Centre for Midwifery and Family Health
Faculty of Nursing, Midwifery and Health
University of Technology Sydney
PO Box 123
Broadway NSW 2007
Tel. +61 2 9514 2977
Fax. +61 2 9514 1678

SUBMISSION TO THE HEALTH WORKFORCE STUDY
AUSTRALIAN GOVERNMENT: PRODUCTIVITY COMMISSION
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This short submission addresses the issues particularly for midwives working within the public health system in Australia. The paper is submitted by **Professor Caroline Homer**, Director of the Centre for Midwifery and Family Health at the University of Technology Sydney and **Ms Lyn Passant**, Project Midwife at UTS.

WORKFORCE PLANNING

There is currently a strong demand for midwives throughout Australia and it is likely that this will increase in the next few years. Changes nationally in the numbers of general practitioner (GP) obstetricians and fewer obstetricians, especially in rural areas, will mean there will be a greater demand for midwifery care. This is particularly evident for the care of healthy women experiencing normal pregnancy, labour and birth. Innovative models of maternity care are increasingly being developed and this will also change the midwifery workforce. Midwives are being deployed in flexible models to meet the needs of women rather than organisations. This is changing the way that maternity units are staffed. For example, innovative models of care (like caseload practice which is explained later) means that in labour wards, midwives are on call, rather than being 'rostered' on to work, and are not present unless women are in labour.

It is essential that access to funding for midwifery care is improved especially in rural areas. This will assist the development and implementation of new models of care and ensure that appropriate planning, deployment and use of midwifery skills can occur.

The new Bachelor of Midwifery course is also likely to impact on workforce planning. This course, where midwives are educated over a three year period without prior nursing qualifications is a cost effective and efficient way to produce the requisite workforce. This will, however, change the way that midwives can be deployed into other settings. This course is new in Australia (the first cohort graduated in 2004) and requires support and facilitation from government and employers. It is likely that in 10 to 20 years the majority of midwives will be prepared in this way in line with midwifery education patterns in the European Union, Canada and New Zealand. Therefore, the system needs to adapt now with effective future planning to accommodate this change in workforce composition.

MODELS OF CARE AND SCOPE OF PRACTICE

The nature of practice for midwives in Australia has changed over the past decade. A number of government reports and reviews in Australia have demonstrated the importance of implementing innovative models of maternity care that promote continuity of care and caregiver, and improve satisfaction of the consumer and the midwife. These reports of maternity services have highlighted the need to reform and improve the role of the midwife and have influenced the implementation and establishment of new models of midwifery care. (National Health and Medical Research Council, 1996; Victorian Department of Health, 1990; Senate Community Affairs References Committee, 1999).

When midwives practice midwifery according to the international definition of a midwife (United Kingdom Central Council, 1998; World Health Organisation, 1996; World Health Organisation, 1997), that is providing all facets of midwifery care, they have increased job satisfaction and less attrition (Turnbull et al., 1995; Sandall, 1996a). Opportunities for midwives to work in this way are often limited given the barriers that exist in the current public health system in Australia.

BARRIERS TO IMPROVEMENTS IN MIDWIFERY PRODUCTIVITY

The barriers to improving midwifery productivity have previously been identified in Australia. The Australian Midwifery Action Project (AMAP) identified the barriers and current problems in the organisation of maternity care in Australia (Brodie, 2002; Leap, 2002; Leap, Barclay, & Sheehan, 2003). These include an ageing workforce. The invisibility of midwifery within the community including regulation in some states, the domination of medicine and the lack of opportunities to practise across the full spectrum of maternity care. Workforce shortages, the institutional system of maternity care and the inability to prescribe routine medications and order common tests in maternity care also constitute significant barriers. These need to be addressed if midwives are to be able to function according to their full role and scope.

The shortage in the current midwifery workforce has been previously identified by the Australian Health Workforce Advisory Committee (AHWAC, 2002). The optimal use of the workforce skills to ensure the best health outcomes has been acknowledged by the AHWAC as a guiding principle of workforce planning (AHWAC, 2004). The report recognised that a realignment of workforce roles may therefore be necessary.

Currently, around Australia, midwives are underutilised. For example, midwives in many settings are not permitted to provide antenatal care and women must attend GPs who usually do not bulk-bill. This means that the most cost efficient workers in normal maternity care (midwives) are not able to provide a service that evidence has consistently demonstrated is safe and effective. Ensuring that practitioners can perform the role for which they were educated is a fundamental aspect of maintaining a healthy workforce. It is essential that midwives have the regulatory and legislative requirements to practice, including ability to order tests and prescribe common medications. This has previously been recommended by the NHMRC although no action has been undertaken to date (NHMRC, 1998).

Maternity care is dominated by obstetrics in Australia. This means that most obstetricians (who are highly trained to provide care for women with complications) provide care for the normal healthy population. This is an inefficient use of a workforce trained to deal with complex cases. The obstetric workforce is also in decline with shortages around Australia, especially in regional areas. It seems peculiar that obstetricians are spending much of their limited time on caring for woman experiencing a normal pregnancy, labour and birth rather than caring for those with complex needs. If midwives were able to be deployed more productively, they would cater for the normal and healthy women, and obstetricians could concentrate on the more complex. Both these groups would then be able to work together more effectively as the scopes of practice would be clearly defined. This re-organisation of the system requires significant reform of funding processes.

In many rural and remote settings midwives also have to work as nurses due to ineffective deployment of staff. Midwives are often unhappy about undertaking general nursing work and this is known as one reason for attrition. Rural and remote areas suffer even more with workforce shortages than metropolitan areas. This additional reason for attrition places further stress on the productivity of midwives in these settings.

Another barrier is the industrial award. The award has been developed for nursing and revolves around rostered hours rather than being on call when needed, that is, when women go into labour. This presents challenges for midwives and organisations to work in a way that meets the needs of the women. Some health services in NSW and SA have negotiated and implemented annualised salaries for midwives working in flexible midwifery models of care like the caseload model. An annualised salary agreement enables midwives to 'follow the woman', that is, meet the woman in the health service only when required so the midwives are then 'available' or on call at home. Traditional nursing roster systems contribute to an under-utilisation of midwives during quiet times in maternity care. Being able to work flexibly has shown to be positive for both the woman and the midwife. Many reports suggest when midwives are able to practice autonomously and as the primary carer in collaboration with other health care professionals they are more satisfied professionally and personally. This has impact for the workforce particularly in the areas of recruitment and retention of midwives.

BEST PRACTICE MODEL – CASELOAD PRACTICE

An example of a best practice model is a caseload practice, which is a flexible model of providing continuity of care by midwives. Midwives work in small groups and take on the care of a specified number of women per year (between 40 to50 per year per midwife). The care each midwife provides includes antenatal, labour and birth and postnatal care. Collaboration with obstetricians and other health professionals occurs when necessary.

Midwives who work as caseload midwives will usually require a separate industrial award and an annualised salary, which enables the midwives to work more autonomously. The midwives receive their base salary with an additional on-costs percentage, which incorporates on call allowances and compensates midwives for long periods on call.

Caseload midwifery practices are particularly useful in rural and remote settings where there are fewer women requiring midwifery services. For example, in a rural area, there

may be 100 to 200 women giving birth each year. A group practice of two to three midwives could provide the entire spectrum of care for women who were having normal pregnancies, labour and the postnatal periods. This would mean they would be fully productive and would not need to undertake additional nursing work. This system would also ensure that women had access to maternity services as part of the public health strategy and would not be required to pay separately for this care.

EDUCATION OF MIDWIVES

There are currently two routes of entry to becoming authorised to practise as a midwife – a direct entry means or a postgraduate route after initial registration as a nurse. There is little consistency within the university programs regarding length of the postgraduate courses, clinical time, structure of clinical placements or fee-paying status. The new curricula for the direct entry courses (Bachelor of Midwifery) has been developed in response to international trends and the identification of needs of the community. These courses require ongoing support from government being in the early phases of their development and delivery. In addition, midwifery regulation in a number of states will need to change to accommodate this new way of preparing midwives. The direct entry course is currently only offered in NSW, Victoria and South Australia.

The Bachelor of Midwifery has also been developed to attract Indigenous women to undertake midwifery. In NSW, four places (from the cohort of 30 per year) have been quarantined for Aboriginal women. These women have all been working as Aboriginal Health Workers as part of the NSW Aboriginal Maternal and Infant Health Strategy and have completed a 12 month Maternal and Infant Preparatory Course at Yooroang Garang in Sydney.This strategy to educate Indigenous women as midwives is designed to address the high rates of perinatal mortality currently experienced by Indigenous women and babies. However, additional funding support is necessary to enable Indigenous women to undertake these courses and to ensure that universities can offer the course in distance mode.

The AMAP (2002) study examined midwifery programs in 27 Australian universities and highlighted barriers to providing quality midwifery education and the need for major reform and funding of the education of Australian midwives. The report suggested that increased collaboration between the universities, service providers and clinicians was needed to address regulatory frameworks and facilitate the seamless integration of teaching by academics and clinicians (AMAP 2002). National guidelines for approval of courses leading to registration would also facilitate greater consistency. Currently, there is limited consistency across the states.

It is essential that the education of midwives is maintained in the tertiary sector. Midwives require the level of knowledge and understanding that a university education provides in order to function as an equal partner in multidisciplinary teams. The complexity of health care, maternity care included, means that education programs probably need to be longer rather than shorter, and must include education that covers innovative models of care that will increasingly apply to midwives.

A commitment to short-term retraining for midwives is needed. Currently this occurs at a federal level for nurses through the Royal College of Nursing Australia. It is necessary for the professional organisation for midwifery – the Australian College of Midwives – to be able to offer similar retraining packages and support.

PRIORITIES TO BE ADDRESSED

This paper has identified a number of priority areas for the Productivity Commissions to focus on:

- Federal government support of midwifery models of care is needed urgently. This would incorporate new funding initiatives so that preferred models of care could be more widely implemented. Currently, in many areas this is not possible because women do not have access to Medicare funding for midwifery services. In addition, changes to legislation to enable all midwives to prescribe common substances and order common tests is essential if midwives are to be appropriately utilised and be more productive in the workforce.

- The New Zealand model of maternity care should be explored in Australia. In this model, women choose their Lead Maternity carer (LMC), which is either a midwife, GP or obstetrician, and this is appropriately funded through the public health system. This system has been highly successful and has ensured that the skills of midwives are appropriately utilised and the workforce is productive. This system also ensures that suitable level of care is provided to the community.

- Consistency in legislation and regulation across the eight (8) jurisdictions is also essential. Currently, different systems exist in each jurisdiction which impacts on the capacity to have a flexible, efficient and safe system for nurses and midwives.

- Increased HECS places for midwives, both undergraduate and postgraduate, are needed and the provision of more places for students is also necessary. Additional support may be required to ensure that adequate staffing exists within teaching institutions to ensure that satisfactory education can occur. A requirement of one student midwife per 200 births has been used in NSW to ensure that students receive adequate training opportunities. This requirement is not mandatory and many hospitals choose not to follow this resulting in inadequate numbers of student places.

- Additional government funding support to ensure that adequate numbers of Indigenous women can enter midwifery through a Bachelor of Midwifery route. Funding support may include scholarships from their health service of employment.

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ABOUT THE AUTHORS

Professor Caroline Homer is the Professor of Midwifery and Director of the Centre for Midwifery and Family Health at the University of Technology Sydney. She has previously worked as a clinical midwifery consultant in practice development at St George Hospital in Sydney where she led system-level changes and practice reform. Prior to this she was the salaried investigator on the NHMRC Centres of Clinical Excellence in Hospital-based Reaserch Grant from 1998-2001. She has 11 refereed publications from this work on outcomes, costs, client acceptability and cross cultural elements of the work. Professor Homer has recently led the research team who developed the National Midwifery Competency Standards commissioned by the Australian Nursing and Midwifery Council (ANMC). This produced national competency standards and strategies and tools for evaluation and review of the role and standards for midwives. She also led the Evaluation of the NSW Aboriginal and Maternal Infant Health Strategy; a three year project funded by NSW Health to evaluate the effectiveness and impact of a primary health care model for Aboriginal pregnant woman, implemented in six Area Health Services from metropolitan (Newcastle) to remote (Broken Hill and Wilcannia).

Ms Lyn Passant has worked as a clinical midwife for the past 15 years. She has worked in a variety of settings including caseload and team midwifery models of acre. She has worked as a project midwife establishing new models of maternity acre in St George Hospital an has a particular interest in supporting new graduates to work in these innovative models. She was the project midwife on the research that developed National Midwifery Competency Standards commissioned by the Australian Nursing and Midwifery Council (ANMC). Ms passant has recently been appointed as the midwife consultant in South Western Sydney Area Health Service to establish midwifery models of care at Camden and Cambelltown hospitals.