of practice. The present list of PBS medications is extremely limited at present, and excludes contraception as part of routine postnatal care (though Levonorgestrel tablets are included, this is the only option available), Ondansetron for severe nausea, and Lignocaine for suturing—as a few basic examples. For EMs (who by definition have prescriber qualifications) to effectively work within their full scope of practice, the current list must be dramatically expanded, or we risk losing the potential benefits of minimised GP workload and duplication of effort.

Finally, hospitals and health services across Australia must be directed to negotiate access and admittance rights for EMs in good faith. Australian women have already waited over two years with minimal access to the continuity of carer which is their right, due to the difficulties of negotiating admission and collaborative arrangements with medical practitioners. The initial Determination and the recent changes offer a tremendous opportunity to right this.

Conclusions

The Maternity Services Review suggested there was national, “Consensus that safe, high-quality and accessible care based on informed choice must be the goal to which we aspire... In maternity services, where most pregnancies follow a normal pattern, we must ensure, first, that practice is based on evidence and, second, that we are not allowing our safety and quality concerns to prevent us acting on evidence that supports changes to practice.”(p iii, original italics). It appears clear that not only are national and international evidence strongly in favour of locally accessible maternity care, but that this is strongly evident as the informed choice of rural consumers.

Eligible midwives within health service workforces offer the opportunity to reduce the workload of GP obstetricians and minimise the demands on women, through utilisation of their ability to prescribe PBS medications and diagnostic testing. In private practice, access to Medicare benefits allows eligible midwives to service diverse communities within their community, giving women expanded local access to continuity by their carer of choice (typically a midwife, where known complications are not evident). Even if birthing is not regularly conducted in the community, trained assistance will be on hand in the case of spurious or precipitant labour and birth, and the access to local antenatal and postnatal care will enable early identification of those women who are truly at risk. This reduces the likelihood that all women within a community will be treated as high risk, and forced to assume the economic and psychosocial burden of travel for care. Those who are not will have improved access to safe, high-quality, continuous local care, with all the benefits for mothers, babies, families and communities this entails.
Recommendations

- That the change from a “Named medical practitioner” to “Health provider organisation” in the Standing Council on Health Determination be legislated with minimal delay.

- That subsidised education be available to both assist registered midwives to achieve eligible midwifery status, and to facilitate continuing professional development for eligible midwives working in rural areas.

- That transition to case-load models be encouraged and supported by rural and regional health services, and employment of Bachelor of Midwifery graduates facilitated and encouraged within this model and health services generally.

- That eligible midwives be included in the MSOAP and SOLS outreach services.

- That eligible midwifery access to the PBS be expanded to the full scope of midwifery practice.

- That MBS benefits be made available for antenatal education, individually and in a group, both in person and utilising online health systems.

- That health services and hospitals be directed to negotiate in good faith to expedite eligible midwives’ admitting and practice rights.

References


