Submission by the Australian Nursing and Midwifery Federation

Private Health Reforms – Consultation Paper 1

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Australian Nursing & Midwifery Federation

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Introduction

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives and care-workers across the country.

2. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

3. Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

4. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

5. The ANMF thanks the Department of Health, Disability and Ageing for the opportunity to provide feedback on this discussion paper.

Overview

6. The ANMF believes that health care is a fundamental right, not a market good. A private sector has a legitimate role in complementing a strong, well-funded universal public system and in widening choice for those able to access it, but it must not substitute for public provision, and the profit motive should never displace patient care, equity or safety – including the safety of health care workers.

7. We are therefore cautious about reforms that channel additional public and health consumer funds into privately operated services without corresponding regulations and obligations that ensure patient safety.

8. Where higher benefits or additional funding flow to private hospitals, this must be tied to accountability for how it is used, including proper remuneration for nurses and midwives, safe working conditions, and mandated nurse and midwife to patient ratios. Increased public and consumer contribution should translate directly into better care and a sustainable workforce, not absorbed margin.

9. Reforms must be underpinned by thorough consultation with impacted stakeholders, and independent oversight. Equity of health access for regional, rural and remote communities must be treated as a core objective of the reforms.

Maternity Care – Models of Care and Midwifery Scope of Practice (1.2)

Initiative 1: Sector education

Do you agree or disagree that sector education about innovative models of maternity care would help to raise awareness of models and build a clearer understanding of regulatory enablers? Why do you agree or disagree?

10. Education is an important enabler of innovative models of maternity care, and has the potential to increase awareness of contemporary, evidence-based models of care, improve understanding of existing regulatory frameworks, and build confidence in collaborative, multidisciplinary approaches to maternity service delivery.

11. Education should extend beyond regulatory requirements to include the evidence underpinning maternity care, particularly the well-established benefits of continuity of care models and the contribution of multidisciplinary, woman-centered care. It should also promote a clearer understanding of the roles, scope of practice and capabilities of the maternity workforce.

12. Education must be accessible across metropolitan, regional, rural and remote Australia. These communities continue to experience the greatest barriers to accessing maternity services and often experience broad health inequalities.

13. Targeted education and knowledge sharing will support more consistent implementation of models of care, improve understanding of available service options, and contribute to more equitable access to safe, high-quailty maternity care regardless of where women live.

14. Education should not be limited to clinicians; it should include private health insurers, private hospitals, health service managers, maternity care providers, and consumers. Increased awareness across the sector improves informed decision-making, collaboration and provides organisations the opportunity to identify where and how to implement evidence-based models that improve consumer experience and clinical outcomes.

15. Education must be viewed as an enabler of system wide change.

16. However, education alone will not be sufficient to achieve sustained meaningful reform. It should be accompanied by policies and funding arrangements that enable the maternity workforce to practice to the full scope of practice and competence, support collaborative models of care, and improve equity and access to maternity services across Australia.

17. The ANMF agrees with the consultation paper assertion that sector-wide collaboration is essential to design and implement new offerings. However, whilst there may be a lack of awareness by some in the sector of the ability to introduce new and innovative models of care, there are other factors limiting the diversity of models of care that are offered. Education must target these barriers to innovative models and support practitioners, private maternity services and policy makers to understand where there is scope for new offerings that improve choice and access for women and gender diverse people.

18. For example, medical models of care have historically dominated maternity health service offerings across the board. Midwives have advocated strongly for midwifery-led models of care in public health-sector services over decades and continue to do so, whilst the recognition of midwives' contribution to maternity care as autonomous practitioners has been slow. Medical dominance persists in private maternity health service offerings and is a cultural barrier limiting the diversity of models of care that are offered.

19. The descriptor in the consultation paper "partnership models of care with an endorsed midwife and obstetrician partnership, where the endorsed midwife can primarily lead care" is an example where the scope of practice of midwives and endorsed midwives is poorly articulated. Midwives practice in collaboration with the multidisciplinary team but do not require a partnership model with obstetricians to act as the primary care lead.

20. Education to support implementation of innovative models of care in the private sector must promote a clearer understanding of the roles, scope of practice and capabilities of the maternity workforce. It must also challenge the basis for local policy admitting rights and

credentialling (however titled) in the absence of regulatory barriers.

21. Furthermore, funding mechanisms behind private maternity service delivery is difficult to ascertain and often not publicly available, yet these are an important component to understand and articulate the economic viability of innovative models of care. Private health care funding transparency is required to support this education and ultimately drive new models of care designed to address rising costs of private maternity care.

22. Sector-wide education would help increase awareness of innovative maternity care models and build a clearer understanding of the regulatory enablers that support their implementation in the private sector. Education would improve knowledge of available models, clarify scope-of-practice and governance requirements, reduce misconceptions about regulatory constraints, and increase confidence among providers to adopt evidence-based innovations. However, education should be complemented by clear guidance, funding mechanisms and implementation support to enable sustainable uptake of new models of care.

What mechanisms should be used to educate the sector?

23. *Education must be nationally coordinated and developed in partnership with key stakeholders, including consumers, midwives, obstetricians, private health servicess, and private health insurers. A combination of online information, interdisciplinary workshops and the sharing of successful models of care would support greater understanding and implementation of truly innovative maternity care.*

24. Education should be delivered through a combination of professional development programs, implementation toolkits, case studies, communities of practice and consumer information initiatives. Showcasing the evidence where successful private hospitals have implemented these models of care would provide clear guidance on regulatory requirements, governance arrangements and scope-of-practice considerations.

25. Education for the maternity care sector should focus on the key domains that enable innovation in private maternity care: contemporary models of care, continuity of carer, regulatory and scope of practice frameworks, Medicare and funding mechanisms, clinical governance, workforce reforms, and emerging service innovations. Particular emphasis should be placed on understanding the regulatory

enablers that support midwives and multidisciplinary teams to work to full scope, including private practice, prescribing, credentialing and collaborative care arrangements.

26. To reach stakeholders from government through to clinicians, a mix of education approaches could be used, including policy forums for decision-makers, interactive workshops and webinars for leaders and managers, and practical case studies, communities of practice, and peer learning opportunities for clinicians. Bringing together examples of successful models, lessons from implementation, and opportunities to connect across the sector would help build a shared understanding of the regulatory, funding and workforce changes needed to support innovative, woman-centred private maternity care.

Initiative 2: Increased access and choice to different models of private maternity care.

Would you participate in the development and implementation of innovative models of care with other practitioners in the private maternity sector? Please provide details.

27. The ANMF is committed to enabling midwives to practice to their full scope of practice and supporting choice and access in health care for women and gender diverse people. Successful reform will require genuine collaboration between consumers, midwives, obstetricians, private health services, private health insurers, Aboriginal/CARMI community-controlled organisations, regulators and government. As a professional and industrial body representing Midwives, the ANMF welcomes participation in ongoing consultations to support the development and implementation of innovative models of maternity care. We bring a unique perspective on workforce, professional practice, regulatory and industrial considerations, and can help ensure new models are sustainable, evidence-informed, and enable midwives to work collaboratively and to their full scope.

Initiative 3: Shorter PHI waiting periods for privately provided pregnancy and birth

Do you agree or disagree the maximum waiting period should be reduced for the 'Pregnancy and birth' clinical category? Please specify why.

28. The ANMF supports reducing the maximum waiting period for the Pregnancy and Birth clinical category. Reducing barriers to accessing maternity cover may encourage greater participation in private health insurance for women and gender diverse people seeking maternity care,

maintain choice, particularly in rural and regional areas, where viability of private maternity health services maybe at risk and reduce burden on public maternity health services.

29. However, any reduction in the waiting period should be accompanied by appropriate workforce planning, funding and service capacity to ensure increased demand can be safely met. Changes to insurance settings alone will not improve maternity care if women continue to experience limited-service availability or workforce shortages, particularly in regional, rural and remote Australia. Reforms should, therefore, balance improved access with the capacity of the maternity workforce to deliver safe, high quality, woman centred care.

30. Yes, we agree that PHI waiting periods for maternity services should be reduced to enhance women's choice and access to maternity care. Women already experience significant financial impacts associated with pregnancy, childbirth and time away from the workforce. Lengthy waiting periods can create an additional barrier to accessing the care model that best meets their needs.

31. This is particularly relevant given that approximately 40% of pregnancies in Australia are unintended or unplanned. For many women, this means that unless they already hold suitable private health insurance, they are unable to access private maternity care when they become pregnant.

32. The current waiting period serves primarily as a mechanism to discourage individuals from purchasing cover only when they need maternity services and then cancelling it afterwards. However, its practical effect is that many women and families are excluded from accessing private maternity care at a time when they would most benefit from it. Reducing waiting periods for private maternity cover could improve access to continuity of care, increase consumer choice, and help reduce pressure on the public maternity system. At the same time, concerns about the cost of maternity care to insurers need to be balanced against the evidence that innovative models such as midwifery continuity of care can achieve excellent outcomes with lower intervention rates, including fewer operative births, making them a potentially more cost-effective option than traditional obstetric-led care for many women.

Initiative 4: Review of product tier structure

Do you agree or disagree the 'Pregnancy and birth' clinical category should be a minimum requirement of a product tier other than Gold?

33. The 'Pregnancy and birth' clinical category should be a minimum requirement of a product tier other than Gold. Restricting maternity cover to Gold-tier products creates a significant affordability barrier for many women and families seeking access to private maternity care. Including pregnancy and birth services within a lower product tier would improve accessibility and provide greater flexibility for consumers to choose a level of cover that meets their needs and circumstances.

34. Given that a substantial proportion of pregnancies are unplanned, restricting maternity cover to Gold products can prevent women who do not already hold comprehensive cover from accessing private maternity services when they need them. As a result, fewer women enter the private maternity system, reducing opportunities to utilise private maternity care and undermining women's choice.

35. The requirement for Gold-level cover to access private maternity services is largely driven by the historically high cost of maternity care. However, as innovative models of care emerge, particularly midwifery continuity of care models that are associated with lower intervention rates and potentially lower overall costs, there may be value in reconsidering whether access to maternity care should be limited to the highest level of private health insurance cover.

Initiative 6: Review of MBS items for paediatricians

Do you agree or disagree that there should be consideration of an amendment to the MBS item for paediatricians? Please specify why.

36. The ANMF does not support initiative 6.

37. In a public health service, it is not common for there to be attendance by a paediatrician to check on the health of the newborn. In these services, midwives and obstetric residents and registrars perform newborn health checks and escalate review by a paediatrician only when there is a medical indication for specialist input.

38. Paediatric review of a newborn without medical indication for specialist input is not an essential service. Families may be spared from the out-of-pocket costs associated with paediatric newborn review by midwives employed by the health service, midwives employed by the obstetrician or the obstetrician themselves performing the newborn check.

39. The MBS was introduced to create equity and fairness in healthcare access and providing additional MBS benefits for paediatricians in these circumstances does not align with these principles.

40. Any review of MBS funding across the maternity sector should adopt a multidisciplinary approach that recognizes the contributions of the broader maternity workforce.

41. This includes midwives, including endorsed midwives, nurses, those with relevant postgraduate qualifications and international board-certified lactation consultants (IBCLC's), who provide expert care across the antenatal, postnatal and newborn continuum.

42. Funding reforms must support collaborative models of care and enable all clinicians to practice to their full scope of practice, ensuring women, gender diverse people and newbornss receive the right care, from the right clinician, at the right time making best use of resources for safe, equitable care. Any amendments should aim to reduce barriers to care, support multidisciplinary models of maternity care, and encourage early intervention where clinically appropriate. Consideration should also be given to ensuring that funding arrangements align with contemporary models of care and do not create unintended disincentives for collaboration between obstetricians, midwives, general practitioners and paediatricians.

Regional Private Hospitals (2.1)

43. Across regional, rural and remote Australia, private hospitals are, in some cases, the only local provider of particular services, and their viability is closely tied to the resilience of the surrounding public system and health workforce.

44. The ANMF advocates that the proposed increase to the second-tier default benefit is

introduced on a temporary basis in the first instance and paired with a planned and comprehensive post-implementation review so government can confirm it is genuinely improving sustainability and maintaining services rather than simply lifting operator revenue. Sufficient lead time will be needed to align the change with the existing annual audit, categorisation and rate-setting processes and to allow for orderly system and administrative adjustments. In determining eligibility, the criteria should look beyond classification alone to the services actually provided to the local community, the consequences for the public system (should a facility cease operating), and the distance people would otherwise need to travel to access care.

45. Given continuing cost-of-living pressure, the design must guard against increased out-of-pocket costs or premium rises being passed through to consumers. The effectiveness of the measure will ultimately depend on transparent eligibility and calculation methodology, independent auditing and reporting, and ongoing monitoring of the impact on consumers, hospitals and insurers, so that any additional funding is seen to benefit patients and staff and not merely the private operators.

Conclusion

46. The ANMF thanks the Australian Government, Department of Health Disability and Ageing for the opportunity to provide feedback on the *Private Health Sector Reform, Consultation Paper 1.*