Australian College of Midwives

ACM: For midwives. With women. For the future.

Select Committee on reproductive, maternal and paediatric health services in Tasmania

ACM Submission

Issued September 2024

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The Australian College of Midwives (ACM) is the peak professional body for midwives in Australia; and welcomes the opportunity to provide a written submission to the ***Select Committee on reproductive, maternal and paediatric health services in Tasmania***. ACM represents the professional interests of midwives, supports the midwifery profession to enable midwives to work to full scope of practice (SoP), and is focused on ensuring better health outcomes for women, babies, and their families.

Midwives are primary maternity care providers working directly with women and families, in public and private health care settings across all geographical regions. There are 34,510 midwives in Australia and 1,257 endorsed midwives (NMBA, 2024). In Tasmania, there are 706 midwives, and 22 endorsed midwives (NMBA, 2024). ACM is committed to leadership and growth of the midwifery profession, through strengthening midwifery leadership and enhancing professional opportunities for midwives.

Background

Maternal and infant health and wellbeing, and access to timely and appropriate services are vital to childbearing women and their families across Tasmania. Midwifery care provision is acknowledged as paramount to support optimal health outcomes for women and babies across the childbearing continuum, and midwives have a key role in supporting reproductive health knowledge and wellbeing.

Endorsement to prescribe medications

Endorsed Midwives are midwives who have met the requirements of the Nursing and Midwifery Board of Australia to qualify to prescribe scheduled medicines. This means that they can provide PPM services which meet all the perinatal needs of a well woman and baby. There is low but increasing numbers of Endorsed Midwives in Australia (see below):

Table 3 – Midwives with scheduled medicines endorsement (NMBA, 2024)

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	**Total**
As of 30 June, 2024	22	195	22	399	95	22	208	229	106	**1298**

The priority opportunities for ACM include:

1. Remove the Tasmanian formulary for endorsed midwife prescribing and allow Tasmanian endorsed midwives to prescribe to scope of practice, as per all other Australian jurisdictions.
2. Fund and prioritise the upscale of Midwifery Continuity of Care Models
3. Re-open rural and remote birthing services and establish new services in under-serviced areas, prioritising Midwifery Continuity of Care models.
4. Fund and prioritise the upscale and roll out of Birthing on Country / Birthing in our Community models of care.
5. Support the growth of endorsed midwife numbers and promote midwives working to full scope of practice.
6. Support improved breastfeeding rates through public breastfeeding clinics and Baby Friendly Health Initiative accreditation of health clinics and centres.
7. Work with health services to ensure that endorsed midwives can use their endorsement when working in public and private health services.
8. Provide appropriate software and education to enable privately practicing midwives to access digital interoperability.

9. Work with health services to establish visiting rights for privately practicing midwives.
10. Provide / mandate Trauma Informed Care, respectful maternity care, normal birth, and culturally safe care training modules for all healthcare providers who work with birthing women.
11. Introduce a Bachelor of Midwifery degree in Tasmania, with all mandatory placement occurring in Tasmania.
12. Investigate incentives and support available for midwifery students, and ensure that these are equitable with nursing students, and with mainland midwifery students.
13. Explore incentives to recruit and retain midwives in Tasmania.
14. Include babies in staffing ratios.
15. Investigate workforce and other barriers and enablers to expansion of midwifery continuity of care models.
16. Fund and support continuing professional development modules related to perinatal mental health challenges and bereavement counselling.
17. Fund and support appropriate inpatient mother and baby units for mental health challenges. Commence support from Child Health and Parenting Service at six weeks, with continuous midwifery support until six weeks postpartum.

The ACM Tasmania Branch responses to the Terms of Reference are detailed below:

(a) to assess the adequacy, accessibility and safety of the following services for Tasmanian parents and their children in relation to:

(i) reproductive health services:

ACM advocates for universal access to reproductive healthcare services. 'The midwife has an important role in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood women's health, sexual or reproductive health and childcare. A midwife may practise in any setting including the home, community, hospitals, clinics or health units' (International Confederation of Midwives, 2019).

Endorsed midwife prescribing

The midwifery workforce is an under-utilised profession in relation to reproductive healthcare for women. In 2022, the ACM submitted a response to a senate inquiry into universal access to reproductive healthcare. Within this submission there is robust discussion surrounding improvement to access and affordability of contraceptives and the ability of endorsed midwives to prescribe these. It is within the midwifery scope of practice to provide contraception services to women such as Implanon, Mirena and cervical screening tests. Midwives providing these services increases access and may alleviate some of the pressure on GPs and doctors.

Endorsed midwives are expert primary care providers, and their scope includes sexual and reproductive health. Support for endorsed midwives to work to their full scope of practice will be an important step toward improving access to timely and appropriate reproductive healthcare for women, and particularly those in rural and remote areas. The Pharmaceutical Benefits Scheme

announced changes in the schedule in late 2023 to allow midwives to prescribe MS-2 Step (mifepristone and misoprostol) for medical abortions. State-based legislation changes are still required to enable endorsed midwives and nurse practitioners to prescribe MS-2 Step, including changes to the midwifery prescribing formulary in Tasmania.

Until recently, Victoria and Tasmania were the only two states in Australia which enforced limits on the medications which endorsed midwives could prescribe, rather than allowing endorsed midwives to prescribe to their scope of practice. Recent changes to Victorian legislation removed this barrier, leaving Tasmania as the only state with this restriction. The Midwifery Restricted Substances list is restrictive and outdated. Contemporary, evidence-based midwifery prescribing must be able to rapidly adjust to new evidence and the varied needs of a diverse population of mothers and babies. A static, restrictive list does not meet this need. When legislative changes are made to support midwifery prescription of MS-2 Step, as per amendments to prescribing restrictions, current restrictions within the Tasmanian formulary will prevent this from being enacted. We recommend that legislation is changed to enable midwives with scheduled medicine endorsement to prescribe within their scope of practice. This will support endorsed midwives working in Tasmania to practice in line with mainland peers and ensure women and families in Tasmania benefit from the progress made to support greater access to reproductive healthcare choice.

For further information about challenges related to prescribing and the PBS, please see ACM submission: Nurse Practitioner and Midwife PBS Prescribing Consultation Survey final.pdf (midwives.org.au)

For further information about midwifery scope of practice, please see ACM's submissions to the Unleashing the Potential of our Health Workforce – Scope of Practice Review | Australian Government Department of Health and Aged Care:
ACM Submission_SoP_Oct_2023_Final_.pdf (midwives.org.au)
ACM Submission_SoP_Mar_2024_final (2).pdf (midwives.org.au)
ACM Submission_SoP_IP2_June_2024.pdf (midwives.org.au)

Recommendations

- Remove the Tasmanian formulary for endorsed midwife prescribing and allow Tasmanian endorsed midwives to prescribe to scope of practice, as per all other Australian jurisdictions.

(ii) maternal health services

Endorsed midwives

There are small numbers of endorsed midwives in Tasmania. Increasing the number of endorsed midwives would facilitate midwives to work to full scope of practice and increase care options for Tasmanian women. Promotion of this pathway to midwives, and of scholarship opportunities such as the Primary Care Nursing and Midwifery Scholarship Program, could increase uptake of this qualification. In addition, ensuring that endorsed midwives can use their endorsement when employed within the public and private healthcare systems would increase attractiveness of this qualification, and reduce pressure on the healthcare system.

Removing barriers to privately practicing midwives is another key step in facilitating options and access to maternity care.

Digital health capability

Midwives need to be educated on their access rights to MyHealthRecord and usability function. In addition, software is unavailable, and this is a barrier for midwives in terms of cost. Furthermore, midwives require other digital interoperability to ensure safer and more effective handover of care and collaboration when necessary. This needs to include education for midwives, especially midwives in private practice, on use of digital health tools.

Hospital admitting rights

Most hospitals in Australia do not allow visiting rights for endorsed PPMs, despite clinical outcomes for women cared for by PPMs with visiting rights being more positive than national statistics (Fenwick et al., 2017). This is a significant barrier to midwives working in private practice. The table below presents statistics on the number of Medicare item 82120 claims. Item 82120 is management of labour and birth in hospital by an endorsed midwife in an MCoC relationship with the woman.

Table 4 – Medicare item 82120 processed from July 2010 to March 2024

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Total
Item 82120	232	506	4,525	23	215	1	4	21	5,527

As is apparent, lack of hospital admitting rights is a significant barrier to privately practicing midwives in Tasmania.

Rural and remote birthing services

Centralisation of maternity services across Australia, including within Tasmania, has resulted in the closure of more than 130 maternity units over the past 20 years (Bradow et al., 2021). While ostensibly fiscal decisions intended to save money and standardise healthcare provision, the impact of maternity service closure does not mitigate against inconsistencies in service provision, and the burden of these changes are unfairly felt by those outside larger cities (Bradow et al., 2021). The way in which women receive and access their care is driven by the maternity service; women who live in regional and remote areas of the state are more likely to be disadvantaged by reduced services than those in larger cities. While some public outreach services exist for antenatal care, there are currently only three public Tasmanian Health Service hospitals for birthing in Hobart, Launceston, and Burnie.

The closure of regional and rural maternity services sees some women forced to travel long distances to access maternity services, and is known to result in fragmented care, increased financial constraints, displaced families, increased unplanned birth before arrival and a high emotional burden (Kildea et al., 2015; Sweet et al., 2015). Within Tasmania, the most recent closures were in 2016, when the Mersey Community Hospital lost its inpatient and birthing services in the North West; and in 2023 when the St Helen's mother and baby unit was closed and a smaller unit re-opened within the Royal Hobart Hospital. These choices have been unpopular with women and families, and their impact reported in the media and reports from women to organisations such as the Centre of Perinatal Excellence (COPE) and Women's Health Tasmania.

Midwifery Continuity of Care

Continuity of care models such as Midwifery Group Practice (MGP/caseload), whereby women receive care from a known midwife across the pregnancy continuum, are highly sought after, and women continue to express demand for these publicly funded models of care. However, MGP models are oversubscribed, and often have long wait lists and in some places, staff retention issues. Continuity of care and carer is well documented with high level evidence to demonstrate benefits for women experiencing both low-risk and complex pregnancies. These include reductions in pre-term birth and pregnancy loss, and increased rates of satisfaction, vaginal birth, and breastfeeding (Sandall et al., 2016). In addition to improved clinical outcomes, caseload offers significant cost-saving of up to 22% to health services through reduced interventions, shorter hospital stays, less readmissions and improved satisfaction (Callander et al., 2021).

Additionally, caseload models for First Nations women and babies are shown to enhance culturally safe care provision and support better clinical outcomes (McLachlan et al., 2022). These include reduced pre-term birth, increased breastfeeding rates, increased satisfaction, and greater engagement with care for First Nations women and babies receiving midwifery-led caseload care in programs specifically designed for Aboriginal and Torres Strait Islander families (Bowden et al., 2023; Kildea et al., 2021; McCalman et al., 2023). A key aspect of caseload midwifery care is relational and developing this between women and midwives in service demand and co-design, and more broadly amongst all stakeholders including health service management and administration has been identified as important in establishing and maintaining these services (Bowden et al., 2023; Prussing et al., 2023). While some First Nations women in Tasmania receive care through MGP models through Tasmanian Health Services (THS), this is not a dedicated service and further steps need to be taken to ensure greater access to and provision of culturally safe birthing on country and birthing in community models of care to close the gap in health outcomes between First Nations and non-Indigenous people. The ACM calls for increased access to midwifery-led continuity of care models for all women.

Tasmanian-based research by Hargreaves et al. (2022) has explored the experiences of women in a Tasmanian regional maternity service and identified potential improvements for service delivery. Tasmanian women's experiences are improved if maternity services work towards context appropriate continuity of care models, which are informed by the women and their families. Consumer engagement is important and Tasmanian maternity services need to ensure this occurs – these findings are echoed by Prussing et al. (2023). In addition to highlighting access to continuity of care models, care pathways when women are experiencing breastfeeding issues, depression and anxiety were also identified as essential areas for further development.

There are 5,000-6,000 births per year in Tasmania. Birthplace choices in Tasmania are limited to one of three public hospitals, three private hospitals, a single private birth centre, or home. There are no publicly funded birth centres in Tasmania, and Tasmania is now the only state in Australia that does not offer publicly funded homebirth. Women who wish to birth at home (or birth centre/house) have the option of employing a privately practicing endorsed midwife to support them, however the out-of-pocket costs of this and relatively small Medicare rebate means that this is not a viable option for many families. Freebirth, whereby women birth with either unregulated birth workers or alone, is reportedly on the rise. While data for Tasmania is not available, anecdotally, freebirth rates within the state are rising due to the limited number of private practice midwives offering this service, the high costs of homebirth, lack of access to caseload care and concerns about risk of unnecessary intervention within an over-medicalised hospital-based maternity system. These anecdotal reports are similar to

women's concerns as reported to Jackson et al. (2020) and Sassine et al. (2021). Additionally, notification of changes to midwife professional indemnity insurance packages for midwives and restriction of homebirth to women experiencing 'low-risk' pregnancies has resulted in an anecdotal increase in reports of women saying they will freebirth if unable to access care in their chosen birthplace.

A study exploring women's motivations for choosing private birth houses, such as the Launceston Birth Centre (Shakes, 2020), found women are motivated to seek these birthplaces because of the middle ground they inhabit between home and hospital, and the feelings of safety this can offer to women and family members. Physiological birth rates increase when birth is not framed within the biomedical model – either philosophically or within physical proximity (Dahlen et al., 2021). Compared to hospital, out-of-hospital birth (home or birth centre) for women experiencing low-risk pregnancies are associated with increased normal birth rates and no change in infant mortality (Scarf et al., 2018). Publicly funded birth centres, and particularly those that are freestanding/stand alone, rather than alongside (within hospital walls or grounds) are associated with improved vaginal birth rates, and reduced interventions while continuing to demonstrate safe outcomes (Monk et al., 2014). Publicly funded homebirth is safe (Sweet et al., 2022) and is likely to be associated with cost-savings to health services (Hu et al., 2024).

Birthplace choice is a profound aspect of women's childbirth experience. The limited options available in Tasmania increase the risk of women opting out of maternity care. While respect for women's choice is essential, rising freebirth rates and lack of engagement in maternity care should be understood as a failure of the maternity system to meet women's needs. Greater access to birthplace choice is essential to support safe maternity care for Tasmanian women. Working with women and families to co-design services and models of maternity care will be important steps towards ensuring their suitability and sustainability. Within the state, we recommend expansion of public maternity services to include publicly funded homebirth and the founding of freestanding birth centres.

Breastfeeding

Breastfeeding support is a key area of midwifery practice. The World Health Organization recommends exclusive breastfeeding for six months and continued breastfeeding for two years to provide optimal nutrition. In Australia, the NHMRC recommends exclusive breastfeeding for six months (no other food or fluid) and continued breastfeeding alongside other food continuing for at least 12 months and beyond. The long-term benefits of breastfeeding for mothers and babies are well documented. Accurate contemporary data on breastfeeding rates in Tasmania are not available, however it is reported that initial breastfeeding rates remain high at above 90% and fall after this time. The National Health Survey reports that only 30 percent of women in Tasmania exclusively breastfed for at least six months in 2020/2021 (AIHW, 2023). These state rates are the lowest in the country for that time period.

While not all women wish to breastfeed, breastfeeding support has been shown to increase breastfeeding rates at six months (Cramer et al., 2021). The ACM recognises the importance of Baby Friendly Health Initiative accreditation in supporting breastfeeding by ensuring hospital services reflect best practice recommendations and meet international standards for infant feeding care. ACM commends THS on mandating BFHI accreditation, however, despite BFHI accreditation across facilities in Tasmania, breastfeeding statistics suggest that Tasmanian women are not receiving sufficient support and education to reach optimal outcomes in breastfeeding duration. Barriers to providing care in line with BFHI strategies include lack of time and lack of continuity of care (Pramono et al.,

2022). Workforce shortages and poor skill mix undoubtedly challenge provision of quality breastfeeding support. Fragmented care increases the likelihood of longer hospital stays and with this, risk of women receiving conflicting advice. Conversely, continuity of care is associated with improved breastfeeding rates and duration.

Expansion of models of care and support services demonstrated to improve breastfeeding rates and duration should be key focus areas for our health service. These may include expansion of breastfeeding clinics in a variety of settings, including within the community. One example is the "Parent Place" clinic in Ballarat where women can drop in to see a lactation consultant. The cost of running these clinics across the state could be dwarfed by the long-term costs to Tasmania of the health implications of the 70% of dyads who do not continue to breastfeed for the duration recommended by WHO. Global economic benefits of breastfeeding are extensive and are represented in healthcare treatment savings and future lost earnings due to child and maternal morbidity and mortality (Pramono et al., 2022). THS may also consider extending BFHI accreditation to community health clinics and centres across the state.

Recommendations

- Fund and prioritise the upscale of Midwifery Continuity of Care Models
- Re-open rural and remote birthing services and establish new services in under-serviced areas, prioritising Midwifery Continuity of Care models.
- Fund and prioritise the upscale and roll out of Birthing on Country / Birthing in our Community models of care.
- Support the growth of endorsed midwife numbers and promote midwives working to full scope of practice.
- Support improved breastfeeding rates through public breastfeeding clinics and BFHI accreditation of health clinics and centres.
- Work with health services to ensure that endorsed midwives can use their endorsement when working in public and private health services.
- Provide appropriate software and education to enable privately practicing midwives to access digital interoperability.
- Work with health services to establish visiting rights for privately practicing midwives.

(iii) birth trauma

All women have the right to respectful maternity care. The senate inquiry into birth trauma in NSW highlighted that this issue is of growing concern amongst women, their families and healthcare professionals. The BESt Study led by Dr Hazel Keedle at the Western Sydney University revealed that approximately one in ten women across Australia experience obstetric violence, with as many as one in three women reporting some form of trauma associated with their birth. Obstetric violence can be defined as acts committed in the maternity context that the woman experiences as physically or psychologically traumatic, including unjustified medical intervention and dehumanising treatment. Tasmanian maternity services and health professionals need to recognise that this can and does occur within their maternity services, and it can have a devastating impact on women, their families, and newborns. Broader understandings of what birth trauma and obstetric violence are, and how it can impact women, and their families is essential if maternity care providers are to provide meaningful care that mitigates against creating or exacerbating birth trauma.

Maternity care systems and practices that deny women access to choice and unbiased information, undermine women's preferences, and use coercion and paternalistic approaches to care provision are

associated with increased reports of birth trauma (Tsakmakis et al., 2023). Previous experiences of birth trauma can influence women's decision making for future pregnancies, including who cares for them (Hargreaves et al., 2022) and where they are willing to birth. Some women who have experienced birth trauma report this as their reason for choosing to freebirth in subsequent pregnancies (Jackson et al., 2020; Sassine et al., 2021). Risk is located, in these instances, within the technocratic environment, and/or care providers within this. Placing support services for women experiencing postnatal depression or other conditions due to birth trauma within hospital environments, such as the Mother Baby Unit within the Royal Hobart Hospital, may be counter-productive for some and reduce the benefits of this service.

One of the recommendations from the BESt study is that maternity service providers ensure appropriate education for healthcare staff who care for women and their families within the maternity service. The Maternity Consumer Network have a workshop for Trauma Informed Care, targeted to all maternity care providers. This kind of training is essential to reduce birth trauma, and ACM recommends that Trauma Informed Care training should be mandatory for midwives and all other multi-disciplinary maternity care providers. Other important education to support reduction of birth trauma includes respectful maternity care, culturally safe care, and normal birth training.

For further information about birth trauma and obstetric violence, please see ACM's submission:
ACM Submission to the NSW Select Committee on Birth Trauma Aug 2023 FINAL.pdf (midwives.org.au)

Recommendations

- Provide / mandate Trauma Informed Care, respectful maternity care, normal birth, and culturally safe care training modules for all healthcare providers who work with birthing women.

(iv) workforce shortages

Midwifery and maternity workforce shortages are evident across Tasmania, with high reliance on agency and locum staff, and poor retention in some areas. While formal reports of FTE deficits are not available, these are known to have been alarmingly high in some areas over the past two years, and last year resulted in one service being on bypass, thereby forcing women to travel long distances to access maternity care.

Sufficient staffing and skill mix are essential for the provision of woman-centred midwifery care. A recent study into workforce issues in Victoria (Matthews et al., 2024) reports poor retention of experienced midwives leads to poor skill mix, which in turn presents risk to families receiving care through the service and increases the burden on remaining staff. In cases of short staffing, nurses sometimes provide postnatal care. However, this is a midwifery role and not in the scope of practice of nurses who are not clinically trained or professionally registered to provide midwifery care. This increases the possibility that women and babies may not receive optimal care and may further increase the burden on midwifery staff. Safe staff ratios include counting babies as well as women as a necessary requirement of maternity service reform. The ACM welcomes recent legislation changes in Queensland that support a ratio of 1:6 (one midwife to three women and three babies) and recommends that these changes are implemented across the country. Recent media events in THS South maternity services have highlighted this issue, with calls from midwives for incentives for experienced midwifery staff and greater support for junior midwives to support improved retention rates and morale.

Blackman and Shifaza (2022) recommend retention and recruitment schemes focus on broadening midwifery skills, competency, and full scope midwifery practice, alongside teamwork and communication skill development. Poor communication, low staffing numbers and subsequent increased workload intensity are associated with missed midwifery care episodes. Implementation of schemes designed to retain experienced and early career midwives through providing greater career progression opportunities, improved flexibility in contracted hours, shifts and shift duration may also improve some workforce shortages. Sheehy et al. (2021) found early career midwives reported high levels of satisfaction when working to full scope of practice and being able to develop midwife-woman relationships when providing clinical care; interestingly these factors mitigated against some of the more challenging aspects such as inflexible rostering, high workloads and poor management. Given the known midwifery workforce issues including an ageing workforce and inequitable geographical distribution of experienced midwives, greater understanding of sustainability, and implementation of measures that increase workplace satisfaction and support recruitment and retention is essential. Research and investigation that seeks to understand Tasmanian midwives' reasons for leaving is required to determine specific strategies that will best suit our state. Incentives for midwives to relocate to Tasmania, and to work in areas of greatest shortage may also be necessary. Current recruitment incentives offered within Tasmania are out of step with those offered in most if not all mainland states and are therefore not competitive. Additionally, efforts to have midwifery recognised as a stand-alone profession are undermined when the unique midwifery skillset is poorly recognised, and career progression not prioritised.

A contributing factor reported to ACM Tasmania regarding workforce sustainability, education and retention is the lack of a university presence dedicated to the midwifery workforce in Tasmania. There are limited transparent pathways for registered midwives to further their education and career, particularly in capacity building, research, and higher education within the state. Risks associated with this are a continued paucity of midwifery research undertaken within Tasmania, and that midwives wishing to expand into these areas instead relocate to the mainland. A vested interest from a university such as University of Tasmania into both undergraduate and postgraduate midwifery education would create a far better experience for midwives and help to grow the midwifery workforce from within Tasmania. Investing in Tasmanian residents in this way would be a meaningful step toward capacity building. Developing a robust midwifery training program within the state may also help bring newcomers to the island for education and subsequent employment. While employing interstate staff may be beneficial to broaden knowledge and skills, it is undoubtedly more costly than investing in local training and workforce development.

Currently, there is only one in-state midwifery education opportunity in Tasmania which is only available to the nursing workforce via a two-year Bachelor of Midwifery degree to graduated nurses. This also consequentially reduces the nursing workforce. Other options include a one-year graduate diploma for registered nurses, and a three-year undergraduate Bachelor of Midwifery with interstate learning residentials. However, many Tasmanian student nurses and registered nurses report they have only studied nursing to subsequently study midwifery. This means that the pathway to becoming a midwife is unnecessarily protracted, and for some has them learning about aspects of healthcare they are unlikely to use if they opt to work exclusively within midwifery, rather than having the opportunity to specialise in midwifery over three years of undergraduate study. There is currently no undergraduate Bachelor of Midwifery program whereby Tasmanian residents can complete their studies entirely within the state. While ACM recognises that diverse pathways to study midwifery in

Tasmania are important, current offerings do not meet demand. We have heard numerous reports by women wishing to commence an undergraduate Bachelor of Midwifery which they can complete entirely within the state. This requires learning residentials to be offered within Tasmania, rather than requiring a twice-yearly trip to the mainland, and guaranteed placement within THS facilities for the duration of their undergraduate studies. Additionally, incentives and support for those wishing to study midwifery are not standardised across the pathways, resulting in registered nurses being better supported to further their qualifications into midwifery (and receiving a higher pay once dual registered) than undergraduate students in midwifery. Investigation into the ways that equitable support to grow the midwifery workforce from within Tasmania are required.

Midwifery group practice (MGP) is a preferred model of care for many midwives. It is flexible and enables them to work to their full scope of practice. Research has demonstrated that midwives who work in MGP are twice as likely to have completed a Bachelor of Midwifery than other pathways (Hewitt et al., 2024). Therefore, encouraging educational pathways that support newly graduated midwives to step into the MGP workforce may be a key pathway to futureproof staffing within this gold standard model of care. Currently, the ability to adequately staff continuity of care models to meet expansion targets is not demonstrated within Tasmania and significant work is required to address this. The ACM has called for increased access to continuity of care models, and it is a federal government objective to support more midwives to work in primary care provision. Investigations into how this may best be achieved in Tasmania are warranted and an independent exploration of barriers and facilitators may be beneficial.

Recommendations

- Introduce a Bachelor of Midwifery degree in Tasmania, with all mandatory placement occurring in Tasmania.
- Investigate incentives and support available for midwifery students, and ensure that these are equitable with nursing students, and with mainland midwifery students.
- Explore incentives to recruit and retain midwives in Tasmania.
- Include babies in staffing ratios.
- Investigate workforce and other barriers and enablers to expansion of midwifery continuity of care models.

(v) midwife professional indemnity insurance

Midwives working in private practice are required to hold professional indemnity insurance; this covers antenatal and postnatal care services, however intrapartum care in the home continues to be exempt from insurance requirements as there are no suitable indemnity insurance products available within the insurance sector. The ACM welcomes the decision by the Albanese Government to further extend the professional indemnity insurance exemption for midwives providing homebirth services until 30 June 2025, and to develop an insurance product for homebirth services provided by privately practicing midwives. Currently, there is a single provider of professional indemnity insurance for endorsed private practice midwives (EPPMs) in Australia. We welcome a broader exploration of options for state based EPPMs in Tasmania. However, ACM Tasmania shares concerns with many midwives, women, and families in Tasmania and across Australia that the proposed resolution for intrapartum insurance currently on the table is too restrictive and may lead to increased risk to women and newborns. Many women who opt to homebirth do so because of dissatisfying maternity experiences within hospital facilities. For many women, hospitals and hospital-based maternity care

provision present an unsatisfactory level of risk to their and their baby's physical, mental, and emotional wellbeing. ACM Tasmania is concerned that a restrictive intrapartum insurance product may result in women opting to birth without recommended maternity support.

Greater access to an appropriate, fit-for-purpose and affordable professional indemnity insurance product will support opportunities for Tasmanian midwives to work in private practice, and importantly may contribute to making private midwifery services more affordable, and therefore more accessible to women and families. This will support greater integration with maternity services, a feature that has been found in Australian and international research to improve the safety of homebirth through established and supported transfer procedures. Additionally, the currently proposed product risks putting EPPMs at financial risk through significantly reducing the number of women who will fit the criteria for homebirth.

(vi) perinatal mental health services

Social work and perinatal mental health services are overburdened in Tasmania, and some women who would benefit from this support are known to have been excluded due to their condition not being severe enough. While triage is an important aspect of timely care, concern has been raised for the increased risk of missed care opportunities for vulnerable women. Perinatal mental health concerns are common morbidities experienced by women and can have a considerable impact on women themselves, and relationships within families including parenting and newborn bonding. While nurses and midwives providing perinatal care may be able to positively identify common mental health issues with women, research has demonstrated less confidence in providing care to women in these instances (Noonan et al., 2019). Therefore, specific training to develop knowledge, awareness and confidence around perinatal mental health and recommended care would be beneficial. Commonly used screening tools such as the Edinburgh Postnatal Depression Score (EPDS) are not validated for use by women from First Nations or Culturally and Linguistically Diverse (CALD) backgrounds. Further work needs to be undertaken in this area to ensure suitability of screening tools, and to ensure clear referral pathways and support services access to ensure meaning from conducting screening assessments.

Perinatal loss can have long term impacts on women and families, and heavily influence future pregnancy experiences and the healthcare system. Bereavement midwives are uniquely placed and have a specialised role in supporting women and families who have experienced perinatal loss. While providing this care is within the midwifery scope of practice, studies have demonstrated that the emotional pain experienced by parents is exacerbated when midwives and other healthcare workers are unable to provide the required bereavement care (Kalu et al., 2020). Therefore, organisational support for midwives who work in this emotionally challenging area, and to build capacity by having dedicated bereavement midwives will support better outcomes for women and families.

Women with pre-existing mental health conditions who receive midwifery continuity of care experience improved outcomes compared to standard care (Cummins et al., 2022). From a perinatal mental health perspective, longer breastfeeding duration is associated with reduced risk of postnatal depression (PND), however breastfeeding difficulties can be predictive of depressive symptoms (Del Ciampo & Del Ciampo, 2018; Figueiredo et al., 2021). Dedicated units to support mothers and babies with PND and other mental health concerns requiring inpatient stays need to be offered in appropriate and accessible environments. As previously noted, concern has been raised by service users about the closure of the St Helens Mother and Baby Unit and the relocation of this into a hospital environment.

Recommendations

- Fund and support continuing professional development modules related to perinatal mental health challenges and bereavement counselling.
- Fund and support appropriate inpatient mother and baby units for mental health challenges.

(vii) The Child Health and Parenting Service (CHaPS)

Midwifery scope of practice is to six weeks postnatal, and provision of continuity of care from a known midwifery care provider throughout this time is beneficial to women and families. While CHaPS form an essential component of paediatric services to children from birth to five years, and provide valuable care to families, many CHaPS care providers are enrolled and/or registered nurses without additional qualifications as midwives. This can change the approach to care provided; a midwifery lens seeks to focus on the mother-baby dyad. Handing over care at two weeks postnatal means that opportunities to support breastfeeding and bonding may be missed if this is not within the experience of CHaPS nurse.

We recommend that caseload midwifery services in Tasmania are provided to six weeks postnatal by the woman's known midwife, and care handed over to CHaPS after this time. Extending this service would facilitate tailored care to women and families at a pivotal time during the childbirth continuum. It can take six to eight weeks to establish breastfeeding; for women planning to breastfeed, continuity of care is associated with improved breastfeeding rates. In Tasmania, where breastfeeding rates are some of the lowest in Australia, this would be a meaningful step towards improving this issue. It would also reduce demand on hospital-based lactation support services – which are notoriously over-subscribed – for issues that can be resolved with specialist midwifery support and knowledge.

Of note, midwives can also undertake the postgraduate Maternal Child and Family Health qualifications, and work in this field also. There is no regulatory impediment to this. ACM Tasmania recommends that single-qualified midwives be enabled to apply for Child and Family Health roles in Tasmania.

Recommendations

- Commence support from Child Health and Parenting Service at six weeks, with continuous midwifery support until six weeks postpartum.

Part (b) to examine disparities in the availability of services, staffing and outcomes between:

(i) Tasmania and other Australian states and territories

As outlined above:

- Tasmania is now the only Australian state not offering publicly funded homebirth.
- There are limited birthplace choices within the state and some women are required to travel long distances to access maternity care. Expansion of maternity services to include publicly funded homebirth and freestanding birth centres will support greater options and may help prevent rising freebirth rates and ensure access to safe maternity care options.
- There is no pathway for undergraduate midwifery education whereby Tasmanian residents can complete all training requirements within the state.

- Incentives to study midwifery in Tasmania are not equally applied to each pathway. Some states offer incentives that are applied by universities to subsidise midwifery students.
- Pathways to career progression are not always transparent or based on qualifications or merit. Support and incentives to encourage career progression for both experienced and novice midwives are required. This may address job satisfaction issues and support improved retention rates.
- Recruitment incentives in Tasmania are not competitive with those offered in most mainland states. This, coupled with Tasmania having a history of some of the lowest pay rates for midwives across the country is likely to have impacted attraction to interstate midwives to relocate, and for some staff to remain in the state.
- Staff to patient ratio that includes counting women and babies separately will support safer workplaces, and ensure women and babies receive optimal care.
- Tasmanian midwives with scheduled medicine endorsement can only prescribe to a limited formulary. All other states have removed restrictive formularies to enable midwives to prescribe within their scope of practice. Some of the areas in which the Tasmanian Poisons (Midwifery items) Order 2011 formulary does not meet midwifery requirements are detailed below:

  <u>For treatment of Post Partum Haemorrhage (PPH):</u>
  Tranexamic Acid is used to treat PPH. Privately practicing midwives in all states except Tasmania can keep a stock of this medication to use when there is a PPH in the homebirth setting.

  <u>For genital herpes prophylaxis:</u>
  Aciclovir or valaciclovir are given prophylactically from 36 weeks to birth to minimise the possibility of vertical transmission of genital herpes. Women seeking midwifery care have the added expense of having an appointment with a medical practitioner as midwives in Tasmania do not have these medications on their formulary.

  <u>For treatment of reflux in pregnancy:</u>
  Midwives in Tasmania do not have the ability to prescribe an H-2 receptor antagonist for reflux as the medication allowed on the formulary (ranitidine) is no longer available in Australia. Famotidine is currently prescribed as an alternative, being an H-2 receptor antagonist like ranitidine, however it is not possible for midwives in Tasmania to prescribe it.

  <u>For treatment of UTI:</u>
  The Therapeutic Guidelines recommend several medications suitable to treat a UTI in pregnancy. Nitrofurantoin and cefalexin are both available for midwives to prescribe in Tasmania. However, nitrofurantoin is not advised late in pregnancy and cefalexin is contradicted for women who have allergy to cephalosporins. There is some overlap (although small) between penicillin and cephalosporin allergy, so it is possible a woman could be allergic to both. A recommended alternative, trimethoprim, which would be suitable in the third trimester, is not available for midwives to prescribe in Tasmania.

  <u>For long term contraception:</u>
  While etonogestrel is on the PBS list for midwives it is not on the Tasmanian formulary. This is a cheap and effective contraception which can be inserted by trained midwives and offer long term contraception to women, with minimal cost to the health system.

For termination of pregnancy

Misoprostol and mifepristone. While not all states have access to these medications currently, Tasmanian midwives are the only ones prevented from prescribing it by a formulary. These medications prescribed before 63 days gestation offer an accessible termination of pregnancy and access is potentially even further facilitated when midwives can prescribe it. Midwives can provide the necessary follow up when this is prescribed for women. Midwives often work in an on-call model of care and therefore can be available to offer advice if there are concerns following the termination.

Incorrect spelling

Both lidocaine and cefalexin are spelt incorrectly on the formulary.

(ii) Tasmanians living in regional rural and remote areas

Evidence suggests that women and their families living in regional rural and remote areas are at risk of increased morbidity and mortality. Maternal health services need to ensure that all women can and do have access to services. Living in these areas, especially within poorer social economic areas can be associated with crippling isolation. As mentioned previously, women living in regional and remote areas of Tasmania can have trouble accessing required maternity services. Women require access to appropriate services if they are experiencing pain and bleeding in early pregnancy. Women should have appropriate maternity services available within reasonable distances, rather than having to wait in emergency departments for care, which is the requirement in some areas.

(iii) Tasmanians experiencing socio-economic disadvantage

There are many women currently experiencing socio-economic disadvantage across Tasmania. ACM asserts all women deserve the right to universal access to timely and appropriate maternity care. Expansion of publicly funded maternity services including continuity of care models, increasing outreach clinics, re-opening birthing facilities in regional areas and government funding for out-of-hospital birthplaces will help improve equitable access to care. Integration of findings from research such as that conducted by Women's Health Tasmania into the experiences and preferences of people having babies within Tasmania will be a key step towards co-design. The lack of targeted maternal and reproductive health specific programs aimed at Aboriginal and Torres Strait Islander women needs to be addressed and meaningful ways to engage with this population of women and families should be sought in conjunction with the Tasmanian Aboriginal Centre and other relevant stakeholders.

Part (c) to make recommendations on actions that can be taken by the State Government to ensure reproductive, maternal, and paediatric health and perinatal mental health services meet the needs of Tasmanian parent, families and children.

- Enact changes to ensure endorsed midwives can prescribe medication to their full scope of practice, including legislative changes to support these midwives to work within reproductive health areas and removal of the formulary.
- Ensure endorsed midwives are supported to use their endorsement to prescribe within the hospital (public and private) systems within their scope of practice.

- Provide access to further training and support for midwives to work in the reproductive health area including in Implanon and Mirena insertion.
- Expand MGP models of care and integration of evidence-based practice recommendations into the design and management of these services along with service user involvement.
- Review MGP eligibility criteria to ensure inclusivity (e.g., Establish dedicated pathways to support Tasmania Aboriginal and First Nations women access MGP care and an all-risk approach to accessing continuity of care and carer).
- Explore the feasibility of offering MGP models specifically for women in vulnerable groups including young women, First Nations women, women experiencing high-risk or complex pregnancies and women from refugee and CALD backgrounds.
- Extend the MGP period of care to a minimum of six weeks postnatal with handover of care to CHaPS after this time.
- Commit public funding to expand birthplace options for women including freestanding birth centres and birth facilities in regional locations.
- Extend breastfeeding support services to publicly funded community drop-in clinics, and MGP care to a minimum of six weeks postnatal.
- Ensure all women can see a midwife up to six weeks postnatal especially those experiencing breastfeeding issues.
- Ensure access to out-of-hospital care options for women requiring mother and baby unit support.
- Implement mandatory trauma informed care education for all midwives and maternity healthcare professionals.
- Implement mandatory perinatal mental health training and awareness for all midwives and maternity healthcare professionals.
- Provide pathways and support for midwives to work in dedicated bereavement midwife roles.
- Facilitate service user participation and engagement in all maternity policy and guideline development.
- Develop and enact transparent pathways for career progression.
- Conduct an independent inquest into retention, hiring and workforce issues.
- Invest in a dedicated recruitment drive to support adequate staffing and skill mix, including implementation of strategies to support retention of experienced midwives in both core and MGP roles.
- Act to resolve the longstanding insurance issues for midwives in private practice through the provision of a fit-for-purpose product.
- Ensure pathways for visiting access rights for midwives in private practice are available to support continuity of care and for women to receive maternity care and birth support in their chosen birthplace, with their chosen maternity care provider.
- We recommend that Tasmania, like other Australian states move towards separating the roles of Chief Nurse and Chief Midwife. While the Tasmanian population is relatively small, progressive contemporary and dedicated midwifery leadership remains essential to support optimal maternity service provision and development of the midwifery workforce to meet our full potential. Acknowledgement of the separate nature of the nursing and midwifery professions needs to be demonstrated at all levels. Midwifery is not an adjunct to nursing.

We thank you for the opportunity to contribute to Select Committee on reproductive, maternal, and paediatric health services in Tasmania and look forward to meaningful changes that improve service delivery and outcomes for women and families, midwives, and maternity healthcare professionals.

[redacted]

Helen White

Chief Executive Officer

E: Helen.white@midwives.org.au

W: https://www.midwives.org.au

[redacted]

Alison Weatherstone

Chief Midwife

E: Alison.Weatherstone@midwives.org.au

In consultation with ACM Tasmania branch

Attribution: Rowena Shakes, Tasmanian Branch Secretary

Sally Hargreaves, Annie Barnes and Dawn Reid, ACM Tasmanian Branch Committee

Consent to publish

ACM consents to this submission being published in its entirety, including names.

Consent to provide further information

ACM is available to provide further expert opinion and advice if required.

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