F I N A L R E P O R T

Midwifery Futures

Building the future Australian midwifery workforce

Burnet reach for the many | Curtin University | Nursing and Midwifery Board Ahpra | UTS

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ACKNOWLEDGEMENT OF COUNTRY

The Midwifery Futures Project team and its work acknowledges the Traditional Owners of Country throughout Australia. We pay our respects to Ancestors, Elders, and their descendants, who continue cultural and spiritual connections to Country. We recognise Aboriginal and Torres Strait Islander women as the first midwives in Australia and that Birthing on Country had occurred for more than 65,000 years before colonisation began. It is important to recognise and incorporate these ancient practices to improve the way Aboriginal and Torres Strait Islander women give birth.

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A STATEMENT ON TERMINOLOGY

Midwives aim to provide maternity care that is culturally safe and respectful. We acknowledge the biological, social and cultural determinants that influence health and experiences of birth, including sex and gender. We use 'women', 'woman,' and 'mother' throughout this report. We recognise that not all pregnant individuals identify as women and acknowledge the challenges faced by these individuals in accessing maternity and sexual and reproductive health care. When using these terms, we do so in a way that reflects the majority of those who are pregnant and do not seek to exclude any individuals who access maternity care. For the purposes of this report, we intend these terms to be inclusive of all people accessing maternity care. All individuals seeking maternity care should receive personalised, respectful care, including the use of preferred gender pronouns.

ABBREVIATIONS AND ACRONYMS

ACCHO	Aboriginal Controlled Community Health Organisations
ACM	Australian College of Midwives
ACRMM	Australian College of Rural and Remote Medicine
Ahpra	Australian Health Practitioner Regulation Agency
AIM	Assistant in Midwifery
ANMAC	Australian Nursing and Midwifery Accreditation Council
ANMF	Australian Nursing and Midwifery Federation
ANZCCNMO	Australia and New Zealand Chief Nursing and Midwifery Officers
APNA	Australian Primary Health Nurses Association
CATSINaM	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CDNM	Council of Deans of Nursing and Midwifery
CNMO	Chief Nursing and Midwifery Officers
COAG	Commonwealth of Australian Governments
CoMC	Continuity of midwifery carer
CRANAPlus	Council of Remote Area Nurses of Australia
EAG	Expert Advisory Group
GENKE	'getting em n keeping em n growing em'
GP	General Practitioner
HELP	Higher Education Loan Program
MBS	Medicare Benefits Schedule
MCFH	Maternal, Child and Family Health
MPE	Midwifery practice experience
NHRA	National Health Reform Agreement
NP	Nurse Practitioner
NMBA	Nursing and Midwifery Board of Australia
PII	Professional Indemnity Insurance
PPM	Privately practising midwives
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian College of Obstetricians and Gynaecologists
RDAA	Rural Doctors Association of Australia
RHMT	Rural Health Multidisciplinary Training
RUSOM	Registered Undergraduate Students of Midwifery
WAG	Working Advisory Group

Midwifery Futures

BUILDING THE FUTURE AUSTRALIAN MIDWIFERY WORKFORCE

Midwifery Futures aimed to review the current state of Australia's midwifery workforce and to generate information that would support policy, regulatory, industrial, and educational change in midwifery service provision. While much good midwifery work has been done, our research shows there is unfinished business requiring urgent attention. The midwifery workforce in Australia is in crisis and change is needed. Continuing to do the same and expecting different results is no longer possible. A National Midwifery Strategy and funded implementation plan will provide a pathway forward.

Increased visibility, governance, and leadership

Strong and skilled midwifery leadership is essential for developing the future Australian midwifery workforce, especially the role of Chief Midwife in each jurisdiction.

There is a lack of well-defined professional pathways to identify and train future midwife leaders. Additional resources are needed to ensure current and future midwifery leaders are well-supported in their roles.

Growing the midwifery workforce

There are not enough midwives or current midwifery students in the pipeline to meet the future needs, especially if midwives are not supported to stay in the profession. Urgent and coordinated action is required to increase the number of midwifery students by at least 20%.

All midwifery students should experience working in continuity of midwifery carer models, contributing to their total midwifery practice experience time.

Additional financial support to meet the cost of being a student should be provided, particularly for students from rural and remote areas, also addressing Higher Education Loan Program debt for midwifery graduates.

Aboriginal and Torres Strait Islander people are underrepresented in the midwifery profession. Holding quarantined places for Aboriginal and Torres Strait Islander midwifery students and increasing the pathways to midwifery for prospective Aboriginal and Torres Strait Islander students, including funded cadetship programs will help address the imbalance.

Support the midwifery workforce

Midwifery work can be psychologically demanding, with some midwives reporting high rates of burnout, anxiety, depression and stress. Midwives must be supported to undertake meaningful work that provides professional satisfaction. Quality mentoring, clinical supervision, and continuing professional development for midwives should be readily available to all midwives.

Midwives working an additional 4 hours per week, would reduce workforce shortages. Achieving this requires improved workplace flexibility, adequate working conditions, and ensuring midwives have more career pathway options, regardless of the model of care they provide.

Significant numbers of midwives work in shift-based models, mostly on a roster system. Many midwives want to remain working in this way. Equally, midwives working in CoMC models, will from time to time, rotate back to a shift-based models as their family and personal circumstances change. Therefore, midwives working in shift-based models of care need to be supported and enabled to provide high quality midwifery care.

Professional autonomy, respect, and support in the workplace; and adequate staffing levels with an appropriate skill mix; positively influence the experiences and retention of midwives working in Australia.

The ongoing impact of racism, trauma, and colonisation present significant challenges for Aboriginal and Torres Strait Islander students and midwives and the provision of culturally safe maternity care. Cultural safety education for all midwives and midwifery students is required.

Improve data to support workforce planning

There is no nationally consistent approach to workforce planning. More granular data on the reasons midwives do not renew their registration would be helpful to track the future.

Scale-up midwifery models of care

Women want continuity of midwifery care, especially in primary maternity care settings. Continuity of carer models are also beneficial for midwives.

Midwifery continuity of care must be scaled up in flexible ways to ensure more midwives can provide this model of care. Implementing bundled funding and reforming industrial awards will assist.

Birthing on Country models of care can play a significant role in Closing the Gap between Indigenous and non-Indigenous health outcomes for mothers and babies. Adopting an evidence-based framework like RISE or Replanting the Birthing Trees will help to develop midwifery programs for Aboriginal and Torres Strait Islander women.

Executive Summary

The Midwifery Futures Project (2023-2024) was funded by the Nursing and Midwifery Board of Australia (NMBA), in collaboration with the Chief Nursing and Midwifery Officers of Australia and New Zealand (ANZCCNMO).

Midwifery Futures aimed to review the current state of Australia's midwifery workforce and to generate information to support policy, regulatory, industrial, and educational change to enhance midwifery service provision. Midwifery, and the work of midwives, exists within a wider context of health care delivery and reform, and intersects with the higher education sector as well as with the multidisciplinary sector including nursing and medicine. Understanding this context is important in planning the future of midwifery in Australia.

During the last decade, several Australian national reviews or reports have been conducted with relevance to Midwifery Futures. Midwifery has been well represented in many reports, and much good work has been done. Our review of previous reports and the research conducted in this project has shown there is unfinished business requiring urgent attention.

Our first scoping review on '*What women in Australia want from their maternity care*' highlighted that women in Australia consistently want access to continuity of midwifery carer as an enabler for addressing their maternity care needs [1].

Key findings from the Midwifery Futures project include:

1. The midwifery workforce in Australia is in crisis and change is needed. Continuing to do the same and expecting different results is no longer possible.
2. There are not enough midwives or current midwifery students in the pipeline to meet the future needs, especially if midwives are not supported to stay in the profession. Urgent action is required.
3. Midwife registrant numbers were stable between 2015 to 2020, rose during the early years of the COVID-19 pandemic, and then returned to baseline. The proportion of younger midwives increased over time and fell for older midwives. Despite this apparent adequacy in numbers, we found widespread localised staffing shortfalls, particularly in non-metropolitan areas. Our modelling showed a slight excess in future workforce numbers to 2030, but higher than current attrition rates would have a catastrophic impact.
4. One third of respondents to the Midwifery Futures workforce survey were considering leaving the profession. Many were considering leaving midwifery well before retirement age, for reasons related to their experiences of working as a midwife. Midwives working in midwifery group practice, team midwifery, or private midwifery practice were less likely to report a desire to leave midwifery.
5. Aboriginal and Torres Strait Islander people are underrepresented in the midwifery profession. The impact and ongoing presence of racism, intergenerational trauma, vicarious trauma, and colonisation present significant challenges. Racism in the maternity setting poses a challenge when recruiting and retaining the Aboriginal and Torres Strait Islander midwifery workforce. There are also limited leadership roles for Aboriginal midwives to make systematic changes in health services and policy.

6. Birthing on Country models of care can play a significant role in Closing the Gap between Indigenous and non-Indigenous health outcomes for mothers and babies.
7. Satisfaction with midwifery and likely retention in the workforce was influenced by 'being able to practice midwifery as I see it', having adequate staffing levels and an appropriate skill mix, being respected, supported, and accepted, having professional autonomy, and the absence of bullying or violence in the workplace.
8. Midwifery work is psychologically demanding, with high rates of burnout, anxiety, depression, stress, and low rates of empowerment and satisfaction. Midwives want to undertake meaningful work that provides professional satisfaction. Being able to work in continuity of carer relationships was important to many, but not all wanted to, or could, work in these models. Midwives expressed a need for urgent solutions and frustration about limited progress in reforming many aspects of maternity care to date.
9. Midwives indicted their preferred roles if they had a choice: 37.5% selected midwifery group practice, 33.3% selected standard hospital care roles, and 23.6% chose private midwifery practice.
10. Models of care providing continuity of midwifery carer have been found to be beneficial for midwives, including recently qualified midwives. More midwives wanted to work in continuity of midwifery carer models than were currently employed in these roles. This was particularly the case for recently qualified midwives, with 80% of students expressing a desire to work in continuity of midwifery carer models, 33% of recently qualified midwives feeling confident to do so on graduation, yet only 13% were working in this model of care.
11. Most midwifery students felt their education prepared them well for practice. However, the majority also reported difficulties maintaining balance between university workload, clinical requirements and personal obligations. More than half had considered withdrawing from their degree.
12. Among recently qualified midwives, 11% were not working in midwifery. Graduates from both direct entry and dual degree or post-nursing registration programs valued the option to choose the specific program they selected. The proportion of recently qualified midwives who wanted to work in midwifery group practice or private practice models was more than double the proportion of midwives working in these models.
13. Endorsed midwives make up 3.5% of midwives with general registration. There is a lack of national consistency in the incorporation of privately practising endorsed midwives into the public health sector, with Queensland having been most successful in this regard to date. Midwifery prescribing is also under-utilised in the public sector. The requirements for postgraduate qualifications in prescribing and 5,000 hours of experience in the prior six years have presented barriers to expanding numbers of endorsed midwives.
14. There is little known about internationally qualified midwives working in Australia despite immigration being one potential option to increase the size and experience of the workforce. We also know little about whether there is a pool of people who have recently left midwifery and who might be supported to return to the profession.
15. Strong and skilled midwifery management and leadership is imperative but there was a lack of well-developed professional pathways to support the identification and preparation of future managers and leaders. Current managers found the work challenging and some described not being well supported or resourced for their role. Midwifery is often invisible in health service leadership and not always recognised as a separate and distinct profession.

Recommendations

The Midwifery Futures project makes the following recommendations:

Increase visibility, governance and leadership

1. The Australian Governments fund the development of a National Midwifery Strategy and funded implementation plan.
2. Australian governments recognise the importance of midwifery leadership through the instatement of a Chief Midwife and Office of the Chief Midwife in each Commonwealth and state and territory government, with resources to provide leadership and bring about change. In addition, a First Nations Midwifery Director is established in each jurisdiction to provide leadership for Aboriginal and Torres Strait Islander services and contribute to Closing the Gap.
3. Where there is a maternity service, ensure that leadership is provided by midwives at government, employers executive and clinical levels.
4. Health services and industrial bodies ensure that midwifery and midwives are adequately represented in jurisdictional industrial agreements.
5. Increase opportunities to promote awareness of midwifery among the general population through media and educational initiatives and through schools and career days.

Scale-up midwifery models of care

6. The Commonwealth Government develop, implement, and fund bundled funding for midwifery continuity of care models as a defined care pathway, to fund midwives to work to their full scope when they practise across different parts of the health care system (including primary and admitted care) which currently operate under separate funding arrangements.
7. Health services and industrial awards must ensure that continuity of midwifery carer models are flexible including part-time and job share opportunities with reduced caseload requirements aligning with full time equivalents for midwives working part-time.
8. Health services must ensure that continuity of midwifery carer models are available to all women regardless of risk status, with access to consultation, referral and collaborative models.
9. Australian governments, health services and education providers adopt an evidence-based framework (e.g., RISE [2] and Replanting the Birthing Trees [3]) to develop midwifery programs for Aboriginal and Torres Strait Islander women.
10. Health services should create flexible opportunities for midwives to fulfil their professional scope through work including in maternal, child and family health practice, sexual and reproductive practice, and women's health.
11. Health services, industrial bodies, and universities explore clinician researcher positions for midwifery as a career path option.
12. Health services in rural, regional, and remote settings recognise that midwives who do not hold a nursing qualification provide valuable contributions to the provision of care to women, babies and families. With additional training, these midwives can also provide maternal and child health services and/or sexual and reproductive health services.
13. Explore the opportunity to develop multidisciplinary models of primary care with midwives, general practitioner obstetricians, and nurse practitioners providing a range of health services in a rural setting. This needs testing for feasibility, affordability and cost benefits.

Grow the midwifery workforce

14. Universities, health services, and policy makers work to increase the number of midwifery students, starting as soon as possible, by at least 20% - leading to around 1560 students graduating in 2-4 years (depending on the length of the programs).
15. Universities and health services implement quarantined places for Aboriginal and Torres Strait Islander midwifery students.
16. Universities and health services increase pathways to midwifery for prospective students from diverse backgrounds especially those from Aboriginal and Torres Strait Islander, and migrant and refugee backgrounds, including funded cadetship programs.
17. Strengthen workforce planning mechanisms between Ministers of Health and Education, Chief Nursing and Midwifery Officers, health districts, Aboriginal Community Controlled Health Organisations, and universities to collectively plan the number of midwives required, and therefore the number of students to be recruited into universities and health services.
18. Universities and health services work to ensure that midwifery clinical placements increase the opportunity for students to work in continuity of midwifery carer models, contributing to their total midwifery practice experience time.
19. The Australian Government fund an additional Commonwealth stipend to meet additional costs borne by students from rural and remote areas including temporary relocation to receive experience in a larger centre, also addressing Higher Education Loan Program debt relief for midwifery graduates.
20. The Australian Government, universities, and health services develop and fund accessible re-entry programs to attract midwives who have left back to the workforce, and/ or attract midwives from overseas.

Support the midwifery workforce

21. Government, health services, industrial and professional bodies to strengthen workplace flexibility, adequate working conditions, and ensure midwives have more career pathway options.
22. Government, health services, industrial, and professional bodies must ensure that midwives who work in shift- or roster-based models of care have adequate working conditions and support to ensure they can provide high quality care and are retained in the health system.
23. Government, health services, industrial, and professional bodies must work together to ensure working conditions and appropriate wages allow midwives to provide evidence-based care, meet existing and emerging policy requirements and be retained in the workforce.
24. Universities and health services ensure implementation of cultural safety education for all midwives at all education levels, including pre-registration education and as part of continued professional development, and evidenced in all guidelines. Any standardised education program must be specifically contextualised to the unique roles of midwives and the locality.
25. Government, health services, industrial and professional bodies to ensure midwives can work to their full scope of practice through funding models, educational opportunities, new models of care, and respectful collaboration.
26. The Commonwealth Government should underwrite professional indemnity insurance requirements for the midwifery workforce, ensuring midwives can work to their full scope of practice in private and public settings.
27. The Australian Government ensure that privately practising midwives have access to the Practice Incentives Program and other similar schemes to help them continuously improve, provide quality care, enhance capacity, and improve access and health outcomes for women and families.
28. Australian governments fund development of a national Transition to Practice Program to mentor recent graduates to build knowledge, skills, and confidence.
29. Government, health services and professional bodies to implement and fund quality mentoring, clinical supervision, and continuing professional development for midwives.
30. Health services, industrial, and professional bodies to lobby government for comprehensive national review to evaluate the value of midwifery to contemporary society and use these data to benchmark salary scales to ensure appropriate remuneration.

Improve data to support workforce planning

31. Through the annual NMBA survey, collect data on the number of midwives leaving employment in Australia each year, the number of qualified midwives joining from overseas, the number of midwives actively working in the profession, and the number of dual qualified midwives working mostly in midwifery.

32. The NMBA to consider a mandatory expanded/ refined survey every 3 years to ensure access to a national contemporary workforce data set.

Summary

In summary, midwifery in Australia has made considerable progress in the last decade but much is still to be done. The Midwifery Futures project makes clear that the midwifery workforce in Australia is in crisis and change is needed. Continuing to do the same and expecting different results is no longer possible. Change will require the entire sector to come together – the Ministers of Health across the country, the national regulator, the education systems, the health departments, health districts, Aboriginal Community Controlled Health Organisations, private midwifery practices, other professions and health leaders, the health workforce agencies in each jurisdiction, and the professional and industrial organisations.

Every midwife in the health system is important and everything should be done to support all midwives. There are significant workforce shortages across all workplace settings, especially in rural and remote settings, and inadequate numbers of students and new graduates. Efforts need to be made to ensure midwifery is visible, midwifery leadership is present at all levels, models of midwifery care that provide continuity of carer are scaled up for all women, midwives can work to their full scope of practice especially in rural and remote areas and in primary maternity services, and midwives are able to thrive and have flexibility and agency in their work patterns and planning.

The Midwifery Futures Report provides the evidence-base for a National Midwifery Strategy and funded implementation plan that must be developed, endorsed, and funded by the Commonwealth and the states and territories in Australia in partnership with all stakeholders. Health Ministers and governments across the country are key to a strong future midwifery workforce.

Chapter 1: Introduction

Maternity services in Australia encompass various models of care, healthcare settings, and practitioner collaborations [4]. The maternity services workforce is responsible for the provision of care to approximately 315,000 women who give birth in Australia each year [5]. The midwifery workforce is the largest contributor to the Australian maternity workforce. Maintaining the numbers, diversity, and quality of the Australian midwifery workforce is key to the ongoing provision of safe and effective maternity care, including in priority areas identified by the Australian Government [6] such as providing support in the first 350 days of pregnancy and the postpartum period (see Appendix A) [5-7].

Understanding the Australian context and global drivers are crucial for designing a midwifery workforce able to effectively respond to the needs of childbearing women and other birthing people and contribute to positive childbirth experiences. Investing in midwives and continuity of midwifery carer (CoMC) models improves health outcomes, reduces the long-term burden of chronic disease on the healthcare system, and contributes to Closing the Gap for Aboriginal and Torres Strait Islander peoples [8]. The best outcomes for women, babies, and their families are likely to come from supporting the midwifery profession, ensuring access to safe and effective midwifery care for women and families and enabling midwives to work to full scope of practice.

The most recent Commonwealth Department of Health review, *Australia's Future Health Workforce Report – Midwives*, published in 2019, examined the workforce at that time with predictions through to 2030 [9]. The report predicted an oversupply of midwives by 2030 in most of the scenarios examined. The COVID-19 pandemic subsequently significantly impacted the midwifery profession. Despite a growing Australian population, the ratio of midwives per 100,000 head of population has dropped by almost four percent [10-12].

The Council of Deans of Nursing and Midwifery's (CDNMs) position paper *The future of the midwifery workforce in Australia* [13] identified occupational burnout, ineffectual leadership, slow progress in increasing opportunities to practise in CoMC models, and a lack of diversity in the current workforce, particularly in relation to Aboriginal, Torres Strait Islander, and culturally and linguistically diverse midwives, as current challenges.

This report sets out the aims of the Midwifery Futures project and summarises previous reviews, reports, and initiatives that have impacted on the midwifery workforce. Next, the data generating approaches used for the project are described, followed by detailed findings of the project including the key problems and challenges. The report concludes by setting out key priorities and recommendations needed to ensure the future midwifery workforce is robust and equipped to provide high quality maternity care, to educate and support the future workforce, to develop midwifery knowledge through research, and to further the development of the profession with strong leadership.

1.1 Aims of Midwifery Futures

The Midwifery Futures project (2023-2024) was funded by the Nursing and Midwifery Board of Australia (NMBA), in collaboration with the Chief Nursing and Midwifery Officers of Australia and New Zealand (ANZCCNMO). The Midwifery Futures project aimed to review the current state of Australia's midwifery workforce and to generate information to support policy and regulatory change to enhance midwifery service provision. Within this broader aim, specific goals were to:

- Identify and explore issues influencing the number of midwives in Australia, including educational pathways, workforce participation, models of care, and workforce trends.
- Identify and explore workforce factors including demand for CoMC, Birthing on Country (a way of providing culturally responsive care to Aboriginal and Torres Strait Islander women and families) and other public or private models of care and access and acceptability for culturally and linguistically diverse communities.
- Examine issues and opportunities in the recruitment, retention, and attrition of midwives in Australia, with a particular focus on the retention of the existing midwifery workforce, including the Aboriginal and Torres Strait Islander midwifery workforce and the distribution of the rural and regional workforce.
- Identify gaps in the education, training, skills, and experience of the existing midwifery workforce that impacts the full scope of practice delivering safe, effective, and holistic midwifery care across all service contexts (particularly rural and remote contexts).
- To understand the current state of midwifery prescribing, midwifery scope of practice, and midwifery regulation in Australia.

1.2 The operating context influencing the Australian midwifery workforce

Understanding the broader healthcare context is important in planning the future of midwifery in Australia. During the past decade, Australia has had several national reviews or reports relevant to midwifery. While midwifery has been well represented in many national reports, some missed opportunities were identified. There is still unfinished business requiring attention.

We highlight the key reviews, reports, activities, and issues below, recognising that there are others we have not included.

Woman-centred care: Strategic directions for Australian maternity services

A national plan was developed in 2019 under the auspices of the Commonwealth of Australian Government's (COAG) Health Council. *Woman-centred care: Strategic directions for Australian maternity services* (the Strategy) provided the overarching national strategic directions to support Australia's high-quality maternity care system and enable improvements in line with contemporary practice, evidence, and international developments [14]. The plan aimed to "ensure that Australian maternity services are equitable, safe, woman-centred, informed and evidence-based. Women are the decision-makers in their care and maternity care should reflect their individual needs" (p. 7).

Specifically related to the maternity care workforce, the strategy had the principle that: *Women access care from a maternity care workforce that is responsive, competent, resourced, and reflects cultural diversity.* The enablers for this included:

- Development and maintenance of skills (including clinical reflection and supervision) of health professionals working in maternity services,
- Development of a workforce with broad generalist skills in rural settings to promote the maintenance of services,
- Outreach and telehealth services be provided to support health professionals and improve access for women in rural and remote areas,
- Pathways be developed to support general practices and obstetric practices to work with midwives,
- Maternity health professionals be supported to work to their full scope of practice and utilise their skills and capabilities to provide care in a range of models to meet community need, and
- Service providers facilitate access to review, reflection, and audit for health professionals.

However, the Strategy had no direct focus on the midwifery workforce.

Another principle relevant to Midwifery Futures was *'Improved access to continuity of care and carer' which stated that 'Women have access to continuity of care with the care provider(s) of their choice — including midwifery continuity of care.'* (p. 16) [14].

An evaluation of the strategy was conducted in 2022 [15]. Stakeholders interviewed or surveyed for this evaluation felt the Strategy reflected priorities and activities needing to be progressed to improve the delivery and experience of maternity care in Australia. However, the evaluation highlighted that overall, implementation and evaluation of the Strategy had not progressed well, due in part to its aspirational nature; lack of clearly defined expectations, roles, responsibilities, and timeframes; and lack of coordination between state and Commonwealth governments. A lack of workforce capacity / sufficiency was a critical issue of relevance to all components of the strategy. A subsequent critical analysis of this national review demonstrated extensive similarities with maternity service reviews from every state and territory [16].

The COVID-19 pandemic presented significant challenges and many initiatives already underway and/or those that would have assisted in achieving the Strategy were not able to progress. A lack of targeted funding was a major roadblock as resources were reprioritised to inpatient settings and, in some cases, efforts to improve data assets for monitoring and evaluation were deprioritised. There was significant variability in the extent of progress, both between jurisdictions and within strategic directions and enabling activities. The most promising progress appeared to have occurred for the values of *safety, choice, and respect*, with less progress related to access.

A recent study reported the experiences of 1,750 women who had given birth between January 2020 and June 2023. The aim was to explore whether the experiences of women who accessed Australian maternity services were aligned with the Strategy's values and principles. In total, 50 - 86% of women reported receiving an aspect of care that mostly or always aligned with the values. Women in private models of care were more likely to experience care according to the Strategy. Women in standard and high-risk public hospital care, rural/remote dwelling women, and younger women were less likely to experience care accordingly. Care was universally perceived to be worse in the postnatal period [17].

Australia's Future Health Workforce Report – Midwives 2019

In 2019, Australia's Future Health Workforce Report – Midwives 2019 [9] updated the first iteration of midwifery supply and demand projections conducted by Health Workforce Australia in the Health Workforce Report published in 2012. The 2019 analysis calculated demand using a CoMC approach rather than birth rate. It was acknowledged that midwifery hours of care required vary according to the model of care, and supply and demand are subject to local variation.

The report indicated that the midwifery workforce, in terms of supply and demand, was in balance with a potential over-supply by 2030. However, it was also recognised that while the overall numbers might be in balance, there was a maldistribution with inadequate numbers of midwives in rural and remote areas with unfilled vacancies, difficulty in recruitment of staff, and seasonal variations. It was also observed that:

> *"some jurisdictions also report retention issues associated with newly educated midwives who are seeking to work in CoMC models. The demand from midwives for jobs in caseload midwifery is higher than capacity which suggests a conflict between service delivery models and the current accredited education programs" (p. 5).*

The report made four recommendations:

- updating the workforce modelling results to determine requirements for future adjustments every two years,
- prioritising future policy work to address issues of maldistribution and retention,
- services continue to increase the availability of CoMC models, so midwives can fully utilise their education and training,
- service and education providers collaborate to ensure that education and services are well aligned.

This report was generated and published before the COVID-19 pandemic, which has seen considerable challenges in health workforce numbers including midwives. Many of the recommendations remain works in progress without clear deliverables or identified funding.

'gettin em n keepin em n growin em' (GENKE II) Report 2022

> *"Aboriginal and Torres Strait Islander peoples have been caring for Country and community with unique knowledges and ways of being and doing since time immemorial. Aboriginal and Torres Strait Islander nurses and midwives are holders of knowledges of Country and culture that engender a unique and significant contribution to the ongoing development of nursing and midwifery excellence in growing Culturally Safe and effective Australian health services, especially for Aboriginal and Torres Strait Islander peoples" (GENKE II, p. 10).*

In 2022, the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) released the 'gettin em n keepin em n growin em': Strategies for Aboriginal and Torres Strait Islander nursing and midwifery education reform (GENKE II) report [18]. This report followed from the initial 'gettin em n keepin em' (GENKE I) report which was released in 2002. Only 1.4% of nurses and midwives in Australia are Aboriginal and/or Torres Strait Islander people. GENKE II outlines key national-level strategic reforms for nursing and midwifery education to increase the Aboriginal and Torres Strait Islander nursing and midwifery workforce.

The GENKE II report called for:

- A formalised partnership agreement between the Australian Nursing and Midwifery Accreditation Council (ANMAC) – responsible for accreditation of nursing and midwifery tertiary education programs – and CATSINaM, to co-design, co-produce, and co-accredit nursing and midwifery education as it relates to Aboriginal and Torres Strait Islander health,
- A partnership agreement with the NMBA to co-design, co-produce, and co-accredit nursing and midwifery education to facilitate comprehensive national nursing and midwifery education reform as it relates to Aboriginal and Torres Strait Islander health, and
- A formal partnership between the Australian Government and CATSINaM to form a partnership agreement on national-level strategic reform in nursing and midwifery education as it relates to Aboriginal and Torres Strait Islander health.

A key recommendation in GENKE II was that ANMAC and CATSINaM, in partnership with key professional groups and all governments' Chief Nursing and Midwifery Officers (CNMOs), develop an Aboriginal and Torres Strait Islander nursing and midwifery clinical placement plan. The GENKE II report has many strategic and supplementary recommendations that have direct relevance to Midwifery Futures, and these are included as Appendix B of this report.

It is encouraging that ANMAC is partnering with CATSINaM to develop practical solutions based on the GENKI-II report.

The Future of the Midwifery Workforce in Australia 2023

In late 2023, the Midwifery Advisory Group of the CDNM in Australia and Aotearoa New Zealand prepared a paper to inform decision makers about a pressing need for workforce reforms [13]. The key issues related to workforce challenges were the reduction in clinically practising midwives aged 45–54 which had fallen by 40% since 2013, and the resultant loss of experience and leadership this has brought. The paper highlighted the lack of population parity in the number of Aboriginal and Torres Strait Islander midwives and the challenges facing rural and remote communities. Rural challenges include closures of maternity units with a lack of opportunities for rural midwives to practise and a reduction in rural student midwifery practice experiences (MPEs) which, in turn, force midwifery students from rural areas into metropolitan settings at their own expense.

The position paper made recommendations in relation to:

- Developing and enabling leadership capacity and opportunities for midwives,
- Addressing occupational burnout,
- Strengthening professional recognition by having a designated Chief Midwife in each state and territory,
- Mainstreaming CoMC,
- Sustaining growth and quality of experience in MPEs, and
- Promoting workforce diversity especially in relation to workforce participation by Aboriginal, Torres Strait Islander, and culturally and linguistically diverse midwives.

Midwifery workforce sustainability: the FUCHSIA Report

In 2021, through the COVID-19 pandemic era, a population-based, cross-sectional study was conducted in Victoria. This study is known as "FUCHSIA - Future proofing the midwifery workforce in Victoria" [19]. All midwives employed in public and private maternity services, privately practising midwives, and managers of maternity services were invited to participate. This was a large survey done at a time of particular stress in the maternity care system, has relevance across the country, and so is included here.

Three-quarters of managers who responded to the survey reported their maternity service was inadequately staffed with midwives. A shortage of least 200 full time midwives was identified with deficits across the state. The study also highlighted

challenges with recruitment, especially a lack 'experienced' midwives in the health system. The turnover of midwives was also high, with many experienced midwives either retiring or looking for improved work/life balance, remuneration, or to avoid shift work.

The study showed high rates of potential attrition with 20% of midwives being unsure how long they would stay in the profession. Almost 40 per cent said they regularly thought about leaving the profession, and over one quarter were planning on leaving in the next five years, due to feeling "worn out", experiencing "work-related stress", and being "disillusioned with midwifery". Key challenges included physical and mental health issues (including back problems and burn out); poor workplace culture; heavy workloads, inadequate midwife-to-patient ratios, short staffing; and managing the impact of the COVID-19 pandemic. Positive relationships with their colleagues and being able to provide a high level of care to women and families were also reported.

Many of the findings of the FUSCHIA report resonate with the findings of Midwifery Futures as will be shown in this report.

New South Wales Select Committee on Birth Trauma 2024

The Select Committee on Birth Trauma was established in New South Wales in June 2023 in response to consumer complaints about women's experiences of their maternity care [20]. More than 4000 written submissions were received, and the Select Committee held six public hearings. The final report found that urgent efforts must be made to address factors that contribute to birth trauma and the approaches used to do so must be tailored to meet the needs of individuals [21]. While the work of the committee prioritised submissions from individuals residing in NSW, it is highly likely that similar issues exist in other jurisdictions, and the recommendations are therefore potentially relevant across Australia.

The following recommendations were relevant to the midwifery workforce:

- Ensure all women have access to CoMC models with a known provider, requiring an investment in midwifery CoMC models catering for women in all risk categories, so the number of health services offering such models and the number of women who can access them are increased,
- Fund education on trauma informed practice,
- Provide training and support to enhance informed consent,
- Expand publicly funded homebirth services to all New South Wales Local Health Districts,
- Review regulatory and funding arrangements for privately practicing midwives to ensure they have admitting rights and authority to practice in hospital settings,
- Appointment of a Chief Midwife,
- Take steps to address the shortage of midwives, including reviewing pathways to enter the profession, implementation of a staffing model to ensure quality care, offering competitive pay and working conditions, and prioritising recruitment to CoMC models, and
- Provide culturally safe care for Aboriginal and Torres Strait Island women and babies by investing in and expanding Birthing on Country Models, increasing the size of the Aboriginal and Torres Strait Islander maternity workforce, and implement cultural safety training.

Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032

The *Primary Health Care 10 Year Plan* was developed by the Commonwealth Government as a high-level response to the recommendations of the Primary Health Reform Steering Group and an extensive series of consultations. The following recommendations are directly relevant to the midwifery workforce:

Short term (1-3 years)

- Support more general practitioner (GP) training places; and enhanced GP, nursing, **midwifery**, nurse practitioner, allied health, and Aboriginal and

Torres Strait Islander GP training, particularly in rural Australia.

Medium term actions (4-6 years)

- Reinforce and support best practice models of **midwifery-led care** (including CoMC) for the multidisciplinary team in primary care and maternity services.

National Rural Maternity Forum

Rural and remote issues are critical in any consideration for the future of midwifery in Australia. In August 2023, the National Rural Maternity Services Forum was hosted by the National Rural Health Commissioner, Adjunct Professor Ruth Stewart, and Deputy National Rural Health Commissioner (Nursing and Midwifery), Adjunct Professor Shelley Nowlan.

The *National Rural Maternity Forum* called on the federal government to make rural maternity services a health reform priority at the next National Cabinet meeting on health [22]. Key priority actions coming out of the forum included:

- Rural birthing services be included on the agenda for a National Cabinet meeting focussed on health,
- Expansion of Birthing on Country services nationally, but also more broadly to include rural and remote maternity care,
- Secure funding for a National Maternity Workforce Plan, to build and sustain a strong rural maternity care workforce,
- Establish national minimum standards for rural maternity care access and service for national consistency, and
- Review the National Consensus Framework for Rural Maternity Services, updating it to reflect changes and advances within maternity care, and then its immediate implementation.

National Consensus Framework for Rural Maternity Services

The *National Consensus Framework for Rural Maternity Services* [23] was developed through collaboration with the Rural Doctors Association of Australia (RDAA), the Australian College of Midwives (ACM), the Australian College of Rural and Remote Medicine (ACRMM), the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the National Rural Faculty of the Royal Australian College of General Practitioners (RACGP), and Rural Health Workforce Australia.

Workforce was one of the key principles in the 2008 report:

Principle 5 - Workforce

- 5.1 The maternity care workforce in Australia must be sustained and enhanced by targeted, coordinated strategies that support collaborative care by doctors and midwives,
- 5.2 There must be targeted recruitment strategies for all members of the maternity care workforce,
- 5.3 All maternity care team members must have access to regular continuing professional development, including training in maternity emergency care, and the use of equipment that supports their current scope of practice, and
- 5.4 Terms and conditions for rural maternity service providers should recognise the additional responsibilities and on-call requirements of those providers.

This framework is currently being reviewed with a view to update by the Office of the National Rural Health Commissioner.

Professional Indemnity Insurance for midwives

The availability of affordable and effective professional indemnity insurance (PII) products for midwives has remained unfinished business over the last 15 years. The National Law requires "registered health practitioners to hold appropriate PII arrangements [as] an important part of how the National Registration and Accreditation Scheme (the National Scheme) protects the public by addressing the risk posed by uninsured practitioners" [24]. Since 2010, there has been an exemption for private practice midwives providing intrapartum services for

women planning to have homebirths, under section 284 of the National Law [24].

This exemption is strictly limited to the provision of private intrapartum care provided in a homebirth setting. Midwives working in private practice still require appropriate insurance to provide antenatal and postnatal care to women in their care, regardless of the planned location of the birth. The exemption is only available if midwives meet the requirements set out in section 284 of the National Law.

Section 284 of the National Law is a transitional provision, and this exemption will be available only from 1 July 2010 to 30 June 2025. The 2024 Federal Budget announced "$3.5 million over four years from 2024–25 (and $0.4 million per year ongoing) to expand the Midwife Professional Indemnity Scheme to include indemnity insurance cover for privately practising midwives providing low-risk homebirths and intrapartum care outside of a hospital, and for specified entities providing Birthing on Country models of care" (page 133) [25].

Consultation on expanding PII cover is underway, with a proposal that the categories set out in the ACM Consultation and Referral Guidelines [26] be used to determine women who are considered low-risk, and therefore to also determine the circumstances under which midwives will be insured. Both the ACM response to the consultation, and that of the peak body for homebirth, Home Birth Australia [27] note that the Consultation and Referral Guidelines were not intended to be used to determine place of birth. The ACM does not agree with the way in which Category B and C from the ACM Consultation and Referral Guidelines are proposed to be used to determine low-risk status as this does not require the woman's informed consent and does not facilitate the option of the midwife continuing to provide maternity care once referral to another professional has occurred.

The lack of certainty in this area is an area of acute concern for midwives who are privately employed and for women seeking intrapartum care, or to give birth, at home with a midwife.

Medicare Benefits Schedule items for midwifery

The Participating Midwife Reference Group to the Medicare Benefits Schedule (MBS) Review Taskforce made recommendations regarding midwifery services and continuity of care [28]. Access to continuity of midwifery carer was also detailed in the *MBS Review Taskforce Report on Primary Care* [29]. Several recommendations endorsed by the MBS Taskforce have still not been implemented.

It is encouraging to see that the outstanding five recommendations for MBS items for Endorsed Midwives, from the 2020 MBS Taskforce were announced in the 2024 Federal Budget allowing women greater flexibility and access to best practice primary midwifery care. These items include increasing the duration for initial antenatal appointment to 90 minutes, introducing a new item for antenatal attendance, and for complex antenatal care leading to hospital admission as well as a new 90-minute postnatal item which will allow women access to birth debriefing, and mental health and domestic violence screening [25].

Scope of practice - Unleashing the Potential of our Health Workforce

Unleashing the Potential of our Health Workforce is an independent review, led by Professor Mark Cormack. It is looking at evidence about health professionals' ability to deliver on their full scope of practice in primary care. The review aims to identify opportunities to remove barriers stopping health professionals working to their full scope of practice. It draws on examples of multi-disciplinary teams where members are working to their full scope of practice to deliver best practice primary care [30].

Key issues for midwifery in this review include a recognition that there is:

> *"improved consumer access to care, consumer experience of care and health outcomes when health professionals are enabled to work to full scope of practice. Health professionals working to full scope of practice reduces workload for the acute care sector, increases health professional*

> *utilisation and retention and creates efficiencies at a system level."*

These emerging themes were identified in Issues Paper 1 [30]:

1. **Legislation and regulation** – where legislation or regulation authorise or inhibit health professionals in performing a particular activity,
2. **Employer practices and settings** – service-level practices and settings which influence health professionals' ability to work to full scope of practice, including credentialling, role design, and employment models,
3. **Education and training** – pre- and post-professional entry learning and qualifications, including professional entry requirements and opportunities for professional development, mentoring, supervision and upskilling, and interprofessional learning,
4. **Funding policy** – the way funding and payment is provided for delivery of health care, and
5. **Technology** – integrated and accessible digital tools, communication and information sharing.

These all have relevance for midwifery, especially enabling midwives to work to their full scope of practice, the funding models that enable this, access to education and training and integrating midwifery into existing digital health infrastructure. In particular, Issues Paper 1 made specific mention to midwifery continuity of care (see Box 1).

Issues Paper 2 was released in April 2024 [31]. The review thus far described a range of challenges facing primary care health professionals. These were summarised as:

- Poor recognition of the skills that primary care health professionals have
- Inadequate preparation for primary care
- Legislation impedes health professionals working to their full scope.
- Funding and payment arrangements impede health professionals working to their full scope.

BOX 1

Midwifery Continuity Of Care

Employment practices are especially relevant for continuity of care for models such as midwifery-led care. This model provides mothers with a continuous midwife relationship across health care settings and is strongly associated with optimal consumer outcomes and improved experience. Midwifery-led care is established best practice internationally and a core National Health Service policy in the United Kingdom. In an Australian context, barriers were raised through consultation relating to midwives' scope of practice being inconsistently recognised by different health services at which they work. Removing employer-level barriers to ensure midwives are able to consistently perform activities they are trained to do, regardless of the setting in which they are providing care, has the potential to increase the provision of midwifery-led continuity of care models and therefore significantly improve patient outcomes. (Unleashing the Potential of our Health Workforce, 2024, p. 17)

One of the recommendations from Issues Paper 2 related to bundled funding for CoMC models:

> *Introduce bundled funding for the midwifery continuity of care model as a defined care pathway, to fund midwives to work to their full scope when they practise across different parts of the health care system (including primary and admitted care) which currently operate under separate funding arrangements (page 66).*

In June 2024, the ACM, the Australian College of Mental Health Nurses, the Australian College of Nurse Practitioners, the Australian College of Nursing, the CDNM, the Australian Nursing and Midwifery Federation (ANMF), the Australian Primary Health Nurses Association (APNA), and the Council of Remote Area Nurses of Australia (CRANAPlus) published a statement providing significant support for Issues Paper 2 [32]. However, they highlighted the challenges in implementation especially in the face of potential lobbying from non-supportive organisations. It is essential that the systems and processes ensure equity of access for midwifery and nursing who make up the greatest number of health professionals nationally and have the capacity to provide primary care services as autonomous providers.

Maternal, Child and Family Health nurses and/or midwives

In 2023, the NMBA commissioned a comprehensive exploration and review of the relevant literature and regulatory frameworks that govern and influence Maternal, Child, and Family Health (MCFH) registered nurses and/or midwives and their practice in Australia. Amongst other findings, the report found that for midwives that do not hold nursing qualifications, there is no evidence to suggest any current regulatory risk for the public that warrants changes to the existing regulation in place for MCFH as it is sufficient to protect the public. Midwives working in MCFH who have a postgraduate MCFH qualification are adequately prepared to practise in the MCFH area and should not require any additional regulatory intervention.

This work assists midwives to seek qualification and employment in MCFH and for health services to offer professional development programs to support nurses and midwives as they transition into MCFH for safe service delivery.

OTHER RELEVANT COMMONWEALTH STRATEGIES, INITIATIVES, OR REVIEWS

National Women's Health Strategy 2020-2030

The *National Women's Health Strategy 2020-2030* (the Strategy) outlines Australia's national approach to improving health outcomes for all women and girls in Australia [33]. The Strategy states that:

> *"maternal, sexual and reproductive health is a priority for Australian women and girls and must be considered within the social and cultural context of women's lives. It is not simply about the absence of disease, but refers to a state of physical, mental and social wellbeing across all stages of life. Factors contributing to maternal, sexual and reproductive health include the role of women in society and the control women have over their own bodies, reproductive choices and lifestyle".*

One of the key areas identified as working well was "a focus on improving maternity services and providing breastfeeding support for mothers and babies in Australia, through the development of a National Strategic Approach for Maternity Services and a new Australian National Breastfeeding Strategy 2019 and beyond" (p. 22).

Midwifery was not addressed specifically but one of the actions with relevance to the profession was to:

- Remove barriers to support equitable access to timely, appropriate, and affordable care for all women, including culturally and linguistically sensitive and safe care (p. 24).

The strategy highlighted three key priority areas for action to improve maternal, sexual, and reproductive health for Australian women and girls with relevance for Midwifery Futures:

1. Increase access to sexual and reproductive health care information, diagnosis, treatment, and services,
2. Increase health promotion activity to enhance and support preconception and perinatal health, and
3. Support enhanced access to maternal and perinatal health care services.

A new Women's Health strategy is currently being developed with leadership from the Assistant Minister of Health in the Department of Health and Aged Care.

Australian National Breastfeeding Strategy: 2019 and Beyond

The *Australian National Breastfeeding Strategy: 2019 and Beyond* [34] aims to support all mothers, fathers/partners, and babies in Australia by providing support for mothers to breastfeed. Key areas identified as needing more attention were relevant to Midwifery Futures included:

- A need for more continuity of midwifery care. If women have a known midwife, the education should start early in the antenatal period and be integrated throughout the pregnancy, the period immediately after birth, and for the first six weeks after birth,
- Support in the early days is necessary to establish breastfeeding, but mothers are discharged early from hospital and therefore do not have access to support, and therefore
- There is a need for affordable and accessible universal postnatal support services. This includes midwifery and maternal, child and family health support. There needs to be a focus on the critical transition period from hospital to home/community.

National Health Reform Agreement

The National Health Reform Agreement (NHRA) sought to improve and mature how the Commonwealth, states, and territories fund public hospitals, and to provide a platform for broader collaboration that could achieve a connected, sustainable, and equitable health system. A Mid-Term Review of the NHRA Addendum 2020-2025 was undertaken and released in late 2023 [35].

The ACM submission to the NHRA review outlined the importance of funding reform to facilitate best practice maternity care (2023) [36]. Maternity care funding is currently fragmented, spanning the MBS (for primary care by GPs and including those

with obstetric diplomas, endorsed midwives, and specialist obstetricians), public hospital funding, and private health. The overarching funding model is inefficient, costly, and non-integrated. A key driver for reform is a lack of funding integration between primary care and the acute care sectors. Current fragmented funding models negatively impact women's choice and access to best practice and timely care by presenting barriers to CoMC. Importantly, current models do not allow health professionals to work to full scope, are more costly, and outcomes are poorer.

The existing funding model deems all funding for maternity to be 'acute care'. However, this is incongruous as most women using maternity services do not fit this descriptor, given pregnancy and birth is a normal physiological process and most women are healthy. Maternity care is a predictable care pathway which, in Australia, most commonly leads to a hospital admission for birth care. Funding for maternity service provision is therefore relatively predictable and reflects a comparatively fixed cost. The maternity care sector encompasses both primary and secondary (acute or urgent) care and is fundamentally multi-disciplinary – areas recognised as poorly serviced by current funding models. The current funding model is ineffective. Shifting to bundled funding via the integration of primary and secondary care has been recognised as a priority.

The Review made 45 recommendations seeking to build on the strengths of the NHRA, while proposing reforms and initiatives to enable the health system to address current and future challenges. The key recommendations directly relevant to midwifery were:

- Recommendation 7 – Intersectional alignment and collaboration between Primary Health Networks, Local Health Networks, and Aboriginal Community Controlled Health Organisations (ACCHOs) (highlighting the importance of midwifery as a national issue),
- Recommendation 8 – Measures of primary care access, able to be monitored at the local level, should inform the operation of the NHRA (midwifery is a key primary care model),
- Recommendation 11 – The NHRA should prioritise the development of optimal models of care (which includes maternity bundled funding),
- Recommendation 13 – A structured program of work should be undertaken to develop and implement bundled payments within the NHRA for certain end to end episodes of care (before, during and after a planned hospital admission), with an initial focus on maternity care,
- Recommendation 21 – A review should be undertaken regarding the requirements and implementation of the arrangements for determining funding neutrality for private patients in public hospitals,
- Recommendation 35 - The NHRA should set out the roles and responsibilities in the governance of rural and remote health care provision and include provisions (an important recommendation for rural and remote midwifery services),
- Recommendation 36 - The importance of improving equitable access to health care services in rural and remote areas should be reflected in a new and dedicated Schedule in a future Agreement, with priority actions and milestones incorporated (another important recommendation for rural and remote midwifery services),
- Recommendation 37 - The process for the application and approval of exemptions from Section 19(2) Health Insurance Act 1973 should be reviewed, simplified, and expanded to improve access to bulk-billed primary health care (MBS-eligible GP, nursing, and allied health services) in rural and remote areas and where there are thin and failing markets (has implications for midwifery in rural and remote areas).

HELP for Rural Doctors and Nurse Practitioners

In November 2022, an initiative was introduced that reduces outstanding *Higher Education Loan Program* (HELP) debt for eligible doctors and nurse practitioners who live and work in rural, remote or very remote areas of Australia [37]. The *Higher Education Support Amendment* (2022 Measures No.1) Bill 2022 was introduced on 20 February 2023. The initiative aims to increase the number of doctors and nurse practitioners living and working in rural Australia.

The accompanying Fact Sheet [38] stated that:

> *"This initiative also allows for the waiver of indexation on outstanding HELP debts for eligible doctors and nurse practitioners while they are residing in and completing eligible work in a rural, remote or very remote area. Eligibility commenced from 1 January 2022 with any updates to outstanding HELP debts processed annually through the taxation system."*

Eligibility for nurse practitioners includes:

- Graduates from a NMBA approved program of study leading to endorsement as a nurse practitioner (Masters degree level at a minimum),
- Who accumulated a HELP debt for that qualification.

Midwifery was not included in this program.

In their pre-budget submission, the ACM recommended midwives HELP debt costs be funded similarly through this or an equivalent program to remove HELP debt at a minimum for those undertaking employment in regional, rural, and remote Australia [39].

Rural Health Multidisciplinary Training program

Another program from the Commonwealth Government is the Rural Health Multidisciplinary Training (RHMT) program [40]. This program offers health students opportunities to train in rural and remote communities via a network of training facilities. The RHMT program aims to improve the recruitment and retention of medical, nursing, dental, and allied health professionals in rural and remote Australia.

Midwifery was not included in this program. The ACM has again recommended midwifery be included [39].

Other key incentive programs

Other incentive programs with relevance to Midwifery Futures include:

- **Practice Incentives Program** that encourages general practices to continue providing quality care, enhance capacity, and improve access and health outcomes for patients [41]. This only includes general practices as defined by the Royal Australian College of General Practitioners (RACGP) and only covers GPs and nurse practitioners. *Midwives were not included.*
- **Health Workforce Scholarship Program** provides funds to the health workforce in rural areas to help upskill through professional development, training, short courses, and seminars [42]. This has been extended for a further two years until 2024-25 and includes midwifery along with medicine, nursing, allied health, dental, Aboriginal and Torres Strait Islander health professionals in the Community Controlled Health Services (sector, non-government organisations, and private practices across Australia.
- **Primary Care Nursing and Midwifery Scholarship Program** provides 1,850 postgraduate scholarships over 4 years from 2023–24 across Australia with a focus on nurse practitioners and endorsed midwives [43]. Two of the goals are to significantly increase the number of qualified nurse practitioners to support nurse-led clinics, and significantly increase the number of endorsed midwives to support our strategic directions for Australian maternity services.

Models of care for Aboriginal and Torres Strait Islander women and babies

Closing the Gap is an important national agreement that began in 2008. Indicators relating to maternity services include antenatal care, smoking in pregnancy, adolescent birth rate, and low birth weight [8]. Improved maternity services for Aboriginal and Torres Strait Islander women and babies can contribute to Closing the Gap [2, 44-46].

Birthing on Country models of care are gaining commitment across Australia and are relevant to Midwifery Futures. Birthing on Country models provide Aboriginal and Torres Strait Islander women, babies and families the best start to life with access to culturally safe and responsive maternity care provided in CoMC models, with wrap around services across the continuum of care [47, 48]. Birthing on Country has been shown to increase the number of antenatal visits, reduce rates of preterm birth by half, decrease the incidence of low birthweight babies, increase rates of breastfeeding and decrease removal of children from their families [44, 45, 49].

Enablers to support the scale up of Birthing on Country programs include growing the endorsed midwifery and Aboriginal and Torres Strait Islander midwifery workforce, also a key recommendation of CATSINaM's GENKE II report discussed earlier [18].

More broadly, the RISE Framework has been developed as a mechanism to implement Birthing on Country initiatives and provide culturally safe care [2]. The RISE Framework has four pillars to drive important reform: (1) Redesign the health service; (2) Invest in the workforce; (3) Strengthen families; and (4) Embed Aboriginal and/or Torres Strait Islander community governance and control. Another evidence-based framework under development is the Replanting the Birthing Trees initiative [3].

Another important Aboriginal-led initiative is the Australian Anti-racism in Perinatal Practice Alliance [50]. This Alliance calls for urgent transformations to Australian models of care for pregnant women -

> *"where non-Indigenous health policy makers, managers and clinicians take a proactive role in identifying and redressing ethnocentrism, judgemental and culturally blind practices, reframing the risk narrative, embedding strength-based approaches and intentionally prioritising engagement and connectedness within service delivery" (page 136)* [51].

This work highlights the value of prioritising self-determination, partnership, strengths and communication as these have demonstrated positive outcomes with, and high satisfaction from First Nations women. The Alliance also observes that mainstream maternity services could be significantly enhanced by embracing similar principles and models of care [51].

REPORTS AND INITIATIVES FROM OTHER PROFESSIONS WITH RELEVANCE

National Nursing Workforce Strategy

The Commonwealth Department of Health and Aged Care are developing a *National Nursing Workforce Strategy* to "address workforce challenges and support the nursing profession to deliver person-centred, evidence-based and compassionate care to Australian communities across all sectors now and into the future" [52].

The strategy will cover:

- Registered Nurses,
- Enrolled Nurses,
- Nurse Practitioners (NPs),
- Assistants in Nursing, and
- Nursing students.

Midwives are a separate profession and therefore out of scope. However, many midwives have dual registration so their perspective on nursing issues and the impact of the strategy on them will be considered. So far there has been broad consultation with surveys, workshops, Yarning circles, focus groups, webinars, and written submissions. The team are now analysing the results of these consultations and intend to hold another round of consultation in the second half of 2024.

Nurse Practitioner Workforce Plan 2023

In May 2023, the Commonwealth Department of Health and Aged Care released the *Nurse Practitioner Workforce Plan* [53]. The aim was to enhance the accessibility and delivery of person-centred care for all Australian communities through a well-distributed, culturally safe, nurse practitioner (NP) workforce.

The Plan sets out four overarching outcomes:

- Increase NP services across the country,
- Improve community awareness and knowledge of NP services,
- Support NPs to work to their full scope of practice, and
- Grow the NP workforce to reflect the diversity of the community and improve cultural safety.

The key themes for action include: (1) Education and lifelong learning, (2) Recruitment and retention, (3) Models of care, and (4) Health workforce planning.

RECENT INITIATIVES ANNOUNCED IN THE 2024 FEDERAL BUDGET

It was encouraging to see several initiatives highlighted in the 2024 Federal Budget to support the provision of quality maternity care through strengthening the scope and practice of midwifery. These include:

- Recognition of funding requirements for midwifery placement experience costs in the 2024 Federal Budget, although this is a small amount and means-tested.
- Funding of expanded sexual and reproductive health education for midwives in the 2024 Federal Budget. Funds allocated to the training of health professionals, including midwives, in the insertion, management and removal of long-acting reversible contraceptives.
- Five recommendations for MBS items for endorsed midwives, from the 2020 MBS Taskforce, allowing women greater flexibility and access to best practice primary midwifery care. These include increasing the duration for initial antenatal appointments to 90 minutes, introducing a new item for antenatal attendance, and for complex antenatal care leading to hospital admission, as well as a new 90-minute postnatal item which will increase women's access to birth debriefing, mental health, and domestic violence screening.
- Professional indemnity insurance provisions that will cover 100% of claim costs for privately practising midwives providing low-risk homebirth and intrapartum care outside of the hospital.
- Professional indemnity insurance coverage to enable midwives to provide intrapartum care outside the hospital in Birthing on Country models

1.3 The international context for midwifery in Australia

The Midwifery Futures project (2023-2024) understands Australian midwifery sits within a broader international context and there is value in understanding how Australia compares with other, similarly governed jurisdictions. The International Confederation of Midwives (ICM) recognises midwives as professionals who work collaboratively with women to provide maternity care across any setting, including in the home, in communities or at hospitals:

> *"The midwife is recognised as a responsible and accountable professional, who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures."* [54]

The ICM recognises the scope of the midwife in conducting births, including attending home births within national health systems with appropriate access to referral services as required [55]. The international scope of practice further recognises that midwifery practice may extend to sexual and reproductive healthcare as well as care for young children [54]. Access to midwifery care is considered a basic human right [56]. CoMC is recognised as a professional standard and the preferred model of care in most jurisdictions comparable to Australia, including Aotearoa New Zealand [57], Canada [58, 59], and the United Kingdom [60-62]. Prescribing authority is also recognised as a core competency, while subject to local regulations [57, 59, 60, 63].

Regulation of the midwifery profession varies. In Aotearoa New Zealand [57, 64] and Canada [63], midwifery is overseen by autonomous midwifery regulatory authorities. By contrast, in Ireland [65], midwifery regulatory authorities operate in conjunction with nursing. Midwives practising in Canada are registered and regulated at a provincial level rather than at a federal level [63].

Many of the challenges faced by midwifery workforces internationally are similarly experienced by the Australian midwifery workforce. This includes shortages in workforce numbers, aging workforces, poor workplace culture, and inadequate supports for Indigenous midwives [62, 66]. Financial pressures are also recognised as a factor for attrition among midwifery students in other countries [66]. Some jurisdictions, such as Aotearoa New Zealand, have funded transition-to-practice programs for recently qualified midwives through clinical practice support, mentoring, and access to professional education [67].

Midwifery registration in Australia and similar international jurisdictions requires the completion of a suitable education program [54]. Most pre-registration midwifery education programs internationally are offered as an undergraduate qualification with a duration of 3-4 years and employ a blend of theoretical and practical learning [68-70]. A commitment to CoMC is reflected throughout midwifery education standards globally where it is expected that CoMC experiences are embedded within programs [64, 71-74]. For example, the Nursing and Midwifery Board of Ireland requires students to experience 4 weeks of midwife-led care and to follow one woman through a continuity of carer experience [68]. Some countries mandate minimum numbers of hours and experiences within education programs. Some require more, and some less, than current ANMAC Standards.

Both Aotearoa New Zealand and Canada provide important examples of how midwifery scope of practice and education can support Indigenous midwives, and the provision of culturally appropriate care for Indigenous communities. The New Zealand government has recognised challenges for Māori and Pasifika midwifery students and the need to increase the numbers of Māori and Pasifika midwives in the workforce, so midwifery represents the communities it serves [70]. Te ara ō Hine is a new initiative to support and increase Māori and Pasifika midwifery students where funding enables at least one lead support provider, built-in tutoring and guidance, annual hui to help build relationships, and a national network of Māori and Pasifika midwifery students [70]. Discretionary hardship funds are also available. Moreover, midwifery education programs offer flexible and distance learning options that support students who are based outside of urban areas [64]. Cultural competency has been a requirement for

midwifery registration in New Zealand since 2007 and Turanga Kaupapa (cultural competency guidelines) have been integrated into midwifery education since 2008 [75]. Internationally qualified midwives seeking registration in New Zealand are required to complete a mandatory cultural competence course [75].

The Canadian Association of Midwives acknowledges the distinct traditional role Aboriginal midwives have held with Indigenous, First Nations, Inuit, and Metis communities in Canada. The Canadian Association of Midwives notes the need to include extended families, and to acknowledge the value of traditional oral and experiential knowledge for Aboriginal midwives and communities as part of optimising birth outcomes and providing culturally safe care [76]. Canadian education providers offer two community-based pre-registration programs across three Indigenous communities that emphasise learning, practices, and standards from and appropriate to specific Indigenous cultures [69]. A need for further federal investment in Indigenous midwifery is recognised [77].

Shortages in the midwifery workforce are also a global issue [78] with many countries having difficulty recruiting and retaining midwives. For example, in Aotearoa New Zealand, midwives have been identified as a workforce under pressure. It has been estimated that the health system is currently 1,050 midwives short, equating to 40% of the current workforce [66]. In England, it is estimated the hospitals have a shortage of 2,500 midwives, with understaffing placing unacceptable levels of pressure on staff, and comprising the safety and quality of care women receive [79, 80].

Australia is similar to many other countries in terms of regulation, education standards and scope of practice. The Midwifery Futures Project was undertaken within this global landscape.

Chapter 2: Midwifery Futures Project – Governance and Methods

2.1 Governance

The Midwifery Future Project was guided by an *Expert Advisory Group* (EAG). Members of the EAG included representatives from the NMBA, the CNMOs, the ACM, ANMAC, the ANMF, CATSINaM, the CDNM, the NMBAs Notification Committee: Midwifery (National), and community members.

A *Working Advisory Group* (WAG) was also established to review outputs from the project as they occurred and provide advice to the Project Team. Members of the WAG included representatives from the ACM and the ANMF, as well as midwifery policy officers / principal advisors from each Australian jurisdiction, subject matter experts, and consumers.

An *Aboriginal and Torres Strait Islander Yarning Circle* was established to advise the project and provide an Aboriginal and Torres Strait Islander perspective and guidance.

A *Consumer and Lived Experience Expert Panel* was established to advise the project team, EAG and WAG. Two consumers from this group also sat on the EAG and WAG.

Each of these groups met three to four times during the life of the project.

A *Project Control Group* was also established at the outset and met every two to four weeks for the life of the project. The Project Control Group included the NMBA Chief Executive Officer, the NMBA Project Team and other key staff, and the Midwifery Futures Project team led by the Burnet Institute.

2.2 Methods

The Midwifery Futures project included five key components: workforce modelling, scoping reviews, online surveys, focus groups and interviews, and the Midwifery Futures national symposium.

1. WORKFORCE MODELLING

The workforce modelling utilised routinely collected data from the NMBA and the Australian Government's National Health Workforce Database (including historic and current numbers of midwifery students and midwives), as well as the Australian Bureau of Statistics and the United Nations World Population Prospects 2022 (for the number of births). The Midwifery Futures project team collaborated with international data experts Novametrics to produce a workforce model that considered the current Australian midwifery context and robustly predicts future Australian midwifery workforce trends.

The full-time equivalent numbers of midwives were calculated as the percentage of the headcount of midwives who were engaged in a clinical role (given as 79% in 2019 by Health Workforce Australia) [81], corrected for the proportion of hours actually worked in a 38-hour working week (20 hours according to Health Workforce Australia). Modelling for future requirements assumed that one full-time equivalent midwife is required for every 40 pregnant women in a standard rostered model. This was the average workload for each full-time equivalent midwife in Australia between 2018 and 2022. Projected pregnancy numbers were derived from the United Nations World Population Prospects [82] 2022 database, with individual state estimates based on Australian Bureau of Statistics proportions for 2022.

The headcount required in future predictions considered outflows (defined as deaths, retirement at age 67, plus those leaving the register for other reasons) and inflows (defined as graduate registrations and immigration). Expected proportions for those leaving the register and immigrations were imputed from historical data as this data was not reported by the NMBA or the Health Workforce. As is the case with all future modelling predictions, we are unable to account for unexpected future events and were limited by the absence of data for some of the key variables (such as the number of midwives leaving the register).

2. SCOPING REVIEWS

Scoping reviews are useful for understanding complex and heterogeneous literature. Five scoping reviews were planned for the Midwifery Futures project to map and report the extent of existing research. The reviews covered the follow key areas:

Australian Women's Maternity Care Needs

This review aimed to describe and analyse the current literature on maternity care needs of women in Australia. A total of 59 peer-reviewed research articles were included and examined using inductive content analysis. This review has been completed and published [1].

Midwifery Prescribing

This review aimed to understand midwifery prescribing practices globally in the context of relevant regulatory standards and policy frameworks. Analysis included 21 academic publications and grey literature on global policy and regulation. A report of this review has been completed and provided to the NMBA, and findings from this review are incorporated into this report. An academic paper with the results of this review is being drafted for future publication.

Australian Midwifery Workforce Issues and Education Needs

The aim of this review was to understand the current state of empirical research on the workforce issues experienced by and post-registration education needs of midwives in Australia. In total, 88 publications met inclusion criteria. Data analysis for this review has been completed and findings from this review have been incorporated into this report.

Aboriginal and Torres Strait Islander Midwifery

This review aimed to understand the experiences of Aboriginal and/or Torres Strait Islander midwives and midwifery students in Australia. A team of Aboriginal and / or Torres Strait Island midwifery academics led this work, and the paper is under review. Findings from this review are included in this report.

Midwifery Education

This review aimed to understand the current state of pre-registration midwifery education in Australia, inclusive of factors influencing intake, attrition and retention, and areas of success and improvement in course content. During the development of literature searches, we identified an integrative review that significantly overlapped with our intended review [83]. McKellar et al.'s review examined the historical and current drivers, supports and impediments for pre-registration midwifery programs to identify strategies for strengthening Australian midwifery education. Due to the similar nature of these aims, we chose not to proceed with our review and draw on the findings of the existing work completed in this area in this report.

3. SURVEYS

Three online surveys were conducted between November 2023 and January 2024 to understand the experiences of three key midwifery cohorts in Australia. These cohorts were:

- Midwives on the NMBA register,
- Midwifery students, and
- Midwifery educators in the university sector.

Midwives on the NMBA register

All currently registered midwives in Australia were invited through an email from the NMBA. In total, 3,286 eligible responses were received (Table 1). Midwives who provided data for the Midwifery Futures workforce survey were asked how long they had practiced in Australia. We defined recently qualified midwives as those who entered practice in Australia in the last five years. After data cleaning to minimise the number of midwifery registrants who had entered the Australian workforce in the past five years after working in another country, 659 recently qualified midwives remained. Additional questions were offered to recently qualified midwives as we were interested in their experiences of midwifery education and their transition from being a student into professional practice as a midwife.

Table 1 : *Characteristics of midwifery workforce survey participants*

T.1

DESCRIPTION		N	% OF TOTAL
Gender (n = 2,277)	Woman	2206	96.8
	Man	31	1.4
	Non-binary / other / prefer not to say	40	1.8
Age (years) (n = 2,265)	<30	193	8.5
	30-39	415	18.3
	40-49	435	19.2
	50-59	631	27.8
	60-69	524	23.2
	> 70	42	1.9
	Prefer not to say	25	1.1
Years in midwifery practice in Australia (n = 3,203)	5 or fewer	702	22.8
	6-10	525	16.4
	11-15	417	13.0
	16-20	365	11.4
	> 20	1,194	37.3
State / territory of practice (n=1,445)	ACT	61	4.2
	NSW	356	24.6
	NT	37	2.6
	QLD	253	17.5
	SA	106	7.3
	TAS	41	2.8
	VIC	425	29.4
	WA	167	11.6
	Prefer not to say	9	0.6
Rurality of place of practice (n = 2,587)	Metropolitan	1,485	57.4
	Regional	701	27.1
	Rural	317	12.3
	Remote	84	3.2
Language spoken at home (n = 2,245)	English	2,206	98.3
	Other	30	1.3
	Prefer not to say	9	0.4
Aboriginal and / or Torres Strait Islander people (n = 2,400)	Aboriginal	40	1.7
	Torres Strait Islander	0	0
	Both	3	0.1
	Neither	2,357	98.2
Highest level of education (n =2,985)	Hospital based certificate	555	18.6
	Undergraduate degree	763	25.6
	Graduate Diploma	1,078	36.1
	Masters	498	16.7
	Doctorate	62	2.1
	Rather not say	29	1.0
Endorsement for scheduled medicines (n = 3,189)	Yes	299	9.4
	No	2,890	90.6

Midwifery Educators

This survey was open to midwives working as a midwifery education provider at a university that offered a program leading to registration at the time the survey was conducted. Educators at all levels and contract types were invited to participate. The Trans-Tasman Midwifery Education Consortium assisted with distribution of the survey. In total, 36 eligible responses were received (Table 2 has participant characteristics). All states and territories were represented except the Australian Capital Territory (ACT) and Tasmania.

Table 2 : *Characteristics of midwifery educator survey participants*

T.2

DESCRIPTION		N	% OF TOTAL
Gender	Female	17	94
	Prefer not to say	1	6
Age	<39	3	17
	40-49	2	12
	50-59	6	32
	60-69	4	22
	> 70	1	6
	Prefer not to say	2	11
How long have you worked as a midwife?	<6 years	1	6
	6-10 years	1	6
	11-20 years	4	23
	> 20 years	12	65
Years in the education sector	<3 years	3	17
	3-5 years	4	22
	6-10 years	5	27
	11-15 years	3	17
	>15 years	3	17
Title	Tutor	1	6
	Clinical Midwifery Facilitator	1	6
	Lecturer	9	50
	Senior Lecturer	4	22
	Associate Professor / Professor	3	17

Midwifery Students

Midwifery students currently enrolled in a tertiary midwifery education program in Australia and students who recently completed a program but had not yet commenced midwifery employment were invited through an email from the NMBA. In total, 303 eligible responses were received (Table 3).

All three surveys were comprised primarily of quantitative questions, with several opportunities for open-ended responses. Data analysis for the three surveys used descriptive and inferential statistics for the quantitative data and inductive content analysis of the qualitative data. Findings from the three surveys are included in this report, and selected findings will be published at a later date.

Table 3 : *Characteristics of midwifery student survey participants*

T.3

DESCRIPTION		N	% OF TOTAL
Program (n=303/303)	**Bachelor of Midwifery**	214	70.6
	Bachelor of Midwifery / Bachelor of Nursing*	25	8.3
	Graduate Diploma of Midwifery	48	15.8
	Master of Midwifery **	16	5.3
Enrolment location (n=299/303)	ACT	15	5.0
	NSW	67	22.4
	NT	39	13.0
	QLD	71	23.7
	SA	26	8.7
	TAS	1	0.3
	VIC	42	14.0
	WA	38	12.7
Enrolment FTE (n=302/303)	Full-time	231	76.5
	Part-time	70	23.2
	Casual	1	0.3
Disability or chronic condition (n=264/303)	No	229	86.7
	Prefer not to say	4	1.5
	Yes	31	11.7
Aboriginal or Torres Strait Islander (n=262/303)	Aboriginal	10	3.8
	Aboriginal and Torres Strait Islander	0	0.0
	Torres Strait Islander	0	0.0
	Neither	250	95.4
	Prefer not to say	2	0.8
Gender (n=264/303)	Woman	259	98.1
	Man	3	1.1
	Non-binary	1	0.4
	Prefer not to say	1	0.4
Language used most often at home (n=260/303)	English	248	95.4
	Other***	12	4.6

* *Includes Bachelor of Midwifery / Bachelor of Nursing and Bachelor of Science (Midwifery) / Bachelor of Science (Nursing).*

** *Includes Master of Midwifery and Master of Midwifery Practice.*

*** *Includes Arabic, Cantonese, French, Hindi, Japanese, Malayalam, Mandarin, Portuguese, Persian/Dari, Vietnamese or preferring not to say*

4. FOCUS GROUPS AND INTERVIEWS

Focus groups and interviews were conducted with key stakeholders to generate rich qualitative data pertaining to the current challenges experienced by the midwifery workforce and to identify potential solutions. Key stakeholders included CNMOs, endorsed midwives, midwifery students, midwives working in rural and remote settings, midwifery managers, and key midwifery regulation and education leaders (Table 4). A total of twelve focus groups and six interviews were held across Australia. Focus group and interview transcripts were analysed using thematic analysis, and findings are included in this report.

Table 4 : *Characteristics of focus group and interview participants*

T.4

DESCRIPTION		N = 83
Stakeholder Group*	CNMOs	2
	Midwifery Students	18
	Rural, Regional and Remote Midwives	0
	Midwifery Managers	21
	Key Stakeholders	8
	Endorsed Midwives	11
	Clinician Midwifery Researchers	6
	ACM State Conference Midwives	10
	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)#	7
	Royal Doctors Association of Australia (RDAA)#	10
Location	ACT	2
	NSW	18
	NT	0
	QLD	21
	SA	8
	TAS	11
	VIC	6
	WA**	10
	National	7

* *Determined based on the capacity in which participants engaged with the project. Participants may occupy multiple professional roles external to engagement with the Midwifery Futures project that are not captured here.*

** *Not included here were attendees at the ACM state conference in Western Australia who were involved in consultative process to assist with the development of interview and focus group aims and questions prior to project commencement.*

\# *Other medical colleges were invited but did not respond to the invitation*

5. National Midwifery Futures Symposium, March 2024

The Midwifery Futures Project Team convened the Midwifery Futures National Symposium in Sydney, New South Wales on 14th March 2024. The Symposium brought together key stakeholders in the midwifery profession with the aim of generating solutions and recommendations to key issues facing the future Australian midwifery workforce.

A total of 119 key midwifery stakeholders were invited to the National Symposium. Attendees represented key organisations from across Australia, including ANMAC, the ANMF, Commonwealth Departments, CATSINaM, and CRANAplus (Table 5). Prior to Symposium proceedings, attendees were provided a comprehensive discussion paper outlining existing research, providing an overview of the Midwifery Futures operating context, and presenting preliminary findings from Midwifery Futures research.

Table 5 : *Characteristics of National Midwifery Futures Symposium attendees*

T.5

DESCRIPTION		N = 119	PERCENTAGE (%)
Organisation	Ahpra	4	3.4
	ANMAC	5	4.2
	ACM	7	5.9
	Australian College of Nursing	2	1.7
	ANMF	6	5.0
	CATSINaM	4	3.4
	Commonwealth Departments	7	5.9
	CRANAplus	2	1.7
	Local hospitals and health services	33	27.7
	NMBA	8	6.7
	Research institutes	3	2.5
	State health services	20	16.8
	Universities	14	11.8
	Women's advocacy and support organisations	4	3.4
Location	ACT	11	9.2
	NSW	13	10.9
	NT	4	3.4
	QLD	14	11.8
	SA	7	5.9
	TAS	4	3.4
	VIC	13	10.9
	WA	8	6.7
	National	44	37.0

2.3 Conclusion

The Symposium programme was divided into two components. In the first component, speakers from the Midwifery Futures Project, the National Maternity Workforce Review Project, and National Nursing Workforce Strategy outlined key findings and relevant research. The second half of the programme was dedicated to discussion and solution generation. Attendees were allocated into 12 break-out groups by the research team to ensure maximum diversity of views. Break-out groups were each asked to discuss and generate solutions relating to 3 key topics: future educational pathways for midwives, workforce solutions to support CoMC models, and improving workforce recruitment, retention and attrition. The day culminated with groups working to draft suggested workforce recommendations.

Symposium attendees were asked to record proposed solutions and recommendations in written form throughout the day. Attendees were advised that these written records would be collected and analysed by the research team. Records of break-out group topic discussion were thematically analysed by the research team and synthesised with findings from focus groups and interviews. Recommendations generated during the Symposium (Appendix C) were used alongside broader project findings to inform the development of the recommendations outlined at the conclusion of this report.

This chapter has provided an overview of the four governance groups for Midwifery Futures. It has also provided an overview of the methods that guided data collection in the Midwifery Futures project including the workforce modelling, scoping reviews, online surveys, focus groups and interviews, and the Midwifery Futures national symposium.

The next chapter provides the findings from the Midwifery Futures. Data from the various components of the project have been woven through the findings. Case study examples appear in boxes through this section to illustrate innovative approaches to midwifery care provision and examples of good practice.

Chapter 3: Findings

3.1 What does the future look like for Australian midwifery?

3.1.1

THE NUMBER OF MIDWIVES

According to NMBA data from June 2023 [84], midwives constitute 3.9% of the regulated health practitioner workforce in Australia. At that time, midwives made up 124.9 per 100,000 head of population nationally. The Northern Territory had the highest proportion of midwives to head of population (220.9 per 100,000) and New South Wales the lowest (104.3 per 100,000).

As of June 2024, 33,358 midwives had general registration with the NMBA, an additional 1,143 were registered as non-practising, and nine had provisional registration – a total of 34,510 registrants (Table 6). Of those, 26,227 midwives (75.9%) were dual registrants (both nursing and midwifery).

Table 6 : *Practising (those with general registration) and non-practising midwives by state or territory April to June, 2024, NMBA.*

T.6

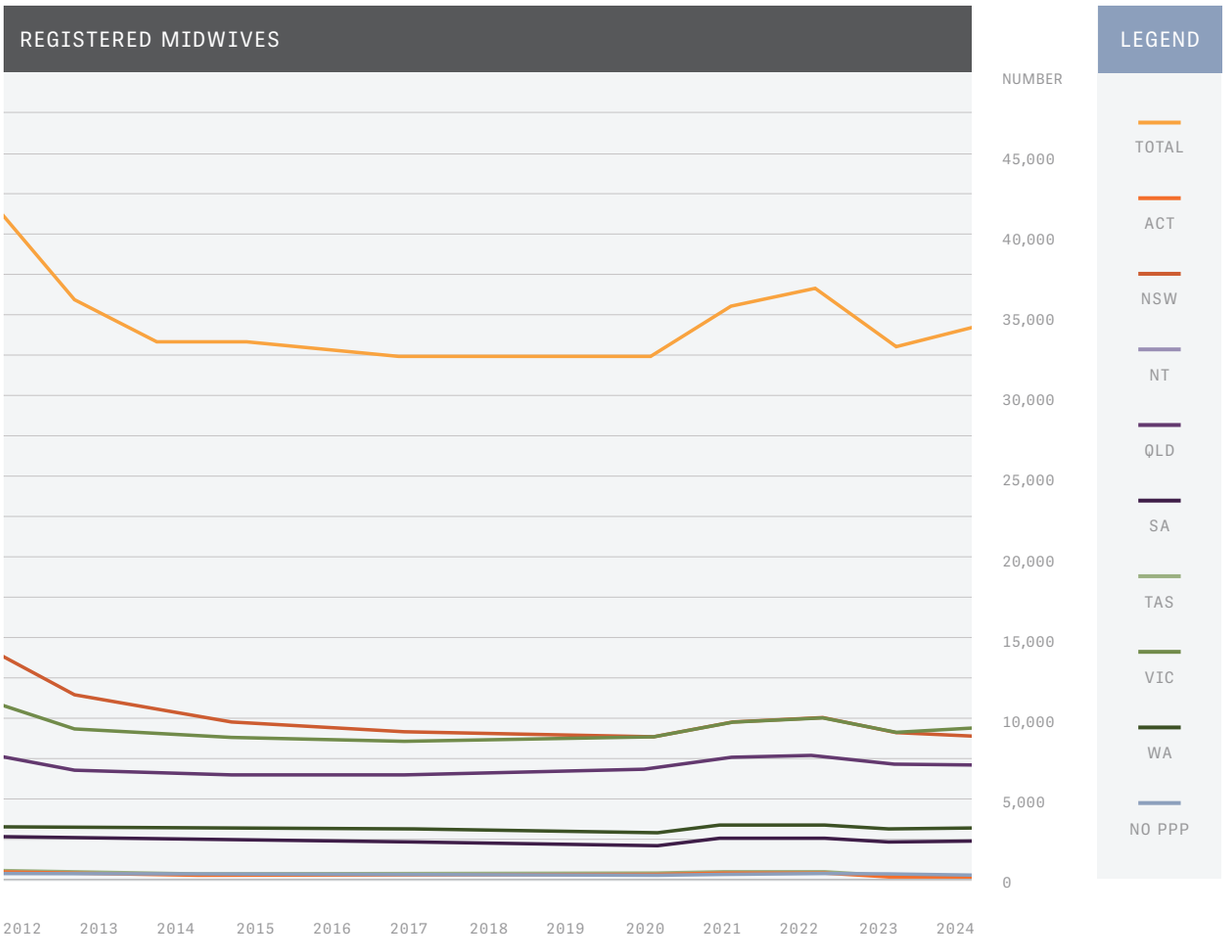
STATE / TERRITORY	GENERAL	NON-PRACTISING
Australian Capital Territory	642	34
New South Wales	8,629	375
Northern Territory	549	8
Queensland	7,141	204
South Australia	2,436	102
Tasmania	689	17
Victoria	9,353	247
Western Australia	3,359	87
No primary place of practice	560	69
Total	33,358	1,143

The number of midwifery registrants fell between 2012 and 2014 (Figure 1). This likely reflects a period of adjustment to the shift to national registration with Ahpra and changed regulatory standards in relation to recency of practice and continuing professional development. From 2015, total registrant numbers remained stable until 2020 (Figure 1). Much of this rise may be due to the return of midwives to the register in response to national calls for additional health professionals during the COVID-19 pandemic, or a delay in retirement. By March 2023, the number of registrants had returned to pre-pandemic levels.

Victoria had the largest number of registrants, and the Australian Capital Territory the least. Fluctuations in the number of registrants in each state and territory over the past decade mirror those seen for the national statistics (Figure 1).

Figure 1 : *Registered midwives by state / territory over time – March 2012 - March 2024, NMBA*

F.1



The mean age of midwives in June 2023 was 47 years [84]. The number of registered midwives according to age category in June 2024 is provided in Table 7. Midwives aged 55 years or more (and therefore eligible for retirement in the next decade) made up 34.8% of those with general registration. A similar proportion (37.8%) of midwives with general registration were aged under 40 years.

The recent rise then fall in registrant numbers was most prominent for midwives aged 60 years and above (Figure 2). There has been a slow rise over time in the number of registrants under the age of 40 years, while there has been little change over time in the number of registrants in the 40 – 44 years age range. A consistent decline in numbers was seen for registrants aged 45 to 59 years since 2014.

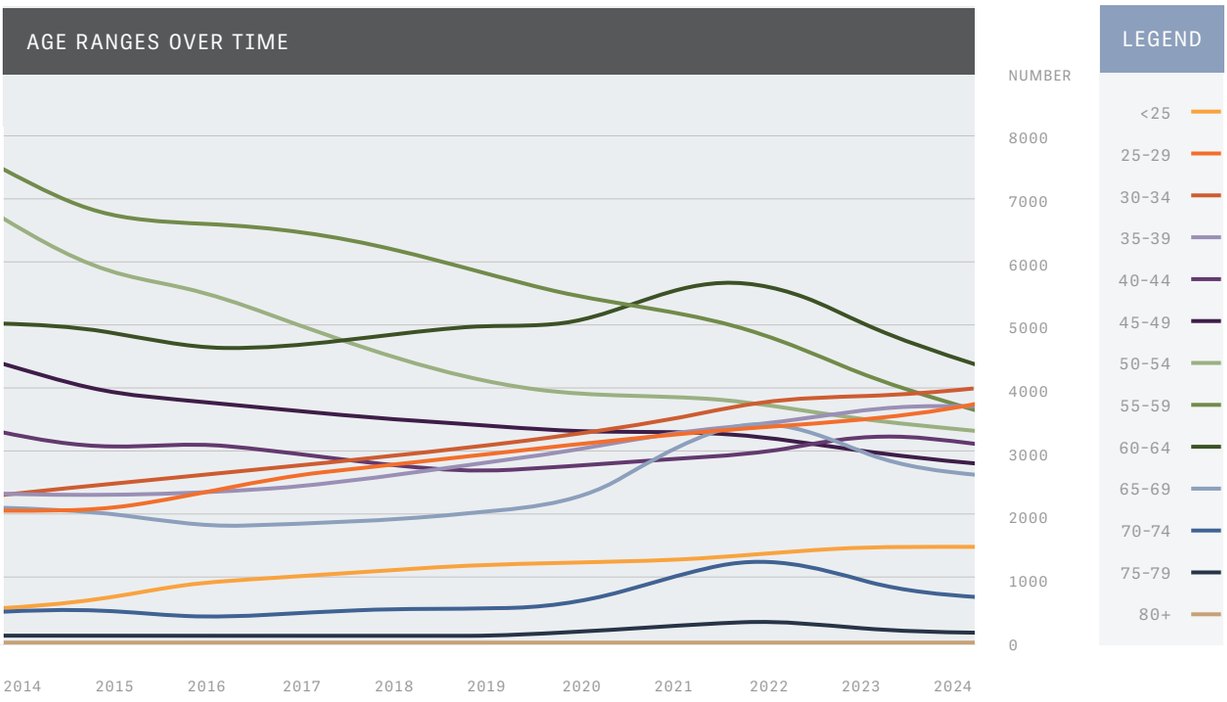
Table 7 : *Practising and non-practising midwives by age category April to June 2024, NMBA.*

T.7

AGE CATEGORY	GENERAL	NON-PRACTISING
<25	1,368	8
25-29	3,719	44
30-34	3,965	56
35-39	3,649	72
40-44	3,117	59
45-49	2,793	57
50-54	3,269	79
55-59	3,620	100
60-64	4,475	208
65-69	2,633	265
70+	930	195

Figure 2 : *Registered midwives by age over time – March 2014 - March 2024, NMBA.*

F.2



3.1.2

IS THERE CURRENTLY A SHORTFALL IN THE MIDWIFERY WORKFORCE?

Research exploring the potential for a future shortfall in the midwifery workforce is not confined to recent years, with concerns about potential shortfalls in the Victorian midwifery workforce raised in 2008 [85]. They noted a high proportion of midwives were employed on a less-than-full time basis at that time.

In more recent years, Callander et al. [86] projected future workforce numbers would fall in comparison to the number of registered midwives in 2018, returning to this number by 2038 if conditions impacting workforce entry and attrition remained constant. Their 2023 projected figures were accurate in comparison to the published NMBA statistics from that year for younger aged midwives, but midwives above the age of 55 remained on the register at higher than predicted rates. This might have been a temporary effect of recruitment efforts to shore up the midwifery workforce during the COVID-19 pandemic. Many of this older cohort will retire over the next five to ten years leaving a crisis in the midwifery workforce numbers.

In the Midwifery Futures survey, we asked midwives working in managerial roles whether their maternity service was currently fully staffed with midwives. Only 2.2% answered yes. Most (53.9%) indicated staff turnover was higher than prior to the pandemic. Only 14.1% reported being able to fill all advertised midwifery positions in the previous 12 months, with 83.9% indicating that recruiting midwifery staff was difficult or very difficult.

Answers provided to the question of whether midwifery managers wanted us to know anything else about the midwifery workforce confirmed the current challenge of ensuring adequate staffing levels, with one manager describing it as "the most challenging time I have ever experienced in my 20 years in the service". Rural and regional settings were noted to be even more challenged in relation to adequate staffing. A respondent described their concerns about this:

> *"It is getting so bad that rural and regional maternity settings are becoming untenable to run. I am incredibly concerned about displacing more women from their homes and families in these settings as we try to keep maternity services open with no midwives."*

In addition to low numbers of staff, managers also reported reductions in hours worked per midwife. Midwives participating in Midwifery Futures interviews and focus groups reported workforce shortfalls in their areas, with increased levels of attrition particularly for early-career midwives. Maldistribution of the workforce was also described, with more acute shortages in non-metropolitan maternity services.

Other findings from our survey of midwives also suggest workforce staffing concerns are common. We asked respondents to rank their level of satisfaction in their current role with several issues on a scale of 1 (not at all satisfied) to ten (extremely satisfied). For staffing levels and skill mix, 47.9% selected a ranking of one to four, indicating dissatisfaction. With respect to workload, 54.5% of respondents selected a ranking of one to four.

Current workforce numbers from the NMBA register have returned to the pre-COVID-19 baseline, suggesting there are no current national workforce shortages. However, data from the Midwifery Futures survey and focus groups, along with previously published workforce models, demonstrate a lack of secure workforce provision for the future. One potential explanation for the mismatch between registrant numbers and people's experiences in midwifery workplaces may be that not all midwives are working as midwives, or they are not engaged in providing clinical care. Our survey findings provide valuable insights into the current employment experiences of midwives.

CS.1

CASE STUDY

Supporting rural and remote based midwives to provide quality care

Western Australia (WA)

WA Country Health Service is the largest health service by area in the world, dispersed over 2.5 million square kilometers. Several innovative support services have been implemented to support midwives working in isolated or resource limited services to provide quality clinical care. These include:

Antenatal Education via Telehealth - Positive Birth Program

During the pandemic, face-to-face local antenatal education programs were shifted to a telehealth service and the Positive Birthing Program is now offered to all families living in country WA. Rural and remotes midwives are supported by the program as marketing of the program means more women are engaged in childbirth preparation and are better prepared to participate in their antenatal and intrapartum care.

Telehealth Lactation consultant service

Telehealth lactation consultant services provide lactation support to women living in country WA. Most country midwives felt this was an essential adjunct to care as it reduced the need for midwifery care and prevented some re-presentations and readmissions.

Midwifery and Obstetrics Emergency Telehealth Service (MOETS)

MOETS provides expert midwife and obstetrician advice to all WA health services around the clock. MOETS supports midwives by providing clinical advice and second opinions, logistical support during transfers to free up local staff to provide the clinical care, oversight and scribing during emergencies, and mentoring support for newly qualified midwives and midwifery students.

Midwives who work in rural or remote locations play a critical role in ensuring positive maternal, newborn, and family health. Midwives may be the only health professional providing regular face-to-face health services within a community. They are often the only midwife on shift with a high burden of responsibility and requirement to be skilled across the full spectrum of care. These initiatives provide practical and expert advice to support the work of local midwives as they deliver quality care for rural and remote communities.

3.1.3

WHAT WORK ARE MIDWIVES DOING IN AUSTRALIA?

Our survey of midwives registered in Australia provided additional information about what work midwives were doing (Table 8). More than three-quarters (77.8%) of the 3,286 midwives who provided survey responses were working as a midwife, and of these, 66.1% worked only in midwifery. Of the respondents who said they were working as a midwife, 78.7% were providing clinical care, 11.7% worked in a management role, 6.8% in research or academia, 2.6% in policy work, and 9.7% in other roles (respondents could select multiple options if they worked in more than one role). Answers to the "other" role question demonstrated the diversity of roles held by midwives, including working as a MCHF nurse or midwife, or working in midwifery plus a role other than nursing, such a working as a lactation consultant or paramedic, or in the fields of public health, safety and quality, or research and / or education.

Most survey respondents worked less than full time, with 30.5% reporting working 26 to 35 hours per week. Only one in five worked full time (36 – 38 hours per week, 19.2%) and 7.8% worked more than 38 hours per week. For those working less than full time hours, some also worked in another (non-midwifery) job or had reduced their hours as they were approaching retirement or had parenting responsibilities. Some chose reduced hours because

Table 8 : *Midwives' roles from workforce survey data, n = 2460.*

T.8

ROLE	NUMBER	%
Hospital based	1,396	56.7
Antenatal clinic	80	3.3
Birthing	298	12.1
Postnatal	227	9.2
Community / domiciliary postnatal visiting	64	2.6
Midwifery group practice	140	5.7
Team Midwifery	50	2.0
Antenatal / Day Assessment / Maternal Fetal Medicine	33	1.3
Specialist Midwife	57	2.3
Midwifery manager	136	5.5
Lactation consultant	49	2.0
Casual midwife	146	5.9
Hospital Education	66	2.7
Private practice	101	4.1
Full scope of practice including homebirth	44	1.8
Full scope of practice excluding homebirth	32	1.3
Limited scope of practice	25	1.0
Child and family health / maternal child health nurse / midwife	147	6.0
Policy work	30	1.2
University education	50	2.0
Research midwife	45	1.8
Other	696	28.3

of physical injuries or to prevent or manage burnout. Only one respondent who was working part-time indicated a desire to work more hours.

Some in full time work indicated a desire to reduce their hours, but that this was not possible because of the position description or because of personal financial pressures. Others described their enjoyment of their work or a desire to build their experience and confidence. Among those working more than full time, some explained they were in senior management roles that required this, and others indicated their service was short-staffed, so they were undertaking overtime work.

Over half the respondents were engaged in hospital-based roles as their main role in midwifery (54.7%), with birthing services being the most common of the hospital-based roles (12.1%). Midwifery group practice (5.7%) and team midwifery models (2.0%) where less often selected. Of the 4.1% of midwives who were working in private practice, 43.6% indicated they were providing homebirth services.

When asked what their preferred roles would be if they had that choice, 37.5% of respondents selected midwifery group practice, 33.3% selected standard hospital care roles, and 23.6% chose private midwifery practice. This suggests that there is a strong interest in working in midwifery group practice and private midwifery practice, but there are barriers limiting midwives from doing so.

Our findings provide evidence that while the headcount of midwives on the register suggests adequate numbers, this does not account for the proportion of midwives not working in midwifery and not providing clinical care. Non-clinical roles are essential to support the development of the profession. It is important that workforce models account for midwives in non-clinical roles and do not assume that all midwives are participating in clinical care.

The high proportion of midwives working less than full time hours also makes it clear that workforce models need to account for part-time work. As the average number of hours worked per midwife falls, a larger head count of midwives is needed to meet the maternity care needs of Australian women and families.

3.1.4

INTENTION TO LEAVE MIDWIFERY

Over the past decade, researchers have asked midwives about their intention to leave midwifery, with rates of 23% in the next 10 years [87], 27% in the next 5 years [88] and 35% having considered leaving during the previous six months [89], reported in the literature. The FUSCHIA study also showed high proportions of midwives considering leaving the profession due to feeling "worn out", experiencing "work-related stress", and being "disillusioned with midwifery" [19].

Among midwives who completed the Midwifery Futures workforce survey, 46.0% indicated they were currently considering leaving their current job, and 36.6% indicated they were considering leaving the midwifery profession. Of the respondents considering leaving (we call them leavers in this analysis), 70.1% were considering leaving for reasons other than retirement, and 68% were under the age of 50 years. This is concerning, as it represents a significant loss of workforce potential.

3.1.5

MODELLING THE FUTURE WORKFORCE – BEST CASE SCENARIO

The Midwifery Futures workforce model was based on assumptions of:

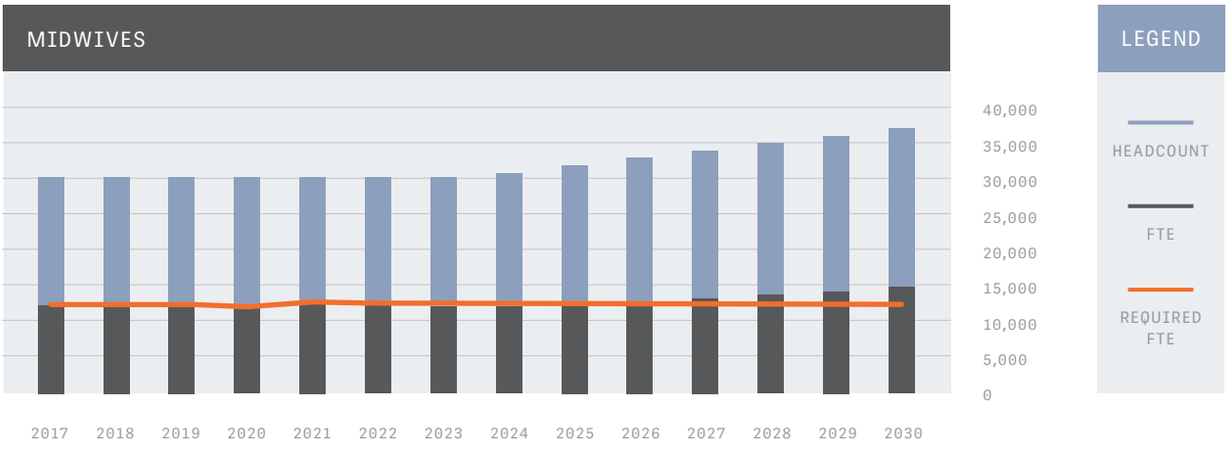
- A full-time workload of caring for 40 women per year,
- 79% of the workforce engaged in a clinical role,
- Average hours worked per midwife of 20 hours per week,
- An immigration rate (of midwives trained out of Australia entering midwifery registration) of 2.4%,
- No leavers (other than deaths and retirement of all midwives at age 67), and
- 1,305 new Australian graduates joining the register annually.

Based on these figures, the total number of midwives in Australia is expected to increase in future years (Figure 3). Over the same period, the expected number of pregnant women and gender diverse people was forecast to remain stable. Consequently, by 2030, numbers of midwives should be enough to reduce the average workload per midwife (from 40 to 34 pregnancies per midwife per annum), or to reduce the need to replace midwives who leave the workforce.

Most states and territories showed a similar pattern to the national estimate, with a forecast increase in midwives compared with the number required to maintain the current workload. The main exception is South Australia, where a shortage of 61 full-time equivalent midwives (7% of the total) was forecast for 2023. This shortage was forecast to then reduce slowly until in the shortage ceased to exist 2030.

Figure 3 : *Modelled number of midwives for Australia 2023 – 2030.*

F.3

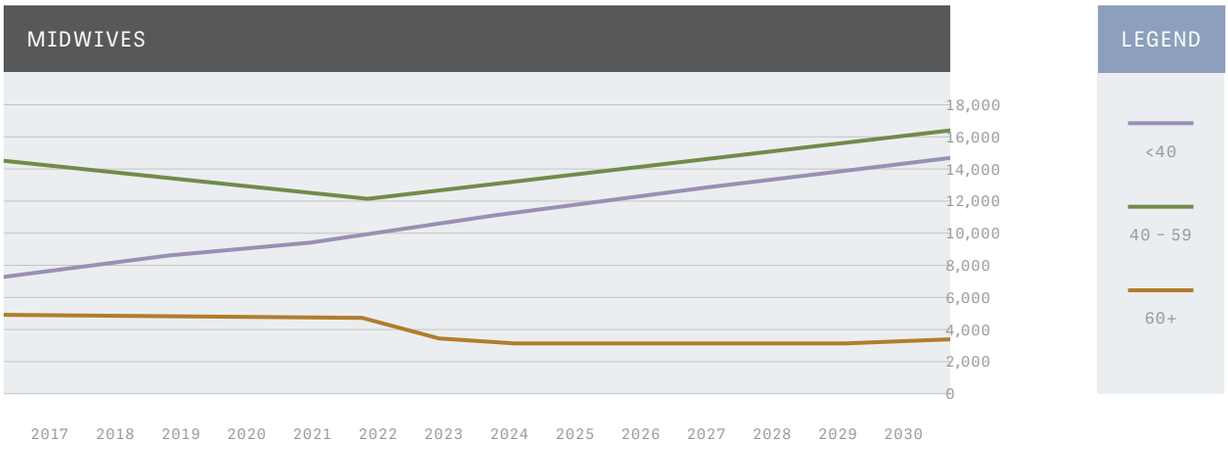


Using the same assumptions, we predicted how the age profile of Australian midwives would change (Figure 4). The model assumed that all midwives retire at the Australian pension age of 67, and this would significantly reduce the proportion of midwives who are aged sixty or older, from 21% currently to 12% in 2030. History indicates that a minority will, in fact, continue to practice into their seventies (for example, at June 2024 there were 930 midwives aged 70 or more years, 2.8% of NMBA registrants), so this presents a 'worst case' scenario in terms of diluting the experience levels of midwives.

Modelling individually for each state and territory showed a marked reduction in the proportion of midwives aged 60 and older. The reduction was most sharp in New South Wales, where the proportion was forecast to fall by more than a half, from 23% in 2022 to 11% in 2030. Victoria (20% to 10%) and the Northern Territory (22% to 11%) show a similar reduction. The smallest impact would be in Queensland (20% to 13%) and Tasmania (22% to 14%).

Figure 4 : *Expected age profile for Australian midwives*

F.4



3.1.6

ALTERNATE WORKFORCE MODELLING SCENARIOS

We offer two scenarios to illustrate a 'worst case' situation and a 'severe' assumption. We have done so as we had data for the number of new graduates joining the profession from Australian training institutions each year and could reliably estimate the expected number of retirements and the very small number of deaths in service. However, we were not able to find state or national data on leavers from the Australian midwifery workforce, nor for the number of new midwives joining from overseas each year. Consequently, it is possible that the apparently stable workforce prediction provided in Figure 3 disguises a level of underlying 'churn', with midwives leaving the profession and being replaced at a similar rate by new registrations from overseas.

In an ideal world, Australia would be self-sufficient in producing midwives and not need to recruit midwives from other countries. The lack of leavers data does not allow us to estimate exactly how many graduates need to be produced each year to be self-sufficient, so our two scenarios examine the number of graduates required to prevent a workforce shortfall.

3.1.6.1

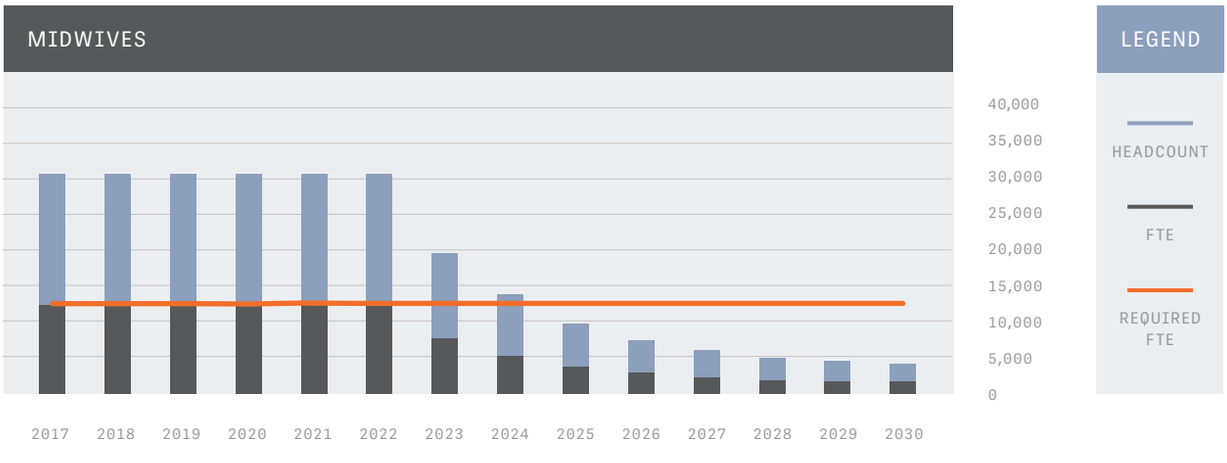
WORST CASE SCENARIO: 36.6% OF CURRENT MIDWIVES LEAVE

A high proportion of respondents in the Midwifery Futures survey (36.6%) said they were currently considering leaving midwifery. If this were to be actualised each year through to 2030 (while all other assumptions remain as per our original model) then the effect on midwife numbers would be catastrophic, as illustrated in Figure 5. In this scenario, the average workload for the remaining midwives would increase fourfold, from 40 pregnancies per full-time equivalent midwife per year in 2022 to 169 per full-time equivalent midwife per year in 2030.

The number of new graduates required to fill the gaps left by a 36.6% leavers rate is unrealistic. In the first year alone, 13,000 new graduates would be required to bring the Australian midwifery workforce back up to the numbers required to maintain a workload of 40 pregnant women per full-time equivalent midwife per year. This is a tenfold increase on current graduation rates. In this worst-case scenario, the situation would be similarly catastrophic in all jurisdictions.

Figure 5 : *Effect of 36.6% annual leavers rate on Australian midwife numbers, 2023-2030.*

F.5



3.1.6.2

SEVERE SCENARIO: 10% OF MIDWIVES LEAVE EACH YEAR

Of course, not every midwife who indicates they are considering leaving the profession, will go on to do so. Studies have shown that the actual leavers rates for health workers are far lower, although most studies examine total attrition rates, including leavers, retirees, and deaths in service. Castro Lopes and colleagues have cited midwives' total attrition rates of between 4.5% and 16% in four low-middle income countries [90]. The average attrition rate for Australian midwives was estimated to be 7% across the five-year period 2018 – 2023 [86].

Based on this limited evidence, we modelled 10% leavers per year as our 'severe' scenario, and the results are illustrated in Figure 6. In this scenario, the impact is still rapid and devastating, as the average workload for the remaining midwives would rise by more than 50% to 66 per full-time equivalent midwife per year in 2030.

A 10% leavers rate would bring significant reductions in the midwife workforce in all states and territories, but the effect of this change is not uniform, as illustrated in Table 9, due to the different immigration rates and midwife age profiles in each state.

A 10% leavers rate would increase the annual workload per full-time equivalent midwife by more than 50% in all states and territories, but South Australia and the Northern Territory would be most severely hit, with the effective workload increasing by 85%.

Figure 6 : *Effect of 10% annual leavers rate on Australian midwife numbers, 2023-2030*

F.6

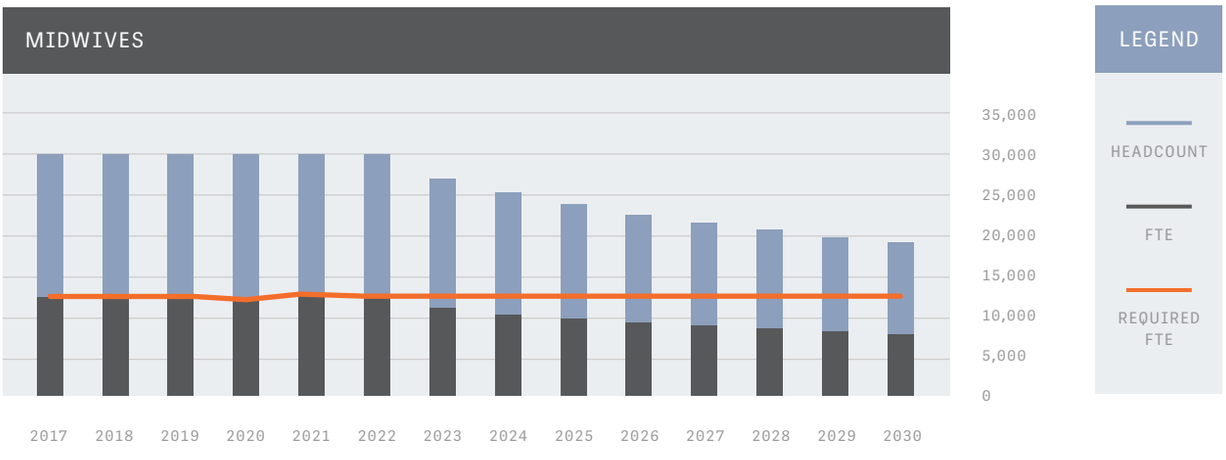


Table 9 : *Effect on 10% leavers rate on average workload per full-time equivalent midwife, by state and territory*

T.9

WORKLOAD, PREGNANCIES PER FULL-TIME EQUIVALENT MIDWIFE								
	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Current workload, 2022	50	36	38	33	43	36	26	35
Forecast workload in 2030 if 10% leavers per annum	80 +60%	56 +53%	63 +66%	61 +85%	71 +65%	64 +78%	48 +85%	57 +63%

3.1.6.3

SEVERE SCENARIO: GRADUATES REQUIRED TO REPLACE 10% LEAVERS RATE

To fill the gaps left by a 10% leavers rate, without recruiting qualified midwives from overseas, it would be necessary to produce many more graduates, as illustrated in Figure 7.

It is not possible to immediately replace midwives who leave the profession with new graduates due to the duration of the education program, but Figure 7 illustrates the theoretical scale of the challenge. If 10% of midwives were to have left in 2023, then 5,272 new graduates would have been immediately required to replace them, assuming all other key variables remain constant. This is a fourfold increase in the actual number of new midwifery graduates in 2022. The number of graduates required is especially high in the first year of the model, as it assumes all midwives who are older than national retirement age will leave the workforce, and history tells us that this is unlikely. Once these retirees have been replaced, the graduate numbers required fall and begin to level out – albeit at a level more than twice the current number of graduates.

As expected, the situation at a state and territory level is slightly varied, considering the different workloads, clinician proportions, and immigration rates. Jurisdictional level estimates are shown in Table 10. As with all our modelling, the state and territory level estimates worked with the best available data for the specific geographical area, whereas the Australian national model used country level assumptions, and therefore aggregate values do not absolutely match.

Table 10 indicates that by 2030, all states and territories would need to be producing graduates at twice the current levels, and the situation is notably marked in Tasmania, where graduate numbers would need to increase threefold, albeit from a low base. This is particularly salient as Tasmania does not have a midwifery education program within the state.

Figure 7 : *Australian midwifery graduates required to replace 10% leavers rate, 2023-2030*

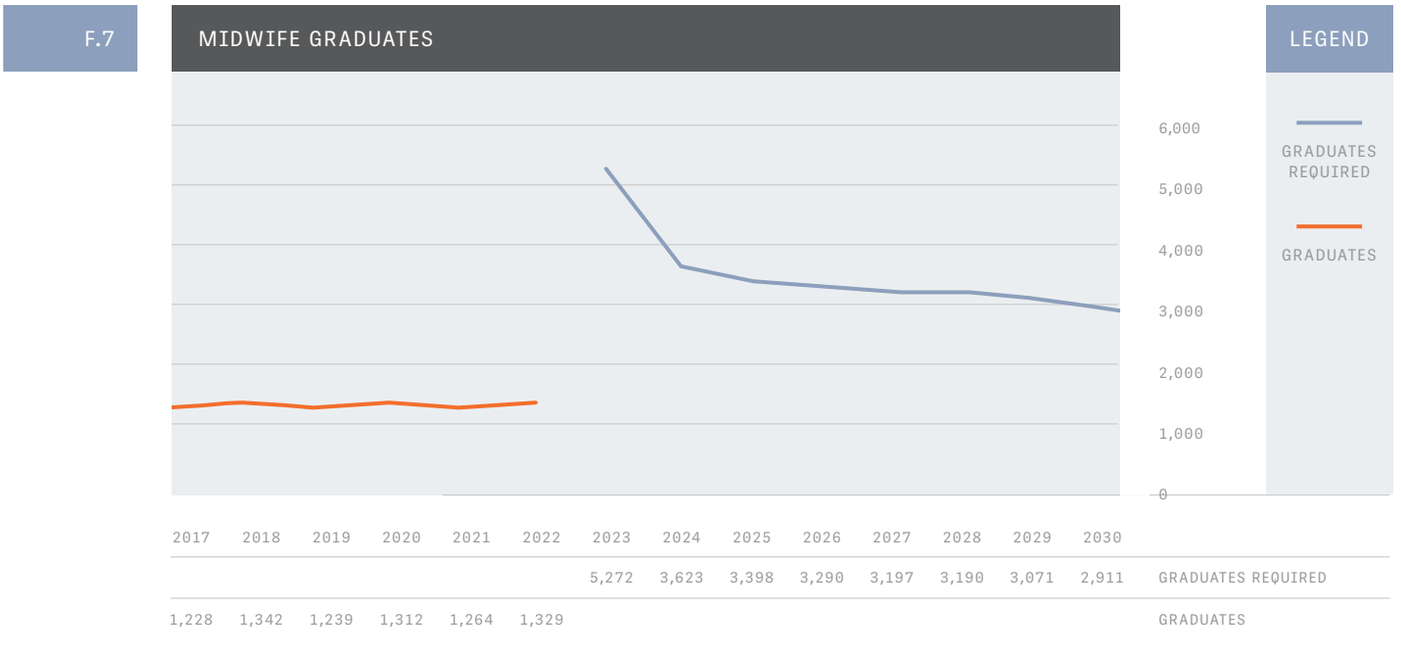


Table 10 : *Effect on 10% leavers rate on graduate numbers required to maintain average workload per full-time equivalent midwife, by state and territory*

T.10

GRADUATES	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Average graduates, 2019-2023	332	401	300	103	107	18	19	24
EFFECT OF 10% LEAVERS RATE PER ANNUM								
Graduates required 2023	1,292	1,331	1,147	455	318	63	144	121
2024	890	985	814	311	346	69	64	69
2025	819	919	775	298	324	66	59	64
2026	788	888	753	290	314	64	57	62
2027	763	863	733	283	306	62	56	60
2028	760	861	731	282	305	61	56	60
2029	729	828	706	273	294	58	53	58
2030	687	784	671	260	279	55	51	54
	+107%	+96%	+124%	+152%	+160%	+205%	+168%	+125%

3.1.6.4

SEVERE SCENARIO: WORKING A FEW MORE HOURS TO REPLACE 10% LEAVERS

It may also be possible to fill the gaps left by midwives leaving the profession, provided remaining midwives worked more hours per week in midwifery. The current average hours worked per week for midwives is 20 hours per week. This is driven by the large number of midwives who are dual-registered and work some of their time in nursing roles, and high rates of part-time work. However, increasing midwifery hours amongst nurse-midwives may result in commensurate gaps within the nursing workforce. The average hours required per week are shown in Figure 8.

The hours worked per week is 'one of the most sensitive variables', as noted in the Australian Department of Health's 2019 Future Health Workforce report [9]. This becomes clear if we compare the projections for our severe scenario (with 10% of midwives leaving each year) with either 20 or 24 hours worked per week on average each year, as in Figure 12.

In this severe scenario, if the average hours worked in midwifery could be increased by 20%, from 20 hours to 24 hours per week, then the shortfall in 2030 would be reduced by 30% - from 4,960 to 3,444 midwives.

Figure 8 : *Average hours per week required by Australian midwives to replace 10% leavers rate, 2023-2030*

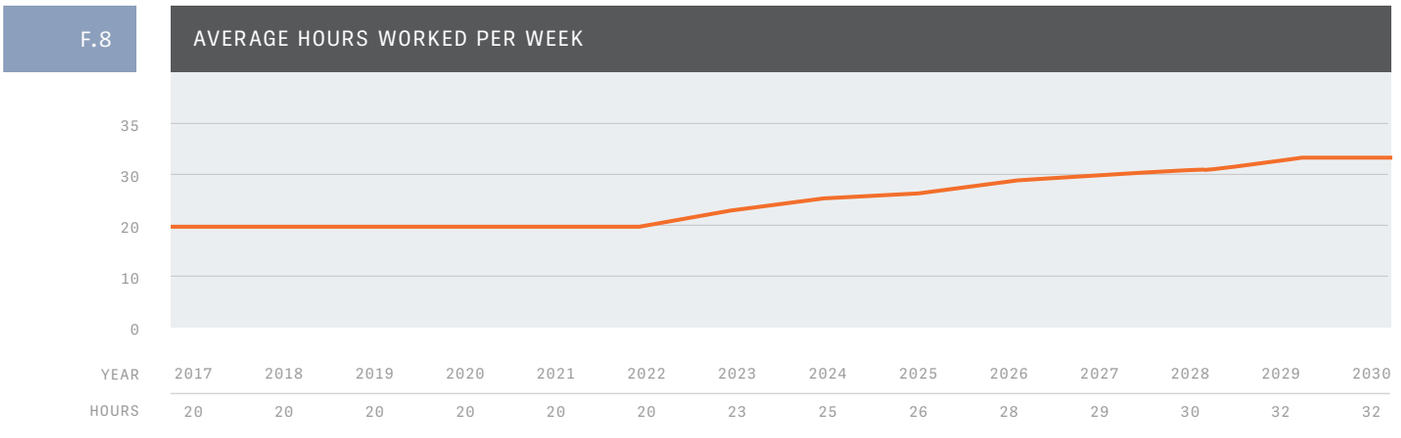
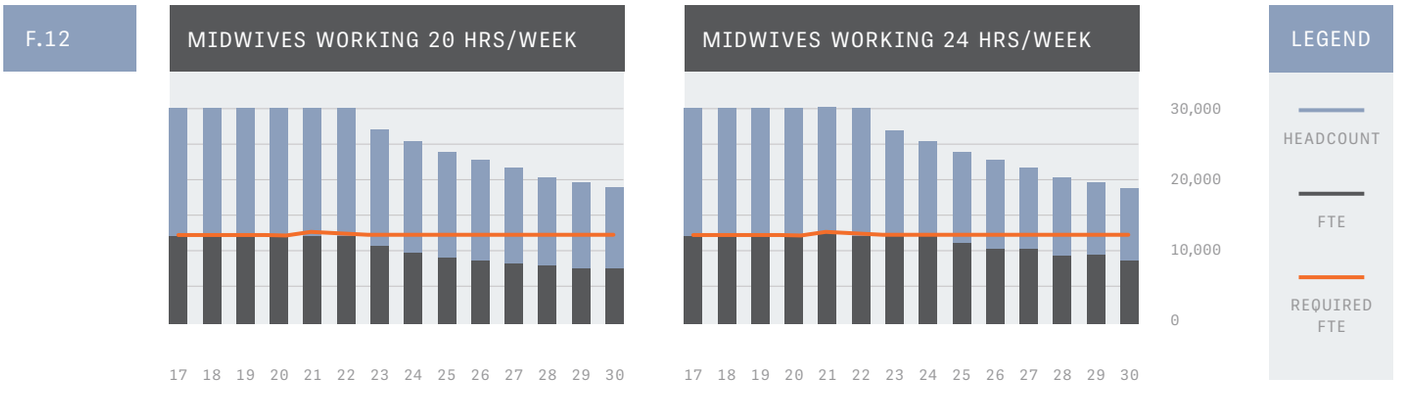


Figure 12 : *Severe scenario - comparison of average hours worked per week*



3.1.7

SUMMARY

While some indicators suggest adequate workforce numbers, other data suggest a current and predicted shortfall in midwives. This is particularly the case for non-metropolitan areas. There are gaps in our data about the midwifery workforce. There is also no consistent, coordinated approach across Australian governments to model the future workforce. Different states use different approaches to planning workforce numbers (such as Birth Rate Plus in New South Wales, and the use of patient ratios in Queensland).

The modelling analysis shows that addressing one lever (eg. graduate numbers, attrition, number of hours worked, overseas recruitment) is not enough. A combination of increased student and therefore graduate numbers, enabling midwives to work more hours per week, reducing attrition and increasing overseas graduates are all needed.

3.2 Looking back to build a better future

3.2.1

WHY DO MIDWIVES CONSIDER LEAVING MIDWIFERY?

The Midwifery Futures workforce survey asked respondents who were considering leaving for reasons for their intention (multiple reasons could be selected). The responses were dominated by work related issues (75%) and mental or emotional health issues (48%). Specific work-related issues heavily influenced leavers intentions to leave, including feelings of burnout (59.9% of leavers), poor staffing (54.9%), not feeling valued (54.6%), and poor skill mix in the workplace (50.1%). The most important factor influencing their decision to stay in midwifery was being able to do a job they enjoyed and found rewarding (selected by 40.3% of leavers), with other commonly selected factors including a positive working culture (35.4%) and appropriate pay rates (33.1%).

Leavers who selected "other" as their reason to consider leaving midwifery were invited to provide a written response. The most common responses (21 of 155 responses) related to professional dissatisfaction. Other common reasons offered for considering leaving are provided in Table 11.

Table 11 : *Examples of midwives' other reasons for considering leaving midwifery*

T.11

REASON	EXAMPLE
Professional dissatisfaction	"We don't get to use our skills and I don't like the way midwifery is heading and the increase in induction of labour and caesarean section rates and the workload is horrendous and nobody listens!"
Burnout	"The constant stress of caring for the women and babies while not giving the best of care I know they need."
Vaccine mandates	"Currently unable to be employed as I have not had any COVID vaccinations."
Lack of safety	"Safety concerns for staff and patients and increasing level of patient acuity without any due consideration."
Lack of support	"Very poor leadership, no support from upper management."
Disrespect	"Workplace treating staff like factory workers rather than professional health care workers."
Ageing	"Having to work night shift after age 55."
Staffing / workload / skill mix	"It is not the same. Staff crying all the time, unable to complete all their tasks in the shift due to workload. More and more repetitive paperwork. Junior staff in roles they are not capable of doing leaving them disenchanted and not able to be the best version of themselves. It is a complete mess. No succession planning. No plans for the ageing workforce. No middle skills coming through the system."
Bullying	"I worked in public maternity ambulatory services where bullying was accepted. I never want to experience that again."
Lack of career progression opportunities	"Lack of opportunity to progress within this profession."
Lack of flexibility to support midwives with family responsibilities	"Work-life balance. Ability to have set shifts and not have to contract hop to get something that suits my family. No one wants a midwife who can only work 2-3 days a week."

Our findings mirror the common reasons for considering leaving described in published research, which include [87-89]:

- dissatisfaction with the organisation of maternity care,
- dissatisfaction with their role as a midwife,
- poor work conditions,
- lack of managerial support,
- excessive workloads,
- inflexible rostering,
- family commitments,
- fear of litigation,
- poor pay,
- ill health, and
- planned retirement.

Leavers who indicated they were considering leaving partly or only due to retirement, rather than those considering leaving for other reasons, were significantly more likely to indicate that personal life / family reasons influenced their decision (29.2% vs 16.7%, p<0.001), and were less likely to indicate that work related issues (64.7% vs 79.7%, p<0.001), financial issues (10.2% vs 21.6%, p<0.001), or mental / emotional health issues (36.4% vs 54.1%, p<0.001) influenced their decision (Table 12). There were no significant differences between those retiring and those considering leaving for reasons of physical health or other issues not listed.

All leavers who were retiring were aged 50 years or more, while 59.5% of leavers who were not retiring were aged under 50 years. This represents a significant loss of years for the future workforce.

Table 12 : *Comparison of the factors influencing the decision to leave midwifery for leavers who were retiring and those who were not retiring.*

T.12

DESCRIPTION	RETIRING (N=264)		NOT RETIRING (N=621)		P VALUE*
	n	%	n	%	
Work related issues	171	64.7	495	79.7	<0.001
Personal life / family issues	77	29.2	104	16.7	<0.001
Financial issues	27	10.2	134	21.6	<0.001
Mental / emotional health	96	36.4	336	54.1	<0.001
Physical health	69	26.1	133	21.4	0.126
Other	50	18.9	110	17.7	0.665

* (Pearson Chi-square test)

To better understand who had an intention to leave midwifery and who did not, leavers were compared to non-leavers (the 42.3% of respondents who answered no to the question of whether they were considering leaving midwifery). More leavers than non-leavers fell in the 60 to 69 years of age categories, with slightly more non-leavers in all other age categories.

A higher proportion of leavers reported working 25 or fewer hours than was the case for non-leavers. More non-leavers than leavers reported working full time. Rather than increased hours being protective, it is likely that midwives considering leaving the profession reduced their work hours to mitigate the impact of factors (such as burnout) that were driving that decision.

A higher proportion of leavers than non-leavers were from public hospital and standard care models. This was reversed for midwifery group practice plus team midwifery, and for private midwifery practice where the proportion of non-leavers was higher than for leavers. This finding reflects what has been reported previously in the literature, with work in CoMC models associated with lower attrition rates [88].

Our findings have illustrated the potential future fragility of the midwifery workforce. Midwives considering leaving were mostly doing so because of their experiences in the workplace. Detailed information from the Midwifery Futures workforce survey helps to better understand midwives' experiences of their current work environments, and what they would like to see addressed to improve their role.

CS.2

CASE STUDY

Woman at the Centre: The North West Maternity Services Transition Project

Burnie, Tasmania

The North West Maternity Services Transition Project, initiated by the Tasmanian Department of Health and project managed by a midwife, successfully transitioned a long-standing privately contracted public maternity service to a publicly governed one. The complex transition included the creation of Tasmania's first Women's Health Advisory Group.

The "Woman at the Centre" transition strategy included a bespoke education program for midwives addressing feedback from the community, and equipping midwives to meet women's expectations. This 4-day training program focussed on trauma-informed care and gender violence training. The education program also focused on leadership development and expanding midwifery scope of practice. Midwifery leaders were provided with individual coaching and group workshops to build their capacity and confidence to support change and focus on kind, influential leadership within the new service.

The project supported scope of midwifery practice expansion by enrolling 30 midwives in the Australian College of Midwives' Midwifery Refresher Program. This initiative supported staff to work across all areas of midwifery practice under a single employment contract, promoting opportunities for continuity of care. The education program highlighted the project's commitment to innovative midwifery education and practice, fostering a deeper connection between the community and the service. This holistic approach ensured that consumer voices were integral to midwifery education and culture change, promoting a respectful, responsive maternity service.

CS.3

CASE STUDY

The Midwifery Graduate Research Intern Program

King Edward Memorial Hospital, Western Australia.

The Midwifery Graduate Research Intern (GRI) Program commenced in 2009 at King Edward Memorial Hospital in Western Australia and has been ongoing since then. The GRI supports recent midwifery graduates to increase understanding of the research process and develop associated research skills through engagement in activities such as research studies and quality improvement projects. The Program was originally offered to two graduate midwives annually and has since been extended to accommodate more. Participating graduates are placed in the midwifery research team within the Department of Nursing and Midwifery Education and Research to conduct their projects.

The GRI Program builds the research capacity of midwives through immersion in a research environment. Program evaluation shows participating midwives increased their research-related confidence, awareness, and skills; and developed professional connections with research staff. Midwives report increased mindfulness in their clinical practice following involvement in research on the positive and negative experiences of women receiving healthcare. The GRI Program offers an opportunity to strengthen the future midwifery research workforce through promoting higher degree by research pathways. Many midwives in the Program felt encouraged to pursue future research degrees.

3.2.2

WHAT IS IMPORTANT TO MIDWIVES

Midwives who completed the Midwifery Futures workforce survey were asked to rank nine factors, in order of importance to them in their current role as a midwife. The answer ranked as most important was “being able to practice midwifery as I see it” (25.2%), with “staffing levels / skill mix” (16.1%) and “workload” (13.5%) subsequently identified as important. The factor least often ranked as most important was “administration / paperwork” (0.5% of respondents). “Pay” (7.8%) and “opportunity for professional development” (7.0%) were considered moderately important in comparison to other factors. Respondents were given the opportunity to provide a written response identifying additional factors that were important. Common answers included being respected, supported, and accepted; professional autonomy; absence of bullying or violence in the workplace; being able to work without being required to be vaccinated for COVID-19; and having safe staff to patient ratios.

3.2.3

WHAT ARE MIDWIVES SATISFIED ABOUT?

Midwives were asked to rank the same list of factors in order of how satisfied they were about this aspect of their current role. The factor respondents most often reported as being extremely satisfied with was their working hours (14.2%), and the least often reported was ‘administration / paperwork’ (2.1%).

We additionally asked midwives to identify five things that provided them with satisfaction at work. Respondents (n = 626) described having adequate time to do quality work, in a work environment that was relaxed, positive, and fun as a source of satisfaction. Being respected and supported, positive relationships with colleagues and being able to provide a meaningful contribution by educating, supporting, and providing practical assistance to midwifery students and colleagues were also described as satisfying.

Pay rates that recognised the work done, including payment of penalty rates contributed to job satisfaction. Respondents wanted good rostering

practices, specifically to have agency over their work hours, to be rostered in ways that reduced fatigue and burnout, that were fair for all midwifery staff, and to be given adequate notice about their roster. They wanted regular meal breaks that could be shared with other colleagues. Flexible and family-friendly work hours were also important, as these helped achieve work-life balance. Some wanted the option of working from home, and of being able to find work close to home.

Workplaces that were free from racism, bullying, and / or violence significantly improved job satisfaction. When workplace problems arose, respondents wanted these addressed quickly and effectively. Respondents wanted to be able to provide safe care, and this involved working with well-educated and capable midwifery and medical colleagues.

Respondents described wanting to work in ways that were meaningful to them, aligned to their values, and with professional autonomy. Being able to have continuity of carer relationships was important to many. Job satisfaction came from being able to meet women's needs and goals for good outcomes from their maternity care, and from being able to fully utilise their knowledge and skills when providing this care.

Workplaces with adequate levels of staffing and access to resources that were needed to do quality work supported satisfaction. Respondents valued having good administrative support, an effective records management system that avoided the need to document the same information in more than one place and having ready access to research to inform their practice.

Other factors that improved satisfaction at work for respondents included having opportunities for professional development and to progress their career, with some wanting opportunities to engage in research. Having good role models and being able to work in ways that contributed to making midwifery better for other midwives were described as important. Respondents wanted to make a positive impact on their workplaces, with agency to influence policy and service delivery.

CS.4

CASE STUDY

Endorsed midwife prescribing in the public sector

Northern Health, Melbourne, Victoria.

Endorsed midwife prescribing was introduced at Northern Health in Melbourne when a collaborative agreement with credentialled private midwives was introduced in 2016. This collaborative agreement enabled endorsed and locally credentialled midwives to provide private midwifery care to women in a hospital setting and meant that women were no longer restricted only to home birth when accessing private midwifery care across the pregnancy, childbirth and postpartum continuum.

There was extensive discussion and consultation at the time regarding prescribing – historically only medical professionals and nurse practitioners were able to prescribe medications. Supportive leadership and executive enabled an update to Northern Health procedures allowing endorsed midwives to prescribe medications to women in their care, in line with legislation. Prescribing authority is authorised for the individual midwife, rather than their role on a given day – so midwives with a collaborative agreement can continue to prescribe when they are working on a shift and are employed by the hospital.

Providing this framework at Northern Health has ensured that endorsed midwives are able to seamlessly care for their women without the delays sometimes experienced when waiting for a medical practitioner to be available. In this model of care, prescribing is done by a known and trusted clinician, where shared decision making is facilitated.

3.2.4

WHAT LEADS TO DISSATISFACTION?

We asked respondents to provide five things that generated dissatisfaction at work. The majority of the 460 responses were the inverse of those provided for the previous question about satisfaction. These responses were echoed in focus groups and interviews, with many raising poor workplace culture, inability to practice to full scope and in preferred models of care and workforce shortages as causes of dissatisfaction. Other responses provided included high rates of intervention in pregnancy and birth, the medicalisation of pregnancy and birth, and obstetric domination of the workplace.

Research by Oliver and Geraghty [91] echoed survey responses. Using the Nursing Workplace Satisfaction questionnaire to assess Australian midwives' job satisfaction, they found that while 54% of respondents agreed or fully agreed that their job gave them a lot of satisfaction, most respondents disagreed or definitely disagreed with the statements "I have enough time to deliver good care" (80%) and "I like the way my ward is run" (72%). Respondents' comments highlighted short staffing, shift work, lack of breaks, lack of managerial support, and time constraints as negatively impacting work satisfaction. Midwives and key midwifery leaders raised concerns about the use of the nursing workforce to supplement midwifery staffing shortfalls in some settings.

Midwifery Futures workforce survey respondents also described dissatisfaction arising from a lack of national consistency in guidelines and pressure to provide care that was not evidence-based. They reported a lack of psychological support for midwives, with limited opportunities for debriefing or for clinical supervision generating dissatisfaction. Governments, midwifery regulatory bodies, and hospital management were criticised for not prioritising women's emotional health and not having sufficient focus on midwifery as a primary care preventative model.

3.2.5

WHAT ELSE NEEDS TO BE ADDRESSED?

The final free text question in the Midwifery Futures workforce survey asked whether there was anything else respondents wanted the research team to know. A strong sense of frustration was clear in the responses, relating to being unable to practice quality midwifery, and seeing women and babies receiving poor care. Many spoke of having recently left, or planning to leave, midwifery as they considered the work untenable. This respondent's comments were typical of many provided:

> *I left my midwifery employment of 34 years in July 2019. I could no longer endure the heavy workloads. The lack of staffing was unrelenting. The lack of support and respect, in particular the lack of leadership from executive team, compounded my feelings of hopelessness in providing adequate professional care for new mothers and babies. The executive team were obstructive to securing adequate staffing compounded by being obstructive to endorsing overtime. The last straw occurred when an executive member on a Friday afternoon stated she would advise me on the following Monday if overtime would be granted, despite being aware that I had a heavy workload and was already working.*

The lack of progress in improving issues impacting on midwifery was commented on, noting that "midwives are tired and angry and sick of saying the same things over and over and no one listening". Another respondent wrote "I have filled out so many of these surveys over the years. This will be my last as they seem so pointless as no one really wants to hear the true issues as they are hard to fix."

The responses made clear that there is urgency to address problems facing the Australian midwifery workforce. For example:

> *"I believe there needs to be an immediate and significant change in work culture to retain and recruit midwives. It is a dying profession due to poor work conditions / working relationships."*

> *"HELP US PLEASE - it is unsafe."*

3.2.6

BURNOUT, POST-TRAUMATIC STRESS, AND MORAL DISTRESS IN MIDWIFERY

Workplace experiences for Australian midwives can culminate in burnout, post-traumatic stress, and moral distress. Psychological states impacting Australian midwives have been widely examined in the literature over the past two decades, with measures of burnout, depression, anxiety, stress, empowerment, and professional satisfaction [92-101]. Levels of burnout have been consistently high across studies, with lower rates of client-related burnout compared to personal and work-related burnout. For example, in a sample of midwives from Melbourne, 68% were experiencing person burnout, 51% work-related burnout, and 10% client-related burnout [98].

Higher burnout scores have been associated with:

- Younger age [97, 98, 100],
- Lower years of experience [95, 97, 98],
- Providing postnatal services [97],
- Working part-time [97],
- Not having recently taken leave [97],
- Being dissatisfied with time off available [94], and
- Working in an urban area [95].

As noted above in the section about midwives who were considering leaving the profession, our survey found that 59.9% of leavers indicated that feeling of burnout influenced their thoughts of leaving. Some comments responding to the question of what other influences were relevant included reference to burnout. For example, one respondent explained their intention to leave was due to:

> *"the ongoing restructure of the maternity service in my area with poor consultation with those of us in clinical roles. I will be leaving the workforce at age 60, much younger than I ever anticipated I would, but I'm burnt out."*

Exposure to birth trauma has been reported as common in published literature, with 94% of midwives surveyed indicating they had either professional or personal experience of this [102]. Seventeen percent of midwives with exposure to a traumatic event met criteria for probable post-traumatic stress disorder [103]. Probable post-traumatic stress disorder was strongly associated with an intention to leave midwifery. Midwives may experience moral distress, the psychological harm occurring when an individual's moral integrity is compromised, where they are unable to provide what they identify as appropriate care [104]. The experience of moral distress may inform considerations of leaving the profession, however research on this issue in the Australian midwifery context is limited [104].

CS.5

CASE STUDY

Midwife-led early pregnancy care

Adelaide, South Australia

Miscarriage is often a very frightening time for women and their families and timely care provides them with support and understanding when they feel very vulnerable. The Early Pregnancy Unit at Lyell McEwin Hospital in Adelaide has been running for over 10 years and remains the only midwifery led Early Pregnancy Unit in the state providing care to women who experience pain or bleeding in the first trimester of their pregnancy.

The service offers both booked and walk-in appointments from Monday to Friday. Women can self-refer to the service or be referred by their GP or another midwife or medical practitioner. Midwives work closely with senior medical staff to develop and deliver an individualised management plan for each woman.

Each of the midwives has completed rigorous training in relation to ultrasound and early pregnancy assessment and are required to complete ongoing training to maintain their Advanced Scope of Practice in early pregnancy care. The Early Pregnancy Unit meets the needs of the women and provides a pathway for midwives to grow as clinicians. Midwives play a pivotal role for a family whether they are celebrating a pregnancy or grieving the loss of a pregnancy, providing assessment, education, support, and follow-up. Consumer feedback for this approach has been excellent.

CS.6

CASE STUDY

Endorsed midwives employed to provide continuity of carer in the public sector

Perth, Western Australia

The Midwifery Birth Centre (MBC) at Bentley Hospital is Western Australia's first stand-alone birth centre, developed with both women and midwives in mind. Midwives employed in the MBC are publicly employed, credentialled, and endorsed. They provide care with a known midwife for women experiencing a low-risk pregnancy. A core tenant of the MBC remains is to support its midwives, creating an environment and model of care midwives want work in.

The MBCs endorsed midwives provide care for women in a 'no risk out' model from conception until six weeks postpartum – something not previously offered in the public healthcare system in WA. MBC midwives will follow the women to other health services should risk factors arise. Being endorsed means the midwives can utilise their prescriptive authority and order investigations. This streamlines care for women and further enhances the quality of the midwifery care women experience in this innovative model.

3.2.7

CONTINUITY OF MIDWIFERY CARER MODELS ARE ALSO GOOD FOR MIDWIVES

The benefits of CoMC models for women, their infants, and families are clear and widely recognised [105-107]. Evidence shows CoMC models are the best model of care for women, their families and babies. Health outcomes for women (including mental health) are better, there are reductions in preterm birth, stillbirth, and medical intervention [45, 49, 95, 108-111]. If provided in the primary care setting, the total cost of care is significantly less than for standard care. Public midwifery group practice caseload care costs 22% less than other models of care [112] and would realise significant cost savings for the public health care system by reducing the rate of operative birth [113]. Birthing on Country models increase women's participation in antenatal care, reduce preterm birth, and increase breastfeeding rates [37].

Increasing evidence supports the assertion that working in a CoMC model is beneficial for midwives, with:

- Lower rates of burnout than their peers in non-continuity models and the level of burnout reduces over time while continuing in the model [93, 95, 100, 101],
- More positive attitudes towards their work [93], with improvement over time [100], particularly in relation to professional satisfaction, support, and client interaction,
- Lower scores for anxiety and depression scores [94],
- Higher midwifery empowerment scores [94, 101], and
- Increased work satisfaction [91].

Midwives working in CoMC models report enhanced autonomy, knowledge, skills development, and stronger professional identity [114-122]. Working in a CoMC model provided a sense of being a "real" midwife [117, 120]. Midwives valued the flexibility of working hours that was possible [123]. Work-life balance was a concern [114, 119] but was less of a concern over time while midwives continued to work in the CoMC models [114]. Negative experiences included heavy caseloads, on-call requirements and rostering issues, and lack of organisational support for the model [114, 119, 120, 122]. Participants in

the workforce interviews, and our scoping reviews highlighted that a proportion of midwives do not want to work in CoMC models, and employment in these models can be particularly challenging for midwives with caring responsibilities. Part-time CoMC models also provided difficulties with the time on-call required in some services.

There is limited current data on the number of services offering a CoMC model, the number of midwives working in such a model, and the proportion of women having their maternity care provided in such a model. For respondents to the Midwifery Futures workforce survey, only 5.7% were working in a midwifery group practice model in the public sector, 2.0% in a team midwifery model in the public sector, and 3.1% provided care across the full scope in private midwifery practice. We asked survey respondents where they wanted to work if they were able to choose to do so. The most common answer selected was midwifery group practice (37.5% of respondents) with another 23.6% indicating a desire to work in private midwifery practice.

Barriers to implementation and expansion of CoMC models reported in the literature include general understaffing, a lack of interest from midwives, lack of medical support, and lack of financial support [124]. Recommendations to overcome barriers have included midwifery leadership skills (such as resilience, vision, and problem-solving abilities), motivation and commitment, the development of strategic relationships, education of midwives and maternity care users, and funding of project officer positions to support the work of implementation and expansion [125, 126].

3.2.8

SUMMARY

Midwives are leaving midwifery because they are dissatisfied with the options available for them to practice midwifery. There is an urgent need to address the midwifery workplace to improve job satisfaction, reduce attrition and reduce distress and burnout.

While not all midwives wish to work in CoMC models, more do than there are currently positions available. Working in CoMC appears protective for midwives' mental health and reduces workforce attrition.

Creating workplaces that are positive places to work, providing flexibility in ways of working as a midwife, and opportunities for growth and development might reduce attrition rates, and encourage the re-entry of recent leavers to the profession.

CS.7

CASE STUDY

Midwifery student led clinic

Griffith University, Queensland

In 2023, a student-led midwifery clinic was established within Griffith Health Clinics on the Gold Coast campus. This clinic currently operates two days a week and offers an alternative model of care for women giving birth at the Gold Coast Health service. The student-led midwifery clinic provides antenatal placements for students, with university employed Practice Lecturers providing students assistance to recruit women for continuity of care experiences through the clinic.

Once recruited, the student and Practice Lecturer provide antenatal and postnatal continuity of care and support for the woman, and the student provides continuity of care during birth by accompanying the woman during her hospital admission. Education classes are also facilitated through the clinic, with students leading facilitation with the support of the Practice Lecturer. It is envisaged that a similar student-led midwifery clinic will also be established at Logan campus, Griffith University and will be available for women giving birth at Logan Hospital.

In addition to providing a pathway for students to complete continuity of care experiences, the clinics provide hands-on support and assessment of students' practice by Practice Lecturers and facilitate maintenance of clinical skills and recency of clinical practice for Practice Lecturers. Often clinically based staff are reluctant to consider a midwifery academic role for fear of losing midwifery skills and clinical credibility, so the clinic also serves as a recruitment and retention strategy by addressing this. It is planned in the future that Practice Lecturers will maintain a small continuity of care caseload of women alongside a student.

3.3 Educating for the future

3.3.1

ENSURING QUALITY EDUCATION FOR MIDWIFERY STUDENTS

Positive educational experiences prepare students for future practice, promote sustainable work-life balance, and protect against midwifery student attrition. Most students who completed the Midwifery Futures survey felt their education program adequately prepared them with the knowledge (84.5%) and clinical skills (76.9%) to practice midwifery. However, many (87.0%) also reported difficulties maintaining balance between university workload, clinical requirements and personal obligations. The course requirements, lack of wellbeing support, and financial and caring obligations were motivators for taking leave or withdrawing from their midwifery program. One in three (33.1%) students had taken or were considering taking leave and one in two (57.3%) had considered program withdrawal. Designing midwifery education programs in ways that prepare students for future practice and support wellbeing, including enabling work-life balance, are crucial for promoting positive educational experiences and student retention.

Pathways should be strengthened to support midwives to pursue their preferred employment. For the vast majority (92.4%) of midwifery students surveyed, a clinical midwife role was the preferred role following graduation. Students were able to select multiple responses, and interest in a non-clinical research or academic role was the second most desired employment option (15.1%). Reasons for interest in non-clinical roles included student acknowledgment of the importance of these roles for the growth and sustainability of the midwifery profession. Relevant education and postgraduate pathways should aim to support interest in clinical and non-clinical midwifery roles to grow the clinical and academic midwifery workforce.

Midwifery students' MPE should prepare them for future clinical practice. The majority (85.6%) of surveyed midwifery students reported that MPEs primarily took place in standard care models within public hospital settings. Students noted a disconnection between their midwifery education and their clinical experiences in standard care model MPEs, and viewed the opportunity to undertake MPEs in different settings, particularly in CoMC models, as beneficial. While all Australian midwifery students are required to follow women in continuity of care experiences, only 39.4% of students reported

MPE in public hospital midwifery group practice models. Opportunities to be placed in a variety of models provide students with important educational experiences and help them to identify models of interest for future workforce entry. MPE in continuity of care models is particularly important to enable students to understand how aspects of their education translate to practice.

Placement poverty, the financial burden experienced by students when they attend clinical practice, can lead to diminished student wellbeing and influence attrition [127]. Focus group and interview participants raised concerns about MPE costs, such as the cost of transport, parking and accommodation. This was particularly identified as an issue for students from rural and remote areas, where significant travel costs were often incurred due to lack of locally available MPEs.

Aboriginal and Torres Strait Islander students face disproportionate cultural, educational, and financial barriers entering midwifery education. Yarning Circle members noted that universities and healthcare learning environments were not always culturally safe spaces and First Nations students did not always receive the support they needed at university. The existence of racism in the healthcare system was raised in a number of forums through this project.

Aboriginal and Torres Strait Islander midwives in the Yarning Circle highlighted the lack of comprehension and appreciation of the cultural load associated with requiring students to leave their Community to complete their midwifery education. Yarning Circle members, Symposium attendees and focus group participants also identified Aboriginal and Torres Strait Islander students as being disproportionately impacted by placement poverty. Costs incurred prior to MPE commencement, such as First Aid certification required in some programs, were also raised as concerns.

Experiences of being employed as a midwifery student, namely assistants in midwifery (AIMs) or registered undergraduate students of midwifery (RUSOMs), are associated with improved work-life balance, reduced financial stress and self-perceived increases in competence and confidence [128, 129]. The time as an AIM or RUSOM do not always count towards clinical experiences, thus, while mitigating some aspects of placement poverty, these models do not sufficiently support student work-life balance and wellbeing.

Other employment models, such as the MidStart program in New South Wales, exist but have not been reported in research literature. Pathways into maternity, including AIM, Aboriginal Health Practitioner and Aboriginal and Torres Strait Islander Cadetship programs, would enable Aboriginal and Torres Strait Islander students to experience the scope of midwifery practice while studying.

3.3.2

STRENGTHENING MIDWIFERY EDUCATION PROGRAMS

In addition to providing quality educational experiences for students, there is a need to strengthen midwifery education programs and ensure sufficient graduates in the future midwifery workforce. Recruitment strategies used by education providers varied, including pathways and supports specific to Aboriginal and Torres Strait Islander students. Cadetships, where Aboriginal and Torres Strait Islander students are part-funded to work as well as to study, were seen as being very effective to grow the Indigenous midwifery workforce.

The availability of clinical MPEs is a determinant of student intake. This highlights the importance of health services and universities working together to plan student clinical placements for the future, rather than on a year-by-year basis.

Although increases in midwifery student numbers alone will not resolve projected workforce shortages, current midwifery student intake is static and inadequate to meet future needs. Midwifery educators in our survey referred to recruitment strategies including open days and information evenings, social media, partnering with health services, and word of mouth. When asked about recruitment strategies specific to Aboriginal and Torres Strait Islander students, 39.1% reported their university had a specific recruitment strategy in place. These included visits to secondary schools with high numbers of Aboriginal and Torres Strait Islander students, offering a preclinical year of academic preparation, employing Aboriginal and Torres Strait Islander staff, and having a designated enrolment pathway. One fifth (21.7%) of respondents reported their university had no recruitment strategy specific to Aboriginal and Torres Strait Islander students.

The limited availability and rising costs of MPEs remain a challenge for preparing adequate numbers of midwifery students [83]. Most educators (54.2%) reported that the number of MPEs available was a determinant for the number of enrolments offered at their university each year. All educators indicated that their universities offered MPEs in hospitals and 86.4% offered MPEs in midwifery group practice models. Half (50%) of educators reported that MPE opportunities were available at their universities with privately practising midwives. Educators were not asked how many individual MPE opportunities were available for students within each setting given the diversity of university roles occupied. The least common MPE offering was in Birthing on Country models (36.4%). Aboriginal and Torres Strait Islander women and communities should have access to midwives, and this should be reflected in midwifery education, such as through MPE settings [83].

Relating to student retention, educators noted five key strategies employed by their universities. These strategies were:

- Individualised support from academic staff, particularly for first year students
- Financial support to enable students to successfully undertake their course
- Flexible individualised study pathways to complete the program
- Peer support and mentoring, and
- Student representative body who met regularly with named staff member(s) to address issues in the university and clinical setting.

3.3.3

EDUCATIONAL EXPERIENCES OF RECENTLY QUALIFIED MIDWIVES

Examining the educational experiences of recently qualified midwives provides further insights into midwifery education. Of the 659 midwives answering the workforce survey who had qualified in the preceding five years, just over one third completed their degree in under 3 years (37.6%) and a similar proportion completed their degree in four or more years (35.2%), with 27.3% completing in three years (Table 13). Any changes to midwifery education aimed at resolving workforce issues will take time to produce an impact.

Table 13 : *Recently qualified midwives (5 or fewer years of practice in Australia)*

T.13

DESCRIPTION		n	% OF TOTAL
Years taken to complete degree (n = 604)	1 year		19.9
	2 years		17.7
	3 years		27.3
	4 years		25.7
	5 years		6.1
	6 years		2.2
	7+ years		1.2
Reason for degree choice respondents could choose more than one option) (n = 659)	This was the program located closest to my residence	278	42.2
	This was the program where I met the entry criteria	117	17.8
	I was not aware of other midwifery programs	32	4.9
	Because it was a dual degree	82	12.4
	Because it was a direct-entry program	187	28.4
	This university / midwifery program had a good reputation	233	35.2
	This program allowed me to attend homebirths	13	2.0
	This program offered the option of part time study	68	10.3
	Other	94	14.3
Educational preparation for practice (N = 573) **(Likert scale – number and percent of respondents answering agree or strongly agree)**	My program prepared me with the theoretical knowledge I needed to practice midwifery	486	84.9
	My program prepared me with the practical skills I needed to practice midwifery	407	71.4

Recently qualified midwives chose their midwifery program because it was close to their home (42.2%), and because of the reputation of the university or the program (35.2%). Being a dual degree program was given as the reason for 12.4%, and 28.4% selected their degree because it was a direct-entry program. For those choosing a direct-entry degree (with no requirement for a prior or simultaneous nursing qualification), by far the most common response (84.4%) was that they did not want to become or practice as a nurse. For respondents who chose a dual degree, many felt that holding both qualifications offered better opportunities for future employment, including in rural and remote settings.

Recently qualified midwives mostly considered that their program had provided them with the theoretical knowledge (84.9%) and practical skills (71.4%) required to practice midwifery. Being paid during MPEs was the case for the minority (30.3%), with most being students who were already registered or enrolled nurses and were employed as such while studying (25.7%) or were in a paid Graduate Diploma of Midwifery program. While 30.7% of recently qualified midwives had experienced MPE in midwifery group practice, for students this was 39.4%, suggesting that there are positive changes to increase access to CoMC models for current students.

Continuity of care experiences were reported as beneficial educational experiences, with 81.1% of recently qualified midwives agreeing or strongly agreeing to this. Concerningly, only half agreed or strongly agreed that their MPE was an enjoyable experience (58.4%). As was the case for the students we surveyed, most had found it a challenge to balance their university workload with the clinical requirements of the degree (82.0%).

We asked recently qualified midwives if there was anything else they would like us to know about their midwifery education. Most of the respondents' comments focussed on how challenging the degree was, and this was compounded by financial hardship and competing demands on student's time. Respondents also provided examples of inadequacies in their educational preparation, with many commenting that their education had not prepared them for the realities of working in the hospital setting as a midwife. Others commented on the numbers of births required to meet the requirements of the degree, and how this had led to a focus on "the numbers" and not on what might be learned from their clinical experiences.

The experiences of midwifery education provided by recently qualified midwives mirror those described by students. University education appears to be effective in providing knowledge and skills for practice, however navigating MPEs and continuity of care experiences was challenging for most.

3.3.4

SUMMARY

To meet demand for the future midwifery workforce, midwifery education programs need to intake greater numbers of midwifery students. Ensuring the quality of midwifery students' education experiences are important for maintaining and growing the Australian midwifery workforce to meet future workforce demands. Quality education experiences both prepare students for future practice as a midwife and support student wellbeing. This includes addressing placement poverty and providing the opportunity for varied MPEs, particularly experiences in CoMC models. Skilled and capable midwifery educators will be required in greater numbers, both in the university sector and in health services, to support the expanded number of students.

3.4 Investing in the future – recently qualified midwives

3.4.1

CURRENT WORK ROLES OF RECENTLY QUALIFIED MIDWIVES

Literature has reported higher rates of burnout for midwives who have recently entered the profession [97, 100, 130]. This places this cohort at risk for leaving the profession early, a phenomenon that was also described by focus group participants. Understanding and addressing issues affecting recently qualified midwives is an important part of securing the future workforce.

Most recently qualified midwives were working only in midwifery (66.8%), with 19.9% working in both midwifery and nursing (Table 14). It is of concern however, that 10.8% were not working in midwifery. Within three months of graduation, 85.2% of recently qualified midwives had commenced practice in midwifery. Three quarters (76%) of recently qualified midwives had completed a formal transition to practice program.

One third of recently qualified midwives (30.7%) had undertaken their MPE in a midwifery group practice model, and a similar proportion (32.6%) reported feeling confidence to provide midwifery care in a CoMC model. More than a third (39.9%) said their preferred option for their role was midwifery group practice, and 25.2% selected private midwifery practice for this question. Compared to these preferences, only 12.4% of recently qualified midwives were working in midwifery group practice or team midwifery and 1.4% in private midwifery practice.

Evidence from the literature demonstrates that recently qualified midwives benefit from working in

Table 14 : *Recently qualified midwives (5 or fewer years of practice in Australia)*

T.14

DESCRIPTION		n	% OF TOTAL
Years in practice in Australia (n = 659)	< 1year	107	16.2
	1-2 years	186	28.2
	3-5 years	366	55.5
Are you working in midwifery? (n = 658)	Yes – only in midwifery	440	66.8
	Yes – partly in midwifery, partly in nursing	131	19.9
	No	71	10.8
	Other	16	2.4
Time from graduation to commencing practice (n = 540)	<3 months	460	85.2
	3-6 months	52	9.6
	>6 months	28	5.2
Experience of transition to practice (n = 550) (Likert scale – number and percent of respondents answering agree or strongly agree)	My program provided me with the skills and knowledge needed as a newly qualified midwife	395	72.0
	My employer provided adequate support to build my confidence and experience as a newly qualified midwife	319	58.1
	I felt confidence to practice to the full scope of midwifery practice	242	44.2
	I felt confident to provide midwifery care in a CoMC model	179	32.6
Formal transition to practice program? (n = 549)	Yes	417	76.0
	No	119	21.7
	Unsure	10	1.8
	Rather not say	3	0.5

CoMC models. Recently qualified midwives working in CoMC models rated the experience highly and described more support than when working in other models [117, 118, 121, 131]. The higher level of support increased midwives' learning, confidence, and competence. This was achieved even during a short (at least 4 weeks long) rotation into the model and helped these midwives to better adapt on returning to other models of care [131]. Midwives working in CoMC models six to seven years after graduation were more likely to remain in midwifery, irrespective of their prior educational background, than those working in other models of care [101].

Respondents added feedback about their experiences of structured transition to practice programs, with some describing it as ineffective. For example, this respondent described being restricted from accessing opportunities to learn while they were considered as a "new graduate":

> *I did not find the New Graduate program any more supportive than simply being a midwife. We were given a few extra study days which I could have easily enrolled in anyway as a midwife. Instead, I felt restricted or held back and joined midwifery group practice within 6 months of my new grad year, which was ultimately incomplete in a traditional sense. It made me feel less than, and that others looked down on me, as opposed to its aim of being supportive to new midwives. It was more restrictive as I was told "you can't" more than "you can" when enquiring about upskilling and job prospects etc.*

3.4.2

SUMMARY

Shifting into clinical practice generated distress for many recently qualified midwives, with one in ten not continuing in midwifery. The loss of a qualified graduate at this early stage represents a significant loss of potential for the workforce. Placing a higher proportion of recently qualified midwives in CoMC may help mitigate some of the issues.

3.5 Other ways to build the future workforce

3.5.1

INTERNATIONALLY QUALIFIED MIDWIVES

Internationally qualified midwives completed their initial midwifery qualification in a country other than Australia. Workforce immigration offers a potential means of increasing the number and diversity of the Australian midwifery workforce. However, limited research and data exists capturing the current state and experiences of internationally qualified midwives in Australia. While internationally qualified midwives occupy an important role in contributing to the maintenance and growth of the Australian midwifery workforce, our workforce modelling demonstrates that workforce immigration forms only a small part of the solution to Australia's midwifery workforce shortages. There would additionally be ethical concerns arising from sizeable immigration of health workforces, known as medical brain drain [132], from low-income countries to high-income countries like Australia.

No literature was identified that could provide insights into the country of origin or size of Australia's internationally qualified midwifery workforce. However, the NMBA provided data showing 280 internationally qualified midwives joined the Australian midwifery register in 2023. Literature on enablers and barriers to entering the Australian midwifery workforce or how best to transition internationally qualified midwives into Australian midwifery practice was also absent.

The experiences of internationally qualified midwives entering the Australian workforce has been examined by a small body of literature [133-135]. Midwives from the Middle East and the United Kingdom noted their scope of midwifery practice in Australia was more limited and offered less autonomy than their country of origin [133, 135]. For midwives from Iran and Lebanon, the converse was true. Many internationally qualified midwives felt unprepared for unsupervised practice in Australia and described their transition support program as unsatisfying or inadequate [134].

CS.8

CASE STUDY

Clinical midwife to midwifery-researcher – enabling the journey

Emma Shipton, RM PhD candidate, Queensland

I was always interested in research and seeking evidence to support or dispute practices in midwifery, but conducting research seemed out of reach. I wasn't even really sure where to get started. I saw an internal expression of interest to undertake an evidence-based practice role that was mentored by the Clinical Research Manager and decided to apply. I was successful in this and was supported by my line manager to undertake the role, working in it for 1 day a week for 10 weeks. The aim of this position was to research a topic and conduct a literature review, as well as gain support in writing a research protocol and become familiar with ethics applications.

Having this supported day a week to undertake research allowed me to link in with the hospital librarian and attend courses focusing on how to undertake a literature review. I also received support and mentoring from other researchers within the unit. Soon it became clear that my topic was bigger than 10 days of work, and I was approached by the Director of Research within the department who suggested I undertake a PhD. I was supported by them to apply for a Royal Brisbane and Women's Hospital Foundation Scholarship, which assisted in financially supporting me to work on my research for 2 days a week (and allowed for backfill from my clinical role). Although difficult to juggle my clinical position and offline research time, being successful in this scholarship was hugely beneficial to commencing and continuing my PhD research. Without it, I wouldn't have been able to undertake my research while still working full time in a clinical role.

3.5.2

RE-ENTRY TO PRACTICE

Re-entry to practice has been identified as a possible means of addressing midwifery workforce shortages. Re-entry to practice involves upskilling midwives who chose not to re-register to return to practice in the contemporary clinical workforce [136]. There is limited research on the midwives' rationale for leaving the profession. Limited opportunities and incentives for re-entry programs and difficulties contacting potentially interested midwives compound re-entry challenges. One study, undertaken in Queensland between 2008 and 2010 showed that both theory and MPE components were seen by participants as contributing to their confidence to return to the health workforce. The study found that most nurses and midwives returning to the workforce who responded to the survey were approaching retirement age in 10–15 years. Clinical supervision and contract learning, that is development of a learning contract articulating expectations based upon individual participant learning needs, should be central to a return to workforce induction programme for registered but non-practising nurses and midwives [137].

Although there is some research that examines the intention of midwives to leave the profession, there is an absence of research reporting reasons for leaving. Existing research [87-89] and findings from our workforce survey demonstrate a significant intention to leave the midwifery profession. Reasons for intent to leave consider dissatisfaction with their workplace and working conditions, family commitments, and ill health. While intention to leave is significant in providing insight into workforce attrition, there is no research that reports the rationale of midwives who have de-registered from the profession. The NMBA does not currently collect data on reasons for de-registration. Further research and data on the experiences and motivations of midwives who have left the profession is needed to improve understanding of both the determinants that lead to de-registration and the supports required to facilitate re-entry to practice.

Limited opportunities and incentives for re-entry into midwifery reduce the likelihood of midwives returning to practice. Midwives completing the workforce survey commented on the lack of availability of quality re-entry programs. Midwives are required to complete an NMBA-approved re-entry to practice program, which are currently only offered by two education providers.

There are no national incentives and limited state and territory incentives for midwives to participate in re-entry programs. These factors may be exacerbated by difficulties identifying and contacting previously registered midwives to invite them to such programs. Additional re-entry programs and re-entry incentives and improved contact tracing for deregistered midwives are likely to support midwives to return to practice, though the number of midwives who might make use of these opportunities is unknown and possibly small.

3.5.3

SUMMARY

Internationally qualified midwives and encouraging previously registered midwives to return to practice provide two potential means to build the future workforce. While these midwives offer only a small increase in the workforce, they remain potentially useful and under-resourced pathways to addressing workforce shortages.

3.6 Ensuring an equitable future

3.6.1

THE ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE

Aboriginal and Torres Strait Islander women were the first midwives in Australia. In the contemporary, post-colonial workforce, Aboriginal and Torres Strait Islander midwives must be supported in their professional practice through culturally safe work environments. The Midwifery Futures Yarning Circle and focus group discussions highlighted the importance of culturally safe workplaces and Aboriginal and Torres Strait Islander leadership to improve workforce recruitment and retention. Racism persists in midwifery and maternity workplaces and education spaces and must be addressed and followed by appropriate actions and outcomes [51].

Culturally safe workplaces are intrinsically linked to the effectiveness of strategies to attract, educate and retain the Aboriginal and Torres Strait Islander nursing and midwifery workforce. Colonisation and intergenerational trauma have a profound impact on Aboriginal and Torres Strait Islander women, families, and midwives. Workforce models need to be cognisant of the additional cultural load required from Aboriginal and Torres Strait Islander midwives to navigate colonial healthcare systems and advocate for culturally safe workplaces and healthcare. Providing care for Community members is a key strength of Aboriginal and Torres Strait Islander midwives. However, Yarning Circle members noted that corresponding social responsibilities are not widely acknowledged or supported by employers in healthcare settings, often demonstrated through a lack of flexible ways of working.

Aboriginal and Torres Strait Islander midwifery leadership is needed as a pivotal condition and strategic enabler to attract, educate and retain the Aboriginal and Torres Strait Islander workforce and support the development of programs such as Birthing on Country initiatives.

Mentorship is particularly essential in the recruitment and retention of Aboriginal and Torres Strait Islander midwives [138, 139]. Existing literature shows mentoring between Aboriginal and Torres Strait Islander midwives to be beneficial in enabling culturally safe spaces for mentors and mentees to provide clinical and cultural support and supporting career goals [138].

For workplaces to be culturally safe for Aboriginal and Torres Strait Islander midwives, institutional racism in maternity settings must be addressed. Midwives in the literature reported either direct experiences or observations of discrimination and racism [139-141], marginalisation and stereotyping in the workforce [141, 142]. Participants in interviews and focus groups also noted that reports of racism and bullying were not always handled appropriately. While Aboriginal and Torres Strait Islander midwives were assertive

CS.9

CASE STUDY

Birthing on Country: Privately Endorsed Midwives Access to Public Hospitals

Waminda (South Coast Women's Health & Welfare Aboriginal Corporation), New South Wales

Birthing on Country services are maternity services designed in collaboration with, and for, Aboriginal and Torres Strait Islander women and their communities. Waminda, South Coast Women's Health and Wellbeing Aboriginal Corporation located on the lands of Cullunghutti and Wandi Wandandian peoples of the 13 clans on the south coast of New South Wales, is the first ACCHO in the country to offer a Birthing on Country program that employs, insures and enables privately practising midwives to provide continuity of care as the primary midwife within the local public hospital - Shoalhaven District Memorial Hospital.

Initially, Waminda's Minga Gudjaga – Birthing on Country program, provided antenatal and postnatal care only but did not have access to public hospitals to provide intrapartum care. From May 1, 2024, Waminda's endorsed midwives now have visiting rights to Shoalhaven District Memorial Hospital and are able to provide intrapartum and continuity of midwifery care to women having an Aboriginal and/or Torres Strait Islander baby. The implementation of visiting rights enables Waminda Endorsed midwives to provide care that is culturally safe and continuous maternity care for women. Waminda's 10-year strategic plan includes building a birthing center to support women having an Aboriginal and Torres Strait Islander baby who wish to give birth away from hospital and reclaim ceremony back into birthing practices.

CS.10

CASE STUDY

Birthing in Our Community: Private Midwife and Aboriginal Community Controlled Health Organisation collaboration

North Brisbane, Queensland

BiOC North (Birthing in Our Community) is a partnership between My Midwives (a private midwifery business) and the Institute for Urban Indigenous Health (an Aboriginal Community Controlled Health Organisation). The BiOC North hubs are supported by an Indigenous workforce strategy and are delivered from culturally safe and welcoming Aboriginal community-controlled community-based hubs. My Midwives are contracted to provide midwifery continuity of care. All midwives in this model are endorsed midwives or midwives who are working towards endorsement and are being supported in their practice.

BiOC North has hubs in Strathpine and Caboolture and women give birth at one of three Metro North hospitals of their choice, where the individual midwives are credentialed. The three birthing facilities at Metro North each offer different services that cater to women's individual preferences and cultural needs. One hospital has tertiary care, one has a birth centre, one is a small hospital, and one is close to the water. Being credentialled across all facilities means midwives can continue to provide midwifery care to the woman if she is transferred from one hospital to another.

The midwives care for women across all risk categories, working closely with a multidisciplinary team, including obstetricians, paediatricians, family support workers, social workers, psychologists, and transport providers. The model of care means that 86% of women giving birth with My Midwives are attended by their primary midwife at birth. The BiOC model of care is reducing the rate of child removals for First Nations families and keeping families together. As well as pregnancy and intrapartum care, the My Midwives and BiOC team prioritise unlimited postpartum care for up to 6 weeks, including education, mother and baby wellbeing assessments, assisting with recovery after birth, breastfeeding support, newborn care, and contraceptive advice and provision.

in calling racism out [140], there persists a need to dismantle systems and practices that permit racism within the health workforce and reduce the associated load on Aboriginal and Torres Strait Islander midwives. It is essential that all workplaces are culturally safe for Aboriginal and Torres Strait Islander midwives, and acheiving this is also the responsibility of non-Indigenous health care staff at all levels.

The needs of the Aboriginal and Torres Strait Islander workforce are distinct from non-Aboriginal and Torres Strait Islander midwives. Specific recommendations are needed to create culturally safe workplaces for Aboriginal and Torres Strait Islander midwives and to recognise their contributions to the workforce. Our scoping review showed that strategies meeting workforce and education parity need to connect Aboriginal and Torres Strait Islander midwives and students together, and with non-Indigenous people, clinically and academically. Strategies must enable midwives and students to balance work, study and life responsibilities. The contexts must be culturally safe by respecting and embracing Aboriginal and/or Torres Strait Islander cultures and actively opposing racism in the personal, Community and organisational interfaces.

Implementation of the national multi-year Cultural Safety Accreditation and Continuous Professional Development Upskilling Framework and Strategy is another important strategy that will protect Aboriginal and Torres Strait Islander Peoples from racism in healthcare [143]. This framework and strategy are currently being developed and will be finalised by the end of 2024 [144].

The Strategy aims to improve the patient safety of Aboriginal and Torres Strait Islander Peoples by eliminating racism from the health system and making cultural safety the norm for Aboriginal and Torres Strait Islander patients. This includes recognising that patient safety includes the inextricably linked elements of clinical and cultural safety, and that this link must be defined by Aboriginal and Torres Strait Islander peoples [143]. Once the multi-year National Accreditation and Continuous Professional Development and upskilling Framework and Strategy for the registered health practitioner workforce is realised, it will be important to ensure that it is further adapted for the maternity health workforce.

3.6.2

CAPACITY-BUILDING FOR THE PROVISION OF CULTURALLY SAFE CARE

All women have the right to access culturally safe and appropriate maternity care. Many Aboriginal and Torres Strait Islander women desire care from Aboriginal and Torres Strait Islander midwives or, where this is not possible, they desire care that is culturally safe [1]. While the provision of culturally safe care is important to midwives [119], there persists a need to support the training and employment of Aboriginal and Torres Strait Islander midwives and to continue to build the capacity of the broader midwifery workforce to provide culturally appropriate maternity care.

Midwives acknowledge that Aboriginal and Torres Strait Islander women require maternity care that support their cultural birth practices [145], such as Birthing on Country models. Birthing on Country models have been described as

> *…a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families' which provides an appropriate transition to motherhood and parenting, and an integrated, holistic and culturally appropriate model of care for all [146, 147].*

Birthing on Country models thus refer to co-designed maternity services that are:

- Community based and governed,
- Provide for inclusion of traditional practices,
- Involve connections with land and country,
- Incorporate a holistic definition of health,
- Value Aboriginal and/or Torres Strait Islander as well as other ways of knowing and learning, and
- Encompass risk assessment and service delivery and are culturally competent.

While midwives acknowledged that Aboriginal and Torres Strait Islander women require an environment that support their cultural birth practices, most could not elaborate on the meaning of cultural safety and often refer to woman-centred care in lieu of knowledge of culturally specific models of care [145]. Research demonstrates that woman-centred care is not a substitute for culturally safe care for Aboriginal and Torres Strait Islander women [145]. Midwives often described themselves as actors in creating cultural safety for Aboriginal and Torres Strait Islander women in culturally unresponsive health systems and services but lacked critical reflection of their professional accountability as within these systems. Inadequate and inconsistent availability to continued professional development education about Aboriginal and Torres Strait Islander cultures and the provision of culturally safe care perpetuate limited understandings and self-reflected in midwifery practice [145]. Professional accountability through formal assessment of cultural competency has been suggested as a method of supporting culturally safe, woman-centred midwifery care for Aboriginal and Torres Strait Islander women [145].

Cultural and linguistic diversity in Australia is often used to refer to a person's country of birth, languages spoken at home, English proficiency or distinct cultural characteristics and customs [148, 149]. This diversity is reflected in the Australian population with more than a third of women who have recently given birth being born overseas [5]. Existing research largely pertains to culturally and linguistically diverse women's maternity care experiences more broadly, rather than midwifery-specific experiences. Culturally sensitive maternity care supports women to feel safe [1]. Cultural sensitivity includes respect and support for cultural practices, such as, the inclusion of family [150, 151], resting during the postpartum period, and body alterations such as piercings [150]. Preferences for female care providers due to cultural values were also significant for some women [152-154]. Some women also preferred to have maternity care providers from similar cultural backgrounds [152, 155]. Access to interpreters was particularly significant for women with lower English language proficiency [152, 156]. For the provision of culturally appropriate care, it is important to recognise the intra-culture diversity and to provide care tailored to the needs of the individual and their circumstances [149].

CS.11

CASE STUDY

Midwives delivering sexual and reproductive health care for rural women

Maryborough, Victoria

Universal access to reproductive health care is a strong predictor of individual health and life potential. Women in the rural Central Goldfields area of Victoria face barriers in accessing pregnancy choices, contraception, and sexual health care due to limited services, distance to travel, cost for services, and long wait time for GP appointments. The effects of these barriers are evident in health outcomes where the number of births for women under the age of 20 years of age are more than double the Victorian state average. The Endorsed Midwife Model of Sexual and Reproductive Health Care was implemented as a service response to these barriers as part of a suite of women's health initiatives. The endorsed midwife is credentialled and employed in the public system at the Maryborough District hospital utilising full scope of skills, including prescribing, diagnostics, and point of care ultrasound.

Access is a process of self-referral via an online booking platform or via practitioners and 1800MyOptions. Scope of service includes contraception, sexually transmitted infection screening, and pregnancy choices such as, emergency contraception, and medical or referral for surgical termination. Early pregnancy assessment, first trimester screening and referral for pregnancy care is also provided, as are 6-week postnatal consultations and contraception. Equity in access is ensured through the utilisation of activity-based funding, ensuring no fee for service. The endorsed midwife works in collaboration with local general practitioners, regional, and tertiary specialists to build strong community partnerships. This innovative model of care aims to change the health care story for rural women in the Central Goldfields community, whilst building career pathways for rural midwives.

3.6.3

CULTURALLY AND LINGUISTICALLY DIVERSE MIDWIVES

There is limited research regarding the number and experiences of culturally and linguistically diverse midwives in the Australian workforce. Internationally qualified midwives from culturally and linguistically diverse backgrounds report challenges working in a new language, feelings of cultural separateness and increased levels of discrimination and bullying [133, 157]. However, research on the experiences of internationally qualified midwives is limited and there is no research regarding culturally and linguistically diverse midwives who initially qualified for practice in Australia. No findings in this project pertained specifically to culturally and linguistically diverse midwives in Australia. Further research is required to ensure workplaces are responsive to the needs of culturally and linguistically diverse midwives.

3.6.4

SUMMARY

Working in culturally unsafe systems, Aboriginal and Torres Strait Islander midwives take on additional cultural load. Structures persist that undermine the contributions of Aboriginal and Torres Strait Islander voices to workplace decisions. Aboriginal and Torres Strait Islander midwives and culturally and linguistically diverse midwives experience workplace discrimination. There is a paucity of research both for Aboriginal and Torres Strait Islander and culturally and linguistically diverse midwifery experiences. Within culturally unsafe systems, Aboriginal and Torres Strait Islander women also require improved access to culturally safe care. To ensure an equitable future, midwifery must be a culturally safe workplace and provide culturally safe care.

3.7 A view to better futures

Midwives completing the Midwifery Futures workforce survey were asked for the top five things they felt needed to be addressed in midwifery in the next five years, with 639 providing a written response. Additionally, midwives who took part in interviews, focus groups, and the National Symposium provided many suggestions of their visions for the future of the midwifery profession. The difference between the midwifery scope of practice and definition of a midwife by the International Confederation of Midwives [54, 158] and the contemporary practice of midwifery in Australia was commented on by many. This difference relates to the provision of sexual and reproductive healthcare, early pregnancy care, and also extending the period of care for women and infants beyond the first few postnatal weeks. Other suggestions for future visions included clearer pathways for midwives to enter roles in education and / or research, either in the university sector or within healthcare services.

The ICM's scope of practice includes: *"The midwife has an important task in health counselling and education, not only for the women and gender diverse people they serve, but also within families and communities. This work should involve antenatal education and preparation for parenthood and may extend to* ***sexual and reproductive health care, and care for infants and young children****"* [54]. This means that in some countries the role of the midwife extends to these areas, although additional training may be needed depending on the content in the entry to practice program.

3.7.1

MIDWIVES AND MATERNAL, CHILD, AND FAMILY HEALTH CARE BEYOND THE EARLY POSTPARTUM PERIOD

Services for women, children and families beyond 6-weeks postpartum have historically been undertaken by registered nurses, some of whom may also hold a midwifery qualification, with additional education in MCFH care. Midwives who do not hold a nursing qualification are now interested in providing MCFH services. Midwives in Midwifery Futures expressed significant interest in being able to seek qualification and employment as MCFH providers. Midwives in this study identified that being able to be recognised as a MCFH provider was important to career progression and further practice opportunities.

3.7.2

SEXUAL AND REPRODUCTIVE HEALTH AND MIDWIFERY

The NMBA *Midwife standards for practice* [159] include provision for midwives to extend their practice to include sexual and reproductive healthcare, supported by additional education, competency, and authorisation. The Australian College of Midwives [160] also positions midwives as appropriate professionals to provide sexual and reproductive healthcare. While midwives recognise the importance of providing sexual and reproductive healthcare, many report a desire for further education to bolster their confidence [161]. Few employment opportunities for midwives to provide sexual and reproductive health services exist, nor is such a role well supported in relevant industrial agreements.

3.7.3

A VIEW TO BETTER WORKPLACES FOR MIDWIVES WORKING SHIFTS IN HOSPITALS

Over half the respondents (56.7%) to the Midwifery Futures workforce survey indicated their primary role was based in a hospital. While information about specific employment agreements was not sought, the majority of these midwives are likely to be employed on a shift-based roster. Respondents in midwifery group practice (5.7%), management (5.5%) and education roles (5.7%) are likely to be employed under other arrangements. One third of respondents to the workforce survey (33.3%) indicated their preferred option for future employment was to work in a standard (shift-based) model of care, and for respondents to the student survey this was the preferred option for 66.5%.

While growing CoMC models is an important priority – with clear benefits for women and babies, the midwives who work in these models, and for health services – midwives working in shift-based clinical roles in the hospital sector remain a vital component of a well-functioning maternity care system. Midwives working in the public sector and in standard models of care were more likely to indicate they had considered leaving midwifery, a finding that reflects previous research [88]. Our data, and that of others [87-89] also clearly demonstrate that midwives' experiences of their workplaces are strong drivers of attrition. Improving workplace conditions for shift-based midwives is therefore likely to be an effective investment in ensuring the stability of the midwifery workforce.

3.7.4

SUMMARY

There is potential for the Australia midwifery workforce to contribute more broadly to improving health outcomes for women and infants, through clinical practice, education provision, and research. Extending access to postgraduate education for additional midwifery roles, and processes to recognise competence, and provide authority to work in these roles are required.

3.8 Leaders for the future

3.8.1

MIDWIFERY LEADERSHIP AND VISIBILITY IS NEEDED

In all forms of data collection, a clear message was expressed that midwives wanted to see stronger midwifery leadership at government, executive, and clinical levels. Midwives also noted that without nursing registration, many leadership roles within health services remained inaccessible for them. Having a designated midwifery leader (Chief Midwife or similar) in each state or territory health department was proposed as both a means to avoid non-midwives making decisions about the midwifery profession and to provide roles for senior midwives to move into that appropriately recognise their knowledge and expertise.

3.8.2

MIDWIFERY LEADERSHIP AND VISIBILITY IS NEEDED

Good midwifery management (particularly in the context of managing CoMC models) has been identified as requiring certain personal characteristics - such as woman-centeredness, a strong belief in CoMC models, personal strength, a willingness to develop their leadership skills, and having access to support [162]. The ideal management style has been described as "midwifing the midwives", achieved by having an open and welcoming communication style, trusting and valuing midwifery staff, assisting midwives to prioritise self-care, supporting midwives' professional development, recognising midwives who are not a good fit for the model and managing their transition to other models of care, and ensuring adequate resources are available.

Participants in Midwifery Futures interviews and focus groups considered midwifery managers had important roles to play in setting workplace culture, with impacts on midwives' experiences of their work and attrition rates. They also reported the absence of a clear professional development pathway and promotional pipeline for midwives into management and leadership roles. Formal teaching of mentoring, management, and leadership skills and attributes was considered beneficial but was currently lacking. Survey respondents wanted to experience consistently good management.

Managers in the Midwifery Futures workforce wanted a clear professional distinction between nursing and midwifery, with different professional employment awards and career pathways, and to have midwives managed by midwives rather than nurses. Some described not being well supported by their own health service's management team, or being asked to juggle multiple tasks that were not part of their job description to keep the maternity service functioning (such as stock ordering and clerical tasks).

3.9 Conclusion

This chapter has provided an overview of the findings from the Midwifery Futures project. These include:

- Challenges in implementing models of midwifery care that provide continuity of carer,
- Limitations in being able to work to the full scope of practice especially in rural and remote areas,
- A shortage of midwives especially again in rural and remote areas although the shortage is also in metropolitan areas,
- A lack of support for midwives to thrive and to be able to have flexibility and autonomy in their work patterns,
- Limitations in workforce planning, and
- A lack of visibility and leadership from midwives for midwifery.

The chapter synthesises the findings to summarise the key problems and challenges impacting upon midwifery and provides some key workforce levers that may be used ameliorate the situation.

Chapter 4: Problems and workforce levers

The Midwifery Futures Project has revealed that the midwifery workforce is in crisis and change is urgently needed. Without significant action soon, the number of midwives will be insufficient to provide quality midwifery care to women, newborns and families in Australia.

This part of the Midwifery Futures Report synthesises the findings and presents the key problems and challenges impacting upon the midwifery profession and its workforce and articulates the key levers that may be used ameliorate the situation. The EAG, WAG, Aboriginal and Torres Strait Islander Yarning Circle, Consumer and Lived Experience Expert Panel and the National Midwifery Symposium provided critical feedback and helped further interpret the findings into articulating these problems and challenges.

4.1 Key problems and challenges

A LACK OF VISIBILITY AND OPPORTUNITIES FOR MIDWIFERY LEADERSHIP

1: A LACK OF VISIBILITY OF MIDWIFERY

The visibility of midwives and the midwifery profession has improved over the last decade. For example, midwifery is now recognised and regulated as a separate profession to nursing. There is a Nursing and Midwifery board, a national registration and notification committee for midwifery that is an operational committee of the NMBA, State and Territory boards, a Nursing and Midwifery Accreditation Council, a Council of Deans for Nursing and Midwifery, and midwifery is named in leadership roles (Chief Nursing and Midwifery Officers; Directors of Nursing and Midwifery). Most jurisdictions have a named midwifery advisor position within the respective health department or ministry.

Despite this progress, there are many instances where the leadership of the midwifery workforce, at many levels, remains governed and managed by the nursing profession and/or non-midwives. In society, midwifery is often invisible as a separate profession, a valid career pathway, and a safe health care option for women. In addition, we heard that midwifery at many levels remains managed by the nursing profession, especially in relation to strategic issues.

The chief nursing and midwifery officers in many jurisdictions have limited power or mandate to influence the health system. This means there is a lack of single points of leadership for both midwifery and nursing. Midwifery and nursing individually need strong leadership that has the power to influence and make improvements.

2: A LACK OF UNDERSTANDING ABOUT THE CURRENT NATIONAL REGULATION OF MIDWIFERY

There seems to be a lack of understanding by midwives about the current regulatory environment in Australia. Since the implementation of the National Law, significant efforts have been made to ensure midwives are regulated by midwives. This includes the NMBA Registration and Notifications Committee: Midwifery (National), chaired by a midwife with at least four midwife members. This committee manages all registration and notification matters referred for further enquiry, including investigation, health assessment, and performance assessment involving midwives, midwifery students, or where the practitioner holds dual registration as a nurse and a midwife, except notifications in NSW. NSW has a co-regulatory environment where the NSW Nursing and Midwifery Council are responsible for midwifery notifications. Many midwives providing data to Midwifery Futures did not seem to understand how the profession was regulated.

3: MIDWIFERY LEADERSHIP COULD BE STRONGER AND MORE VISIBLE AT ALL LEVELS

There is a lack of visible and named contemporary leadership in midwifery. There are few midwifery leadership positions equivalent to nursing positions, even where there is a maternity model of care or service. People leading midwives do not always have a midwifery qualification, either single (midwife) or double registered (RN and midwife). The recent appointment of a Chief Midwife in Queensland is a positive step forward in highlighting the need for midwifery leadership at all levels. The Queensland Government has also recently appointed a First Nations Midwifery Director, a model that would be useful for other jurisdictions to consider. Midwifery leadership is required at every level including national government, state government, healthcare district executive levels, and hospital service management.

Recent evidence on the implementation of CoMC in the UK has shown that a lack of senior health service leadership impacts on the implementation of midwifery models of care [163]. A lack of senior leaders who understand midwifery models affects the level of buy-in and support.

CHALLENGES IN IMPLEMENTING MIDWIFERY MODELS OF CARE

4: LIMITED FULL SCALE-UP CONTINUITY OF MIDWIFERY CARER PROGRAMS

Women want access to CoMC [1, 21] but there are not enough of these models, and they have not been scaled up to be the usual option for women. There seems to be a disconnect between what women want and what health systems intend to provide [21]. Many midwifery group practices and privately practicing midwives (PPMs) have reported long waiting lists and the rates of freebirth are thought to be increasing.

Current barriers to scaling up midwifery group practice models include a lack of midwifery leadership, industrial challenges in some states that limit part-time options, limited access to real-time health information via the My Health Record (to ensure midwives can provide continuity of care and carer within primary care services), insufficient funding, and a lack of funding models available to health services. The lack of an implementation plan for the strategic directions for Australian maternity services report [14] has been a limitation to innovation and scale-up of CoMC services.

There is a lack of consistent access for women to homebirth and midwives are often unable to provide this service. The inability to access appropriate insurance options has implications for access, equity, and workforce sustainability. In addition, the ACM Guidelines for Consultation and Referral have erroneously been suggested as a means to plan place of birth under recently proposed changes to government funded indemnity insurance [26]. The ACM Guidelines for Consultation and Referral were designed to support midwives making consultation and referral decisions and were not designed as a risk assessment tool relating to place of birth.

Throughout Midwifery Futures we heard several myths about the type of midwives who should, or could, transition into working in CoMC models. These myths included needing three years of prior experience providing intrapartum care in hospital, that they must be able to work completely independently including being able to cannulate and undertake perineal suturing, and that they must work full-time. None of these myths are substantiated in the evidence and must be dispelled for CoMC models to be scaled up.

The international literature notes similar challenges in scaling up access to CoMC. A recent UK report showed that the barriers to successful implementation of CoMC models included [163]:

- Lack of senior leadership understanding of model affecting level of buy-in and support,
- Insufficient planning time and funding to undertake a major service change,
- Service context factors including not having safe or sufficient staffing levels; existing stress and poor morale among midwives,
- A section of the workforce not wanting to work in an on-call model, for personal reasons (e.g. childcare) or professional reasons such as lack of familiarity and comfort with other areas of midwifery work or fears about managing a caseload,
- Misinformation about CoMC, influenced by lack of or poor-quality data and lack of in-depth understanding of how CoMC works to achieve its benefits, and
- Pre-existing concerns and negative experiences from prior implementation of models that were not well supported or functioning.

5: THERE ARE NOT ENOUGH MODELS OF CARE FOR ABORIGINAL AND TORRES STRAIT ISLANDER MOTHERS AND BABIES

Birthing on Country models are now being recognised and supported as part of primary maternity care but there are not enough models across the country. There is a lack of funding for development and expansion of Birthing on Country models to close the gap through improving outcomes for Aboriginal and Torres Strait Islander women, babies and families. Birthing on Country, or other CoMC programs for Aboriginal and Torres Strait Islander women, should not be restricted to low-risk women.

6: MIDWIVES DO NOT HAVE EQUAL INCENTIVES TO WORK IN THE PRIMARY HEALTH CARE SECTOR

Midwives are currently not included in all incentive schemes for the primary health care workforces, for example: the Rural Health Multidisciplinary Training (RHMT) program [40], HELP for Rural Doctors and Nurse Practitioners,[37] and the Transition to Practice Program for nurses that is facilitated by APNA [164].

7: BARRIERS TO ACCESSING APPROPRIATE MODELS FOR PRIMARY MATERNITY CARE

The *Unleashing the Potential of our Health Workforce - Scope of Practice Review (Issues Paper 2)* [31] highlighted that midwifery practice is limited by regulatory and administrative issues, institutional conventions, cultural factors and resistance from medical professionals.

Women are often unaware that midwifery models of care exist and have high quality evidence demonstrating their quality and safety. During the Midwifery Futures project, we heard from consumers in our Consumer and Lived Experience Expert Panel and at the National Symposium, that women do not know midwives are an option. GPs often refer women to public hospitals or to a private obstetrician if the woman has private health insurance, without offering a midwifery model of care. We also heard that when women ring the 13Health government help line for Pregnancy and Baby they never speak to a midwife and are not informed about midwifery care options.

8: MIDWIVES ARE OFTEN UNABLE TO PROVIDE ADDITIONAL SERVICES

Single-registered midwives are often unable to study or work in additional areas including MCFH, and sexual and reproductive health services. Work commissioned by the NMBA confirmed that from a regulatory perspective, there is no increased risk to the health and safety of the public by midwives without a nursing qualification practising in MCFH. Some MCFH nurses and industrial and professional bodies have expressed concerns about the lack of protection of the title of a nurse or midwife providing MCFH services.

A SHORTAGE OF MIDWIVES

9: AN INSUFFICIENT NUMBER OF MIDWIFERY STUDENTS AND THEREFORE, ULTIMATELY GRADUATES

There are not enough midwives to address projected shortages. The current number of students is static and inadequate to meet future needs. There is currently a disconnect between the number of students taken by universities and the projected number of midwives ultimately required by the health services and ACCHOs to fill current and future needs.

In particular, there are not enough Aboriginal and Torres Strait Islander midwives. We have estimated there are currently 460 Aboriginal and Torres Strait Islander midwives but to reach parity with the non-Indigenous workforce, at least 1,300 midwives are needed. Flexible pathways through TAFE or other mechanisms (see below), quarantined university places, collaboration with ACCHOs to enable MPEs, and ongoing support and mentoring are not in place in all settings.

10: MIDWIVES ARE WORKING IN A COMPLEX ENVIRONMENT

In all the data collected for Midwifery Futures it was clear that midwives are working in a complex environment, and this is exacerbated by workforce shortages. Maternity care is increasingly medicalised with high rates of induction of labour and caesarean section [5], short postnatal stays and a need to balance a myriad of policies, practices, documentation requirements, and clinical demands. Midwives consistently said that they could not practice midwifery in a meaningful way, often due to medicalisation and an inability to work to their full scope of practice. In addition, midwives work with women and families experiencing grief and loss and are often the key provider for families during bereavement.

The NSW Birth Trauma report [21] crystallised many of the challenges that resulted in women experiencing preventable birth trauma. While the Select Committee prioritised submissions from individuals residing in NSW, it is highly likely that there are similar issues in other jurisdictions. The NSW Birth Trauma report provides an opportunity for all states and territories to review and develop pro-active action plans to address issues that are also likely in their own context.

11: MIDWIFERY STUDENTS ARE NOT EMBEDDED IN PROGRAMS THAT PROVIDE CONTINUITY OF MIDWIFERY CARER

MPEs do not always provide the opportunity for students to experience and provide care in a CoMC model. When students do, this time is not always included as part of the overall course requirements set by universities. There are no practice incentives for PPMs to offer MPEs for midwifery students in a similar way to GPs who support doctors in training [165].

12: A LACK OF STANDARDS TO ENSURE THE QUALITY OF MPES

The Midwifery Futures team heard through focus groups, interviews, and at the National Symposium, concerns about the quality of some clinical MPEs. MPEs are not of equal quality and while some provide a high level of support, supervision, and monitoring of students, others do not.

The Australian Universities Accord Final Report [166] recommended that professional accreditation bodies should have a place in ensuring students have access to quality MPEs although it is not clear how organisations like ANMAC will address these recommendations.

13: A LACK OF FUNDING FOR MIDWIFERY EDUCATION, MIDWIFERY EDUCATORS AND MPEs

The recent Australian Universities Accord Final Report (February 2024) [166] identified the significant issue of placement poverty. Undertaking MPEs is a significant financial burden for midwifery students and can also limit the accessibility and diversity of potential students. The Universities Accord report found that "mandatory placements can involve onerous hours and can financially disadvantage students who are unable to participate in paid work while on placement or need to relocate to undertake their placement".

Other issues related to midwifery education include additional costs for students from rural and remote areas, such as temporary relocation to gain experience in a larger centre and addressing HELP debt relief for midwifery graduates as has been done for GPs and nurse practitioners. We also heard of the costs of preclinical requirements (eg. first aid courses, immunisations, etc) were disincentives for prospective students, especially those from low socio-economic situations.

An important key to quality midwifery education is having quality midwifery educators – both in the university sector and the health services. In Midwifery Futures we heard of multiple pressures on university academics including the need to develop and succeed in a researcher career as well as designing and implementing ANMAC-accredited curriculum, using contemporary teaching methods, and maintaining clinical practice. In the health service, midwifery educators are not always valued and there are usually not enough of them to meet the need. This demand for educators will be exacerbated with more students.

Other research has highlighted challenges in attracting and retaining midwifery academics [167]. This review showed that retaining midwifery academics required accessible promotion pathways, positive work environments such teamwork, professional relationships, support for older academics, and having access to professional development. Preventing attrition includes addressing emotional exhaustion and burnout, and ensuring academics feel valued and are recognised. This scoping review found a a lack of research related to the Indigenous nursing and midwifery academic workforce.

14: LIMITED PATHWAYS TO MIDWIFERY FOR PROSPECTIVE ABORIGINAL AND TORRES STRAIT ISLANDER STUDENTS

Available pathways into pre-registration midwifery education are limited and/or inconsistent. The pathways for Aboriginal and Torres Islander people to enter midwifery vary across the country. For example, recognition of prior learning for Aboriginal Health Workers working in maternity services is inconsistent across universities. The availability of relevant pathways through TAFE or Aboriginal community-controlled organisations to support Aboriginal and Torres Islander people to enter midwifery is not standard across the country.

15: PRESCRIBING IS NOT PART OF PRE-REGISTRATION MIDWIFERY EDUCATION

Midwifery prescribing is part of the international scope of midwifery practice but educational preparation for this not included in Australian entry to practice midwifery programs, and authority to prescribe is not granted on registration. Midwives are currently facilitating prescribing and ordering investigations but through standing orders and asking doctors (often junior doctors) to sign requests. This is not acceptable going forward and prescribing and ordering investigations specific to pregnancy and childbearing is well within midwives' scope of practice.

A LACK OF SUPPORT FOR THE MIDWIFERY WORKFORCE

16: CULTURAL SAFETY FOR MIDWIVES AND IN MIDWIFERY PRACTICE TO REDUCE RACISM

Education and healthcare environments are not always culturally safe spaces for Aboriginal and Torres Strait Islander women or midwives. Cultural safety and cultural supervision are intrinsically linked to the effectiveness of strategies to attract, educate, and retain the Aboriginal and Torres Strait Islander nursing and midwifery workforces.

Internationally qualified midwives from culturally and linguistically diverse backgrounds also report a disproportionate level of workplace discrimination and bullying. In some situations, there do not seem to have been ramifications to these behaviours.

17: MIDWIVES CANNOT WORK TO THEIR FULL SCOPE OF PRACTICE

There are high rates of burnout and a lack of job satisfaction currently in the midwifery workforce. Some of that is attributed to not being able to work to their full scope of practice and feeling valued as a member of the health care team.

Midwives responding to our survey, while acknowledging workforce shortages across the board, commonly identified that antenatal and intrapartum areas were often better staffed than postnatal services. Midwives provided examples of services employing other workers in the postnatal areas such as registered and enrolled nurses. A woman's early transition to motherhood is a critical time in her life and one that should demand skilled care from those educated to provide it - midwives. The recent Birth Trauma Inquiry in NSW [21] clearly highlighted challenges for women accessing compassionate individualised care where skilled midwives have time and space to listen, respond, support, and reflect with women and their partners, acknowledging and validating their birth experience. The ability of services to meet this brief will be more challenging if postnatal wards remain chronically understaffed as well as being staffed by non-midwives. There are also concerns about other workers replacing midwives (doulas, paramedics, nurses) in other area where there are shortages of midwives.

There are several areas where midwives are not working to their full scope of practice. One example is the provision of early pregnancy care, caring for women with early pregnancy complications or wanting therapeutic abortion. Midwives are often not involved in the care of these women due to arbitrary cut-offs of gestational age defined by many health services (eg. in many contexts, midwives only care for women after 20 weeks except for first antenatal visits).

18: MIDWIVES WORKING IN SHIFT-BASED MODELS OF CARE REQUIRE IMPROVED WORKING CONDITIONS

Midwives working in shift-based models make up the majority of the current midwifery workforce and one third of them want to remain working in this way. Therefore, it is essential that they are supported to retain in the workforce, enabled to thrive, and have fulfilling careers. The challenges highlighted in this report, especially the reasons for attrition and reasons to be dissatisfied with midwifery impact on this group disproportionately. Midwives in the survey, focus group, interviews and in our advisory groups repeatedly reported dissatisfaction with 'not being able to practice midwifery as I see it', having inadequate staffing levels and an inappropriate skill mix, having a lack of professional autonomy, and the presence of bullying or violence in the workplace leading to actual or planned attrition.

Other reports have shown similar findings, in particular, the FUSCHIA report from Victoria which showed that the impact of turnover (midwives leaving) was particularly high in regional/rural public services due to lack of available staff, which in turn caused heavier workloads. Other reasons for leaving were the lack of experienced midwives, the need for improved work/life balance, remuneration, or to avoid shift work [19]. In the United Kingdom, there are significant concerns for less experienced midwives

with higher levels of burnout, depression, anxiety, and stress reported in those with less than 10 years of experience compared with more experienced midwives [168].

While midwifery models of care may provide a future solution, it is imperative the majority of the current shift-based workforce are supported with improved working conditions and renumeration. Our modelling showed that if midwives worked an additional 4 hours per week, the workforce shortages would reduce. It is unlikely that this will occur without improved working conditions (workload, mentoring, leadership, wages).

19: A LACK OF WORKPLACE FLEXIBILITY AND CAREER PATH OPTIONS FOR MIDWIVES

The analysis of data collected from surveys and focus groups has highlighted that many midwives reduce the hours they work and/or change to being on a casual roster due to burnout and an inability to have flexibility in their working lives. Rostering practices are often inflexible with limited autonomy, making casual or part-time work more attractive.

Midwifery skills acquired through continuing professional development (e.g. cannulation, venepuncture, perineal suturing, midwife-led postnatal discharge) are not consistently recognised by health service providers. In particular, the credentials PPMs are required to hold to access visiting rights in hospitals and health districts (eg. emergency maternity care, perineal suturing, fire and safety etc) are inconsistent, leading to duplication and reduced workplace flexibility.

There are limited career progressions for midwives who wish to remain in clinical practice. Currently, there is no real progression beyond year 8 after registration, with the only alternatives being clinical midwifery specialist, clinical midwifery consultant, or midwifery unit manager.

Clinical midwifery researchers in health services facilitate and translate evidence into practice and support high quality care, and this role provides further career pathways for midwives. There are currently few designated roles, either in the health system or in enterprise bargaining agreements, that recognise clinical midwifery researcher as a formal career pathway.

20: A LACK OF STRUCTURED AND AVAILABLE MENTORING, CLINICAL SUPERVISION AND CONTINUING PROFESSIONAL DEVELOPMENT FOR MIDWIVES

Mentoring: There are no national standards for a graduate mentoring program for midwives during the consolidation of their first year or two of practice to build confidence, clinical skills and networked support. This is also the case for midwives graduating with a dual degree and needing to consolidate both midwifery and nursing. There are very few programs that prioritise graduates working in rural and remote areas and those going directly into CoMC models. Midwives do not have access to programs like the Transition to Practice Programs provided by APNA and funded by the Australian Government Department of Health [164].

Clinical supervision: Many midwives and midwifery students do not have access to appropriate professional supports (sometimes called clinical supervision) to enable their continued involvement in the profession. Midwifery students and midwives in our studies, particularly those working in clinical roles, reported significant levels of burnout, vicarious trauma, poor workplace culture, and difficulties with work-life balance. Clinical supervision can effectively support midwives to remain engaged in their profession.

Continuing professional development: There is a lack of equity of access to opportunities for continuing professional development programs and up-skilling, especially for midwives working in rural and remote settings. Nurse practitioners and GPs often have access to professional development incentives, but midwives do not.

LIMITATIONS IN WORKFORCE PLANNING

21: MIDWIFERY MANAGERS ARE OVERWHELMED AND LACK SUPPORT

Throughout this project, we heard of the many issues facing midwifery managers. These roles are challenging, with a large part-time staff to manage, a need to manage ward budgets without specific training in financial management, day to day management of staffing shortages, a lack of succession planning, and little administrative support.

22: INSUFFICIENT PROGRAMS TO ATTRACT MIDWIVES WHO HAVE LEFT THE WORKFORCE OR THOSE COMING FROM OVERSEAS

There are only two education providers currently approved by the NMBA to provide midwife re-entry programs, and few midwives seek re-entry through these routes. There are no national incentives to attract midwives back; although, in Victoria, the Midwifery Re-entry Program provides scholarships ($15,000) and support for midwives who wish to return to practice after a period of absence [169]. Further strategies to both attract midwives back and to incentivise education providers to deliver such services would be a useful adjunct.

Many health facilities and districts have undertaken recruitment drives to attract midwives from overseas. For the most part, this has been unsuccessful at scale.

23: BETTER HEALTH WORKFORCE DATA TO MONITOR TRENDS AND PLAN RECRUITMENT AND DEPLOYMENT

The health workforce data currently does not adequately measure the number of midwives moving in and out of the profession as well as the net totals each year. Our modelling work highlighted the inability to estimate the percentage of dual registered midwives (midwife and nurse) working in each discipline, and in the non-clinical workforce.

Our modelling analysis could not include the state and territory-based staffing calculations, such as, minimum midwife to patient ratios or Birth Rate Plus.

There is no publicly available data on university course attrition rates and reasons why students do not complete their midwifery education. Governments have little line of sight of the numbers of students being recruited and workforce being produced to meet the need. This leads to a disconnect between the workforce needs for the future and the number of midwifery students accepted into midwifery programs each year.

4.2 Workforce levers

There are several workforce levers that can be used to address the current crisis.

- Increase the number of midwifery students (increase inflows) – needs to happen urgently.
- Reduce attrition and encourage midwives to work more hours through improving the workplace culture, flexibility, mentoring and support (reduces outflows) - important.
- Scale-up CoMC and primary care models to attract and retain midwives (reduces outflows) - important.
- Encourage midwives to return to practice (increase inflows) – probably limited impact.
- Attract overseas educated midwives and fast-track processes for them to be registered (increase inflows) – limited impact.

4.3 Conclusion

This chapter has highlighted the key problems and workforce challenges found during the Midwifery Futures project. These come from the data as well as key reflections from the EAG, WAG, Aboriginal and Torres Strait Islander Yarning Circle, Consumer and Lived Experience Expert Panel, and the National Midwifery Symposium.

The next chapter provides some solutions to the problems and provides a series of recommendations.

Chapter 5: Solutions and recommendations

It is clear from the data collected from this report that the midwifery workforce in Australia is in crisis and change is needed. Continuing to do the same and expecting different results is no longer possible.

Change will require the entire sector to come together – the regulators, the education providers, the health departments and health districts, the other professions and health leaders, and the professional and industrial organisations.

We discuss the five key areas for attention and then make a series of recommendations for the future. While this report was commissioned by the NMBA through Ahpra, many of the recommendations require a wider approach than the NMBA is authorised to coordinate, and a mechanism to bring all the stakeholders together is critical in going forward. The EAG, WAG, Aboriginal and Torres Strait Islander Yarning Circle, Consumer and Lived Experience Expert Panel, and the National Midwifery Symposium informed these solutions and helped develop these recommendations.

The Midwifery Futures Project provides the evidence base to address the workforce challenges and support the midwifery profession to deliver woman-centred, evidence-based high-quality care to Australian communities across all sectors now and into the future.

5.1 Key issues to address

VISIBILITY AND LEADERSHIP

INCREASE THE VISIBILITY OF MIDWIFERY

Visibility includes the perceived worth and effectiveness of midwives, both as a profession and as a health care option for pregnant women. Promoting and embedding an awareness of midwifery among the general population through media and educational initiatives can yield positive impacts in cultivating an interest in pursuing midwifery as a profession and in enhancing the health outcomes of women engage with midwives for maternity care.

It is important to ensure that women are aware of midwives and are referred to midwifery services, where appropriate. Women also need access to midwives through the 13Health government help line when they call with pregnancy-related issues.

STRENGTHEN MIDWIFERY LEADERSHIP AT ALL LEVELS

Strengthening midwifery leadership is crucial for the continued growth, development and sustainability of the Australian midwifery profession and ultimately, for the health and wellbeing of mothers and babies in Australia. We heard support for the phrase: "Everything for the profession of midwifery is led by the midwifery profession". The NMBA Registration and Notifications Committee: Midwifery (National) is an excellent example of midwives regulating midwives. This now needs to happen at all levels across the health sector.

The Health Chief Executives' Forum has recently announced a review of the regulatory complexity of the National Registration and Accreditation Scheme (the Complexity Review). This may ultimately reduce the number of individual boards. Midwifery needs to be well positioned to ensure adequate visibility as a separate profession while retaining clear governance along with the other health disciplines.

Aboriginal and Torres Strait Islander midwifery leadership is needed as a pivotal condition and strategic enabler to attract, educate and retain the Aboriginal and Torres Strait Islander workforce and support the development of programs, such as, Birthing on Country initiatives. Aboriginal and Torres Strait Islander midwives who are in leadership positions often need further support and development to stay in these roles as there is a significant cultural load to carry for an organisation.

Midwifery leadership is required at every level including national, state, healthcare districts executive levels, and hospital service management. To achieve this, it is essential to have midwifery leadership positions equivalent to nursing leadership positions where there is a maternity model of care or service. The recent appointment of a Chief Midwife in Queensland is a positive step forward in highlighting the need for midwifery leadership at all levels.

Where people are leading midwives, they must have midwifery registration, with or without nursing registration. These leadership roles require accountability, delegation, autonomy, decision making ability, and support. All governance, legislation, and policy/process need to be updated to reflect midwifery leadership roles.

MIDWIFERY MODELS OF CARE

SCALE-UP CONTINUITY OF MIDWIFERY CARER PROGRAMS

Midwifery care must be accessible in Australia to all women for the provision of primary maternity and sexual and reproductive healthcare. Maternity care should be provided and delivered in primary and community-based settings, as opposed to acute care settings, for women and their babies who do not require tertiary level care. In addition, referral pathways that seamlessly facilitate a woman's movement in and out of primary and tertiary care service, should be available.

Women want access to CoMC [1, 21]. There is now an overwhelming body of evidence that this model of care optimises maternal and newborn outcomes [44, 105, 109, 110] and has benefits for midwives and the broader health system [105]. Newly qualified midwives want to work in these models and there is evidence that working in this way is good for job satisfaction. Thus, it is essential that students are embedded in CoMC models during their midwifery education. The quality learning experiences offered to students in this model enhance their midwifery identify, capacity, resourcefulness, and connection and prepare them to work across the full scope of midwifery practice on graduation.

Opportunities for new graduates to transition directly into CoMC are important. This may include quarantined places, transitional, or rotational models. Employment and industrial models need to be available to ensure that newly graduated midwives have these opportunities from the outset and have the necessary mentoring and clinical support.

As most maternity care is provided in the public sector, midwifery group practice with access to the multidisciplinary maternity team should be offered as an opt-out model. Midwifery models of care should be available to all women, not just those who are deemed to be low risk. All CoMC models are inherently collaborative, and should include access to obstetricians, GP obstetricians, and other disciplines as appropriate. Reorganising maternity services will ensure women have access to primary evidenced-based health care while simultaneously supporting their right to select a type of maternity care that best meets their own individual needs and preferences.

There are many ways to provide CoMC with examples including midwifery group practice, team midwifery with small teams of midwives (6-8 midwives), and midwifery antenatal and postnatal programs (known as MAPS). Women generally want to know their midwife during labour and birth, so models of care need to be designed to increase that opportunity. On-call flexibility, job-share, and part-time options (with part-time on call) must be developed to suit both midwives and women.

Clear referral pathways need embedding to coordinate care when consultation and referral, shared care, or transfer of care is required with other health care professionals (PPMs, general practitioners, general practitioner obstetricians, specialist obstetricians, and specialist treating teams or physicians).

Women in Australia require access to homebirth and midwives need support to provide this service. Women and midwives alike require fit for purpose professional indemnity insurance. The inability to access appropriate insurance options has implications for access, equity, and workforce sustainability. The ACM Guidelines for Consultation and Referral were not designed to support place of birth decisions and will need additional work if this is how they will be used.

MIDWIFERY MODELS OF CARE

The international literature highlights the key factors enabling successful implementation of CoMC. The factors from a recent report from the United Kingdom [163] include:

- Strong Trust (health district) support and senior leadership understanding and fully supporting the model,
- Extensive engagement with midwifery workforce and stakeholders to achieve understanding and buy-in,
- Training, resources, and support for CoMC implementation leaders,
- Detailed planning ahead of implementation, with protected time, support, and resources. Transitional funding to support the additional costs of the change process,
- Preparatory and ongoing personalised training and support for midwives joining CoMC teams,
- Midwives wanting to work in this model - more likely with engagement, training, and codesign of a flexible and sustainable midwifery continuity of care model, and
- Sufficient midwifery staffing levels.

PROMOTE, SUPPORT AND SCALE UP CONTINUITY OF CARER PROGRAMS FOR ABORIGINAL AND TORRES STRAIT ISLANDER MOTHERS AND BABIES

Birthing on Country models (also known by other terms including Birthing In Our Community) are now being recognised and supported as part of primary maternity care. Funding further development and expansion of Birthing on Country models provide a key opportunity to expand primary maternity care and Close the Gap through improving outcomes for all Aboriginal and Torres Strait Islander women, babies, and families.

Birthing on Country models provide Aboriginal and Torres Strait Islander women, babies and families the best start to life with access to culturally safe and responsive maternity care provided in a CoMC model with wrap around services across the continuum of care. The RISE Framework [2] has been identified as a priority for implementation across all rural and remote areas to preserve services and increase access to care for rural women and families. Two other examples are the Baby Coming You Ready program [170] and the Replanting the Birthing Trees [3]. Baby Coming You Ready is a model of care and digital platform that has 'cracked the code' to overcome communication barriers between Aboriginal women and their health care provider during pregnancy and after baby arrives [171]. The pilot has successful finished and is now being implemented in multiple sites and in Victoria, South Australia and Queensland. The Replanting the Birthing Trees [3] will be implemented over the next few years and will be important to consider.

Part of expanding access to Birthing on Country models requires strengthening, supporting and building the Aboriginal and Torres Strait Islander midwifery workforce through flexible pathways (see below) and working closely with the Aboriginal Community Controlled Health Organisations. It is essential that these models of care are available to women of all risk status, including social and emotional, as well as obstetric or medical risk.

BOOST INCENTIVES TO MIDWIVES TO WORK IN THE PRIMARY HEALTH CARE SECTOR

Midwives must be included in all future incentive schemes for the primary health care workforces, for example: Rural Health Multidisciplinary Training (RHMT) program [40], HELP for Rural Doctors and Nurse Practitioners,[37] the Transition to Practice Program for nurses facilitated by APNA [164].

The endorsed midwife pathway and workforce in primary care provides an ideal mechanism to increase access to quality midwifery care and provide a career pathway for midwives. The upcoming removal of the requirement for endorsed midwives to have a formal collaborative agreement in order to provide Medicare eligible services assists in expanding opportunities for midwives in primary care. In addition, better utilisation and scale up of endorsed midwives in the public sector is another unique opportunity to enable midwives to work to their full scope and provide quality care.

DEVELOP AND IMPLEMENT NEW FUNDING MODELS FOR PRIMARY MATERNITY CARE AND MIDWIFERY CONTINUITY OF CARE

The *Unleashing the Potential of our Health Workforce - Scope of Practice Review (Issues Paper 2)* [31] highlighted that state-based regulations affect the midwifery workforce; however, practice is also affected by licensing and administrative issues, institutional practices, cultural factors and resistance from medical professionals. Institutions with high interprofessional communication have been found to have less complications and readmissions, as well as improved midwife satisfaction.

To provide midwives with the opportunity to utilise their full scope of practice, barriers that restrict the scope of midwifery practice must be removed. This is particularly important in rural and remote areas.

Midwifery Futures endorses the National Health Reform Agreement Mid-Term Final Report that recommended that:

> *Recommendation 13: A structured program of work should be undertaken to develop and implement bundled payments within the National Health Reform Agreement for certain end to end episodes of care (before, during and after a planned hospital admission), with an initial focus on maternity care, and with additional priority areas identified early in the Agreement in consultation with the national bodies and relevant stakeholders. Bundled payments should be implemented across several priority areas within the period of the next Agreement.*

This is also reiterated in the Unleashing the Potential of our Health Workforce - Scope of Practice Review (Issues Paper 2) [37], which Midwifery Futures also supports:

> *7.3. Bundled funding for midwifery continuity of care models*
>
> *Introduce bundled funding for the midwifery continuity of care model as a defined care pathway, to fund midwives to work to their full scope when they practise across different parts of the health care system (including primary and admitted care) which currently operate under separate funding arrangements.*

MIDWIFERY MODELS OF CARE

ENABLE MIDWIVES TO PROVIDE ADDITIONAL SERVICES

Midwives want to enhance their understanding of the impact of the first 2,000 days by studying and/or working in additional areas including MCFH services and sexual and reproductive health services. Work progressed by the NMBA confirmed that for midwives that do not hold nursing qualifications there is no evidence to suggest any current regulatory risk for the public that warrants changes to the existing regulation in place for MCFH as it is sufficient to protect the public. These midwives, like nurses, need access to appropriate post graduate MCFH qualifications and/or a professional development program, that support their transition into this context of practice and different service settings. Similarly, additional roles for midwives to provide sexual and reproductive health services in the public hospital and community sectors should be developed and supported in relevant industrial agreements.

Models of care in health services, especially primary care services, need to be designed to ensure that midwives with these qualifications can work effectively. This is especially relevant for rural and remote settings but could also be very useful in urban areas as key primary health care services.

We recognise that there are challenges with this approach with some MCFH nurses and industrial and professional bodies expressing concern. The protection of the title nurse or midwife providing MCFH services is important to retain.

DESIGN, IMPLEMENT AND TEST INNOVATIVE MODELS IN RURAL AND REMOTE AREAS

As described above, midwives are keen to provide a wider range of services including in MCFH and sexual and reproductive health in the primary care context. Nurse practitioners are also developing models of care to provide primary care services in rural and remote settings. There may be an opportunity to develop a shared services that caters for rural communities. This needs testing for feasibility, affordability and cost benefits.

The recent Joint Nursing and Midwifery Peaks Statement [32] in response to the Scope of Practice Review (Issues Paper 2) [31] supports possible innovations in rural and remote settings where "supporting and employing a local nurse to become the local nurse practitioner (NP) or a Credentialed Mental Health Nurse (CMHN), or a local midwife to become endorsed, would provide greater sustainability and stability in continuity of care than an expensive fly-in medical service" [32].

GROW THE MIDWIFERY WORKFORCE

ADDRESS THE NUMBER OF MIDWIFERY STUDENTS AND THEREFORE, ULTIMATELY GRADUATES

It is a matter of urgency that student numbers are increased by at least 20% - leading to around 1,560 students graduating in 2-4 years (depending on the length of the programs). Being able to increase the number of students is dependent on increased clinical placements and ensuring that clinical facilities can provide the supervision and support needed to produce quality graduates. ANMAC has a role to play here in assessing whether resources are sufficient, and educators are in place in both the university and health service.

The CNMOs and relevant Government Ministers have an important role to play in workforce planning to ensure an adequate number of students are admitted by universities and placed in health services to meet the ongoing workforce demands. The ACCHOs should also be included in these discussions. The Midwifery Advisors/CNMOs in some states are starting this process of better communication between the sectors (eg. ACT, NSW, WA) which is encouraging.

Midwifery is a highly feminised profession, probably the most feminised in Australia. Increasing the number of midwifery students and midwifery graduates may also play a role in addressing the gender pay gap in Australia.

FURTHER EMBED MIDWIFERY STUDENTS IN PROGRAMS THAT PROVIDE CONTINUITY OF CARE AND CARER

MPEs must increase the opportunity for students to work in continuity of midwifery care or carer models. Experiences in CoMC programs must count towards their total clinical requirements or time. Services must rethink their MPE models. In addition, practice incentives need to exist for PPMs to take students in a similar way that exists for GPs to take medical students.

ADDRESS PLACEMENT POVERTY

The recent Australian Universities Accord Final Report (February 2024) identified the real issue of placement poverty, and this impacts on midwifery students. While the 2024 Federal Budget went some way towards addressing this issue, more needs to be done.

INCREASE PATHWAYS TO MIDWIFERY FOR ABORIGINAL AND TORRES STRAIT ISLANDER WOMEN

Available pathways into pre-registration midwifery education urgently need to be diversified and expanded. Midwifery education providers should develop entry pathways by increasing offerings of recognition of prior learning especially for Aboriginal and Torres Strait Islander students transitioning from other roles including Aboriginal Health Workers or Aboriginal Maternal and Infant Health Workers.

Funded cadetships were consistently identified as being vital and feasible pathways to grow the Aboriginal and Torres Strait Islander midwifery numbers. Other options to consider include pathways from Indigenous doula programs, such as the Djäkamirrs in the remote setting of Galiwin'ku in North East Arnhem Land, Northern Territory [172]. This work, under the title of Caring for Mum on Country, is developing a community-based cohort of Indigenous doulas-childbirth companions who are able to strengthen community support systems and reinvigorate sociocultural care practices. This work will be important to consider in the future as a potential pathway option [173].

INCREASE PATHWAYS TO MIDWIFERY FOR WOMEN FROM DIVERSE BACKGROUNDS

It is also important that the midwifery workforce in the future includes culturally and linguistically diverse perspectives. A standardised pathway and incentives for those who are first generation Australians who want to enter the midwifery

GROW THE MIDWIFERY WORKFORCE

profession would increase the diversity of the workforce facilitating inclusiveness and accessibility within midwifery services.

SUPPORT, NURTURE AND MENTOR MIDWIFERY STUDENTS

Throughout this project, we have heard of the need to support midwifery students, both in the university but mostly importantly, in the clinical environment. Formal mentoring programs, peer to peer support programs and a focus on ensuring students have wrap-around support and access to clinical supervision are all needed.

Support for flexible learning and 'back to base' programs where students can complete much of their education close to home was strongly supported through the project.

We heard from the Midwifery Futures Yarning Circle that being the only Aboriginal student in a cohort, either at university or in the health services, can be challenging. It is important to ensure that Aboriginal and Torres Strait Islander students are linked into cultural support services at universities and have support from Aboriginal and Torres Strait Islander workers in the health service. Ideally, Aboriginal facilitators should be available to these students.

Where possible, and where these exist, Aboriginal and Torres Strait Islander students should have opportunities to be placed in Aboriginal midwifery group practice models of care for at least some of their clinical placements.

STRENGTHEN THE MIDWIFERY ACADEMIC WORKFORCE AND INCREASE THE NUMBER OF MIDWIFERY EDUCATORS AND FACILITATORS

Increasing the number of midwifery students means a greater burden on university-based midwifery academics and midwifery educators and facilitators at health facilities. Strengthening and supporting these educators is essential to ensure quality midwifery education is provided.

The support for faculty development is important to ensure that these educators have the necessary skills, capabilities and experiences to lead, develop, and improve midwifery education programs. Previous research has highlighted the need for ongoing professional development in midwifery education, pathways for career progression, and access to faculty development opportunities as being necessary for educators to provide quality educational experiences [174].

CONSIDER INCLUDING MIDWIFERY PRESCRIBING AS PART OF PRE-REGISTRATION MIDWIFERY EDUCATION

Midwifery prescribing is part of usual scope of midwifery practice and, therefore, should be included in all pre-registration midwifery programs.

Inclusion of midwifery prescribing in pre-registration programs, which will provide midwives to apply for the notation of endorsed midwife, should be considered in the next revision of the ANMAC Standards. It is acknowledged that this requires discussion with education providers, health service employers and the industrial bodies to determine how these roles fit within enterprise bargaining agreements. New variations, much like the variations for midwives in midwifery group practices, may need to be developed.

The transition period between the two workforces (those with midwifery prescribing and those without) will need consideration. The policy infrastructure, including all levels of clinical governance (quality and safety measure) and guidelines, must be created in consultation with the services (employers) and workforce representatives so that these skills are appropriately utilised. Targeted championing and mentoring programmes will ensure the necessary support systems, and professional sustainability are embedded in this change.

SUPPORT THE MIDWIFERY WORKFORCE

ATTRACT MIDWIVES WHO HAVE LEFT BACK TO THE WORKFORCE OR ATTRACT MIDWIVES FROM OVERSEAS

There need to be national incentives to attract midwives back. As an example, in Victoria, the Midwifery Re-entry Program provides scholarships ($15,000) and support for midwives who wish to return to practice after a period of absence [169]. Another example is the re-engaging through Supportive Education and Training for Midwives (RESET M) program in South Australia which is in the pilot phase at present [175].

Further strategies to both attract midwives back and to incentivise education providers to deliver such services would be a useful adjunct. Education providers need to be incentivised to provide midwife re-entry programs. Those undertaking supervised practice as part of a re-entry program need access to professional indemnity insurance, especially if the midwife doing the re-entry program is not employed by the health service.

ADDRESS CULTURAL SAFETY FOR MIDWIVES AND IN MIDWIFERY PRACTICE

Cultural safety is important for all midwives, midwifery practice, and consumers accessing maternity care. Cultural safety is intrinsically linked to the effectiveness of strategies to attract, educate, and retain the Aboriginal and Torres Strait Islander nursing and midwifery workforces. Cultural safety must also include specific initiatives to address racism in all contexts.

To achieve this, we must increase the number of Aboriginal and Torres Strait Islander midwives and culturally and linguistically diverse midwives in leadership positions and ensure discrimination and bullying are managed appropriately. Aboriginal and Torres Strait Islander students and midwives must have culturally appropriate support and supervision.

All midwives should be taught how to, and then encouraged to, critically self-reflect with cultural humility on their professional accountability within culturally unsafe systems and acknowledge that woman-centred care is not synonymous with or a substitute for culturally safe care.

ENABLE MIDWIVES TO WORK TO THEIR FULL SCOPE OF PRACTICE

For midwives, job satisfaction is linked to their ability to 1) work to the full scope of practice, 2) form positive longitudinal relationships with women and, 3) be supported to provide quality woman centred care. Therefore, it is essential that these elements underpin how midwifery care is provided regardless of the area or model in which they work. While services need to move to offering all women CoMC, they simultaneously must reorganise other models in maternity services to enhance the ability of midwives to provide quality midwifery care to each woman and her family.

SUPPORT THE MIDWIFERY WORKFORCE

Actions to enable midwives to work to their full scope of practice need to be considered through a diverse lens. Midwives practising to their full scope of practice includes:

- midwives providing continuity of care as leading and autonomous maternity care providers from first trimester antenatal care through to the postnatal period,
- midwifery led models of care across the reproductive cycle for example in sexual health, and first trimester pregnancy care including miscarriage and pregnancy choice care in collaboration with medical providers, and
- midwives who provide care in discrete areas of practice being supported to practise autonomously and to their full scope.

A component of full scope of practice, regardless of the context of practice, includes increasing recognition and adoption by health services of midwives' capacity to act autonomously and provide diagnostic and prescribing services.

STRENGTHEN WORKPLACE FLEXIBILITY AND ENSURE MIDWIVES HAVE CAREER PATHWAY OPTIONS

Rostering practices that provide flexibility and autonomy may help midwives increase their working hours. There is also a need for access to wrap-around support services that enable midwives to balance their professional and personal lives. Both government and health service providers should implement such support services, including providing free or subsidised onsite childcare, considerations of job-sharing, opportunities to work in different models of care, and part-time workloads.

Midwifery skills acquired through continuing professional development (e.g. cannulation, venepuncture, perineal suturing, midwife-led postnatal discharge) should be consistently recognized by health service providers, such as through a national education and competencies passport. In particular, standardisation of PPM's credentials (eg. emergency maternity care, perineal suturing, fire and safety etc) to have visiting rights in hospitals and health districts is needed to reduce duplication and ensure flexibility.

Work also needs to be done in ensuring greater work-life balance in all models of care so that experienced midwives are valued and retained. This requires the challenges midwives experience with workloads, recognition of expertise, and maternity services culture to be addressed. This is essential to protect the sustainability of the midwifery workforce and ensure midwives are enabled to experience ongoing job satisfaction and continue to contribute to the growth of early career midwives as they themselves develop their expertise.

Investment should be made to support midwives to have a career pathway into other roles, such as being researchers and educators or working in sexual and reproductive health or maternal, child and family health. Education providers should increase offerings of post-registration education relevant and available to midwives. Career pathways may also include clinical leadership roles within midwifery led models of care, and within acute care clinical settings, potentially roles that combine clinical expertise while also doing leadership, management or academic roles.

SUPPORT MIDWIVES WORKING IN SHIFT-BASED MODELS OF CARE

Significant numbers of midwives in Australia work in shift-based models, mostly on a roster system. Many of these midwives want to remain working this way. Equally, midwives working in CoMC models, will from time to time, rotate back to a shift-based models as their family and personal circumstances change. Therefore, midwives working in shift-based models of care need to be supported and enabled to provide high quality midwifery care.

There are a range of strategies that have been identified to support this cohort of midwives in

other reports [19] and have relevance for Midwifery Futures. For example:

- Improve midwife-to-patient ratios (e.g. include babies in the postnatal hospital ratios, introduce the same ratios across all shifts, factor in acuity of women/babies into ratios, and in birth suite (for labouring women) decrease the ratio to one-to-one,
- Increasing the use of RUSOM or student midwifery employment models,
- More flexible work options (e.g. return to work plans for maternity leave or extended leave, job shares, self-rostering),
- more non-shift work opportunities for midwives (e.g. antenatal clinics, in hospital postnatal care and postnatal care at home,
- Targeted, midwife-led strategies for retaining midwives in the middle years of their career,
- Bonded scholarships for rural/remote midwives,
- Individualised lengths of stay (rather than standardised early discharge, which increases workload and limits time in which to offer education/complete paperwork),
- Increasing administrative support, and
- Ensure midwives receive adequate remuneration to reflect the complexity of midwifery work.

SUPPORT MIDWIFERY MANAGERS

Midwifery managers need support including a recognition of the complexity of the role, business management and administrative support and access to training in human resources management and financial planning at a ward level. Midwifery leadership at a higher level will support midwifery managers who manage wards or maternity units.

QUALITY MENTORING, CLINICAL SUPERVISION AND CONTINUING PROFESSIONAL DEVELOPMENT FOR MIDWIVES

Mentoring: There is a need for a graduate mentoring program, delivered with options for online, face to face and hybrid modes, for graduate midwives during the consolidation of their first year of practice to build confidence, clinical skills and networked support. This should initially prioritise graduates working in rural and remote areas and CoMC models to eventually including all graduate midwives and those undergoing re-entry to practice.

In addition, specific programs for Aboriginal graduate midwives are needed where mentoring is provided by an experienced Aboriginal midwife who has quarantined time in her role to be able to provide this mentorship.

It would be useful to have a similar program for midwives as funded by the Commonwealth Department of Health to APNA [164]. Work needs to be undertaken to identify a national provider (eg. ACM), whether it is mandatory/ or an expected part of practice, support for midwives who cannot access, or do not chose to join a new graduate program and how to provide such support for those graduating with a dual degree and needing to consolidate both midwifery and nursing.

Similar models in New Zealand are worth replicating in Australia [67]. The Midwives First Year of Practice Programme is a compulsory national programme for all New Zealand registered midwifery graduates, irrespective of their work setting. The programme is Government funded for New Zealand trained graduates during their first year of practice [176].

Clinical supervision: Midwives and midwifery students should have access to appropriate professional supports (sometimes called clinical supervision) to enable their continued involvement in the profession. Midwives, particularly those working in clinical roles, and midwifery students in our studies reported significant levels of burnout, vicarious trauma, poor workplace culture, and difficulties with

SUPPORT THE MIDWIFERY WORKFORCE

work-life balance. It is essential that the social and emotional work of midwives, especially when caring for bereaved families, is recognised and midwives receive support and debriefing opportunities. In addition, there is a cohort of midwives who return to work after their own perinatal loss and this group is particularly important to recognise and support.

Psychological support resources must be implemented by health service providers for midwives, including debriefing and appropriate access to counselling to respond to psychological safety incidents and vicarious trauma. Clinical supervision and structed mentoring programs regardless of where midwives are in their career journey/pathway.

Continuing professional development (CPD): Equity of access to CPD program and up-skilling is needed especially for midwives working in rural and remote settings. A rotational model, where midwives are funded to have time in another setting like the nurse practitioners and GPs have, is needed [165]

Overseas-trained midwives currently are assessed to ensure they are fit for practice and if they fall into what is called Stream B (hold a qualification that is relevant to the profession, but is not substantially equivalent, nor based on similar competencies to an approved qualification) they must successfully complete Orientation Part 1 and the outcomes-based assessment (OBA). This approach needs to be reviewed to determine if improvements could be made (eg. supported transitional program, fast track process) while not diminishing safety and quality.

BETTER UNDERSTAND THE WORKFORCE MOVEMENTS

More granular data on reasons for attrition and on the midwives who do not renew their registration would be helpful to track the future. It would be helpful to disaggregate the leavers into the following categories: Leavers = midwives leaving the profession entirely; Emigrants = midwives leaving Australia; and Movers = midwives transferring between states and territories within Australia.

5.2 Recommendations

THE MIDWIFERY FUTURES PROJECT MAKES THE FOLLOWING RECOMMENDATIONS:

INCREASE VISIBILITY, GOVERNANCE AND LEADERSHIP

1 The Australian Governments fund the development of a National Midwifery Strategy and funded implementation plan.

2 Australian governments recognise the importance of midwifery leadership through the instatement of a Chief Midwife and Office of the Chief Midwife in each Commonwealth and state and territory government, with resources to provide leadership and bring about change. In addition, a First Nations Midwifery Director is established in each jurisdiction to provide leadership for Aboriginal and Torres Strait Islander services and contribute to Closing the Gap.

3 Where there is a maternity service, ensure that leadership is provided by midwives at government, employers executive and clinical levels.

4 Health services and industrial bodies ensure that midwifery and midwives are adequately represented in jurisdictional industrial agreements.

5 Increase opportunities to promote awareness of midwifery among the general population through media and educational initiatives and through schools and career days.

SCALE-UP MIDWIFERY MODELS OF CARE

6 The Commonwealth Government develop, implement, and fund bundled funding for midwifery continuity of care models as a defined care pathway, to fund midwives to work to their full scope when they practise across different parts of the health care system (including primary and admitted care) which currently operate under separate funding arrangements.

7 Health services and industrial awards must ensure that continuity of midwifery carer models are flexible including part-time and job share opportunities with reduced caseload requirements aligning with full time equivalents for midwives working part-time.

8 Health services must ensure that continuity of midwifery carer models are available to all women regardless of risk status, with access to consultation, referral and collaborative models.

9 Australian governments, health services and education providers adopt an evidence-based framework (e.g., RISE [2] and Replanting the Birthing Trees [3]) to develop midwifery programs for Aboriginal and Torres Strait Islander women.

10 Health services should create flexible opportunities for midwives to fulfil their professional scope through work including in maternal, child and family health practice, sexual and reproductive practice, and women's health.

11 Health services, industrial bodies, and universities explore clinician researcher positions for midwifery as a career path option.

12 Health services in rural, regional, and remote settings recognise that midwives who do not hold a nursing qualification provide valuable contributions to the provision of care to women, babies and families. With additional training, these midwives can also provide maternal and child health services and/or sexual and reproductive health services.

13 Explore the opportunity to develop multidisciplinary models of primary care with midwives, general practitioner obstetricians, and nurse practitioners providing a range of health services in a rural setting. This needs testing for feasibility, affordability and cost benefits.

GROW THE MIDWIFERY WORKFORCE

14 Universities, health services, and policy makers work to increase the number of midwifery students, starting as soon as possible, by at least 20% - leading to around 1560 students graduating in 2-4 years (depending on the length of the programs).

15 Universities and health services implement quarantined places for Aboriginal and Torres Strait Islander midwifery students.

16 Universities and health services increase pathways to midwifery for prospective students from diverse backgrounds especially those from Aboriginal and Torres Strait Islander, and migrant and refugee backgrounds, including funded cadetship programs.

17 Strengthen workforce planning mechanisms between Ministers of Health and Education, Chief Nursing and Midwifery Officers, health districts, Aboriginal Community Controlled Health Organisations, and universities to collectively plan the number of midwives required, and therefore the number of students to be recruited into universities and health services.

18 Universities and health services work to ensure that midwifery clinical placements increase the opportunity for students to work in continuity of midwifery carer models, contributing to their total midwifery practice experience time.

19 The Australian Government fund an additional Commonwealth stipend to meet additional costs borne by students from rural and remote areas including temporary relocation to receive experience in a larger centre, also addressing Higher Education Loan Program debt relief for midwifery graduates.

20 The Australian Government, universities, and health services develop and fund accessible re-entry programs to attract midwives who have left back to the workforce, and/ or attract midwives from overseas.

SUPPORT THE MIDWIFERY WORKFORCE

21 Universities, health services, and policy 21. Government, health services, industrial and professional bodies to strengthen workplace flexibility, adequate working conditions, and ensure midwives have more career pathway options.

22 Government, health services, industrial, and professional bodies must ensure that midwives who work in shift- or roster-based models of care have adequate working conditions and support to ensure they can provide high quality care and are retained in the health system.

23 Government, health services, industrial, and professional bodies must work together to ensure working conditions and appropriate wages allow midwives to provide evidence- based care, meet existing and emerging policy requirements and be retained in the workforce.

24 Universities and health services ensure implementation of cultural safety education for all midwives at all education levels, including pre-registration education and as part of continued professional development, and evidenced in all guidelines. Any standardised education program must be specifically contextualised to the unique roles of midwives and the locality.

25 Government, health services, industrial and professional bodies to ensure midwives can work to their full scope of practice through funding models, educational opportunities, new models of care, and respectful collaboration.

26 The Commonwealth Government should underwrite professional indemnity insurance requirements for the midwifery workforce, ensuring midwives can work to their full scope of practice in private and public settings.

27 The Australian Government ensure that privately practising midwives have access to the Practice Incentives Program and other similar schemes to help them continuously improve, provide quality care, enhance capacity, and improve access and health outcomes for women and families.

28 Australian governments fund development of a national Transition to Practice Program to mentor recent graduates to build knowledge, skills, and confidence.

29 Government, health services and professional bodies to implement and fund quality mentoring, clinical supervision, and continuing professional development for midwives.

30 Health services, industrial, and professional bodies to lobby government for comprehensive national review to evaluate the value of midwifery to contemporary society and use these data to benchmark salary scales to ensure appropriate remuneration.

IMPROVE DATA TO SUPPORT WORKFORCE PLANNING

31 Through the annual NMBA survey, collect data on the number of midwives leaving employment in Australia each year, the number of qualified midwives joining from overseas, the number of midwives actively working in the profession, and the number of dual qualified midwives working mostly in midwifery.

32 The NMBA to consider a mandatory expanded/refined survey every 3 years to ensure access to a national contemporary workforce data set.

Appendices

Appendix A
The Role of Midwifery in the First 2000 days

Adapted from a submission to the Midwifery in the first 2,000 days – Commonwealth Government Roundtable 9 November 2023.

PREGNANCY

The provision of care by a midwife collaborating with the primary care team in the antenatal period provides an opportunity to review risk early in pregnancy and develop a relationship which may support greater uptake of a range of strategies and programs. These include safer baby bundle, specific support for the next birth after a stillbirth and targeted and individualised antenatal education including healthy weight in pregnancy. The benefits also include increased engagement and attendance in antenatal visits, particularly for priority populations. Midwives are experts at screening for domestic violence. Disclosures during pregnancy can support maternal safety. Rates of vaccination are higher in women receiving CoMC, particularly priority populations– vaccination in pregnancy is an important indicator for likelihood of completed courses of childhood vaccination.

Midwifery care uses an integrated pathway for communication with the acute sector in provision of intrapartum care to ensure seamless admission processes and transparency for all members of the multidisciplinary team involved in labour and birth care. The evidence supports midwifery continuity of care.

Midwifery activity	Benefit	Measure
Provide antenatal visit in first trimester	Able to be engaged into care early in pregnancy, build engaged relationship with family	National Core Maternity indicator
First trimester: bloods and ultrasound scans inc. first trimester screening	Early detection of concerns, accurate dating, Improved outcomes; enables consideration of FTS results	Measure pathology orders, radiology, and screening tests.
Review risk factors early in pregnancy: • Smoking • Obesity • Alcohol • Other drugs • Family violence • Mental health	Education and support for risk factors including healthy weight gain in pregnancy; reducing a child's risk of later disease such as asthma, type 2 diabetes, heart disease, stroke; counselling regarding alcohol use in pregnancy. Support from midwives is critical to the reduction or cessation of tobacco, alcohol and other drug use in pregnancy which reduces risk of foetal alcohol spectrum disorders.	National Core Indicator re smoking cessation; completion of mental health & domestic violence screening; monitoring of weight gain
Review and plan around health and previous obstetric history	Continuity of midwifery care provides relational care; integration with primary care team increases opportunity to manage health; previous obstetric history may warrant early referral or may require initial and ongoing birth planning	Number of referrals to other health care providers; Risk factors according to ACM guidelines
Provision of midwifery continuity of care throughout pregnancy	A known carer through the pregnancy builds trust which evidence shows leads to improved birth outcomes.	Improved outcomes and reduced costs

INTRAPARTUM (DURING LABOUR)

Midwifery care during labour and birth, especially one to one care during labour and continuity of care is a unique contribution that no other workforce can provide. Effective care has long term impacts at this time for the mother and baby including improving the rate of breastfeeding.

Midwifery activity	Benefit	Measure
Call provision of known care provider	The woman is able to contract the midwife at any time within a caseload model so has increased confidence in the relational care.	The woman is able to contract the midwife at any time within a caseload model so has increased confidence in the relational care.
Promotion of physiological birth	Outcome measures in priority populations generally demonstrate higher levels of intervention, positive experiences, and greater ongoing morbidity. Evidence indicates lower rates of intervention for CoMC.	Outcome measures in priority populations generally demonstrate higher levels of intervention, positive experiences, and greater ongoing morbidity. Evidence indicates lower rates of intervention for CoMC.
Continuity across acute care sector	Communication within the primary care team	Communication within the primary care team

POSTNATAL

During the immediate post birth period midwives promote, initiate, and protect skin to skin contact which supports neonatal microbiome development, important for gut health, immune system and cognitive development. Skin to skin also promotes bonding, a positive birth experience and positive perinatal mental health outcomes.

Midwifery activity	Benefit	Measure
Targeted and sustained contact – daily visits first week; weekly visits to 7 weeks	Postnatal outcomes include increased establishment and ongoing breastfeeding; mental health screening, detection and referral, support for social health of family, increased understanding of mother/baby dyad and family bonding.	Breastfeeding establishment, six weeks, six and 12 months; Perinatal mental health screening
Administration of vaccinations	Continuity relationship increases uptake of vaccinations particularly in priority groups.	Record of vaccinations
Mental health and family violence screening	Increase in mental health and family violence issues common in post birth period. Relational care may increase disclosure and opportunity for treatment and support.	Number of mental health screening and family violence screening.
Contraception – education and prescribing	Relational based care may offer an opportunity to have education and prescription of contraception	Access to postpartum contraception
Birth debrief	The midwife is well placed to provide birth debrief as they have provided intrapartum care. Birth debrief has consistently been demonstrated to reduce levels of birth trauma.	Measure of birth debrief provided

POTENTIAL FUTURE ROLES

Preconception Care

As experts in sexual and reproductive health, midwives are ideally placed to provide preconception care. Planning pregnancy provides the best opportunity for individuals to screen, treat and address health issues which may impact on their child's health. Midwives' demonstrated expertise in primary care makes them ideally placed to provide education, advice, and referral for those planning pregnancy; or to prescribe/ provide contraceptive support to avoid or delay pregnancy until health issues are addressed.

Similarly, midwives' expertise in vaccination would support pre-pregnancy vaccination and other health checks were attended to, protecting fetal development and subsequently, the health of the child. This strategy would have flow on impacts to most clinical areas improving health in pregnancy and from the very start of the child's first 2000 days.

Fourth Trimester Care

The first 12 weeks after a baby is born are recognised as a critical time of infant development and initiation of early parenting skills. Ensuring midwives can provide care and support throughout this period would support a transition of care to child and family health.

Appendix B
GENKE II report (2022) recommendations

KEY STRATEGIC RECOMMENDATION 1

ANMAC develop a formalised partnership agreement for CATSINaM to co-design, co-produce and co-accredit nursing and midwifery education as it relates to Aboriginal and Torres Strait Islander health.

Supplementary Recommendation 1:

ANMAC and CATSINaM develop a national monitoring, evaluation, accountability and learning framework (MEAL Framework) for implementing the recommendations of the GENKE II report.

Supplementary Recommendation 2:

ANMAC and CATSINaM undertake an out-of-cycle review of nursing and midwifery program accreditation standards, policies, and explanatory notes as they relate to Aboriginal and Torres Strait Islander nurses and midwives and Aboriginal and Torres Strait Islander health.

Supplementary Recommendation 3:

ANMAC and CATSINaM, in partnership with CDNM, develop an Aboriginal and Torres Strait Islander nursing and midwifery education quality assurance framework.

Supplementary Recommendation 4:

ANMAC and CATSINaM, in partnership with CDNM, NENAC and all governments' CNMOs, develop an Aboriginal and Torres Strait Islander nursing and midwifery clinical placement plan.

Supplementary Recommendation 5:

ANMAC and CATSINaM, in partnership with CDNM, undertake a national Aboriginal and Torres Strait Islander health nursing and midwifery curriculum review.

Key Strategic Recommendation 2

NMBA develop a formalised partnership agreement for CATSINaM to co-design, co-produce and co-accredit nursing and midwifery education as it relates to Aboriginal and Torres Strait Islander health to enable education reform.

Key Strategic Recommendation 3

The Australian Government develop a formalised partnership agreement with CATSINaM on national-level strategic reform in nursing and midwifery education as it relates to Aboriginal and Torres Strait Islander health.

Supplementary Recommendation 6:

The Australian Government, in partnership with CATSINaM, NMBA, ANMAC, CDNM, NENAC, NAATSIHWP, and state and territory governments, co-produce a National Aboriginal and Torres Strait Islander nursing and midwifery education strategy.

Supplementary Recommendation 7:

The Australian Government and CATSINaM, in partnership with ANMAC, NAATSIHWP, CDNM, and NENAC, develop a comprehensive articulation plan from the Aboriginal and Torres Strait Islander Health Worker and the Diploma of Nursing package qualifications through to doctoral studies in nursing and midwifery.

Supplementary Recommendation 8:

The Australian Government Nursing Taskforce identify funding initiatives to support the targeted increase of Aboriginal and Torres Strait Islander nurses and midwives.

Appendix C National Midwifery Futures Symposium Attendee Recommendations

The below recommendations are a summarised form of the suggestions provided at the Midwifery Futures Symposium 2024.

1. Provide psychological support to midwives in their professional roles
2. Enable midwives to practice in their full scope of practice
3. Standardise midwifery education and practice nationally
4. Strengthen midwifery leadership
5. Provide adequate supports to midwives to allow them to balance professional and personal commitments
6. Promote midwives as a key provider of primary care and ensure they can provide this model of care
7. Expand and diversity midwifery career pathways
8. Improve cultural safety in midwifery practice
9. Revise funding models to support evidence-based midwifery care
10. Increase the visibility of midwifery

The below recommendations are as written by Symposium attendees. There are more than 12 recommendations as some tables provided more than one. They are broadly colour-coded and categorised to the corresponding summarised recommendation above.

1. Support midwives to assist with psychological safety and vicarious trauma
2. Resources for psychological support for midwives
   - a. Midwives care for women, but who's caring for midwives
   - b. Protected time off for clinical supervision, mentoring, clinical incident debriefing for all midwives (all clinicians) in a timely manner. Both short-term and ongoing, but be individualised (consider building into enterprise agreement)
3. Standardising scope of practice
4. Mandated targets for all services – continuity of care models
   - a. Could consider phased implementation
   - b. Incentives
   - c. Collaborative multidisciplinary teams
5. National goals / baseline percentages for CoMC access
   - a. so that CoMC is the standard of care across the country
6. Nationally agreed definitions of workload models that include industrial reform to recognise midwifery (as standalone specialty) workforce (i.e. midwifery group practice, acute, outpatient, community country midwifes)
7. National recommended midwifery models of continuity of carer.
   - a. CoMC model is the entry model for all maternity care and is opt out model rather than opt-in (with benchmarked targets)
8. Quantify midwives' workloads across all models and areas to understand what work is needed and what is done, as a precursor to developing solutions to reducing workload as a national approach
9. National 'passport' for education and competency
10. Introduction of a clinical supervision framework for all midwives
11. Midwifery continuity of carer target in service agreements

12. National and state chief midwife

a. Midwifery leadership at every level

13. Leadership at every level (national, state, healthcare district, points of care). Leadership is professional and operationalised

14. Establish corner clinic midwifery across sexual health to menopause and pregnancy to post-partum to early childhood

15. That 100% of midwives be enabled to practice to their full scope by transitioning prescribing to undergraduate training with mandatory supervised practice year

16. Organisations are required to remove restrictions / barriers that limit scope of practice

a. Align to national frameworks

b. Midwives able to make decisions about midwifery scope of practice without approval from other disciplines

c. National harmony for scope of practice

17. Life-recognising wrap arounds to the work structure e.g. onsite childcare, job sharing etc

18. Establish subsidised childcare services co-located in health services

19. "Call the midwife" community-based midwifery in a wellness model with clear referral pathways

20. Move maternity care into primary / community-based care and out of acute care

21. Midwifery primary co-care model for every woman in Australia

a. Option to then be referred to private midwife, private obstetricians or GP or home birth public / PPM

b. Consistency across Australia

22. Provision of care falls with midwifery (primary healthcare approach)

a. Initial referral direct to midwife (i.e. pregnancy test --> negative or positive = call a midwife)

b. Appropriately facilitated and funded

c. Adopt elements of New Zealand models to be designed / owned by midwives in Australia

23. Look at developing community midwife role and access as a career pathway to nurture and support Mother + Baby

24. Community midwifery group practice

a. with life-friendly work structure.

b. Funded with bundled funding models

25. Midwifery Group Practice as the primary model (opt out)

26. Develop a midwifery career pathway through:

a. Paid employment models

b. Accreditation and regulation

c. Commencing with Vocational Education and Training (VET) sector

d. Recognition of prior learning into a Bachelor of Midwifery

27. Clinical academic roles

28. Develop national midwifery workforce and cultural safety framework

a. Cultural safety to support staff and consumers (safe care for all)

b. Standardise and mandate cultural safety education at undergraduate, postgraduate and continuing professional development in industry

c. Service accreditation standards

d. Culturally safe care – evidenced in all policies and guidelines

29. Funding model for CoMC is sufficient to ensure safe midwifery staffing levels and pay midwives to reflect the value of work

30. Revise activity-based funding to reflect evidence-based models of care

31. A funding model that supports and values midwifery care providing evidence-based care that meets consumer rights in all settings

32. Embed midwifery through the media (kindergartens, schools, etc.)

Appendix D What is an endorsed midwife?

Appendix E Glossary

The definitions in this glossary have been compiled from publicly available resources from key organisations, including the Australian Nursing and Midwifery Accreditation Council, the Nursing and Midwifery Board of Australia, and the Molly Wardaguga Research Centre.

Australian Health Practitioner Regulation Agency (Ahpra) is the organisation that manages the registration and renewal processes for registered health practitioners and students around Australia. AHPRA supports the National Health Practitioner Boards in implementing the National Registration and Accreditation Scheme.

Birthing on Country is an international social justice movement to redress the negative impact of colonisation and return childbirth services to First Nations communities and First Nations control.

Caseload midwifery is a model of maternity care where women have a primary midwife assigned to them throughout pregnancy, labour and birth and the postnatal period. Each midwife has an agreed number (caseload) of women per year and acts as a second or "back-up" midwife for women who have another midwife as their primary carer.

Continuity of midwifery carer (CoMC) refers to a continuous woman-centred professional relationship provided to the woman by a midwife or midwives. It is the cooperative achievement of quality care over time through integration, coordination and sharing of information. This relationship may extend from preconception to the postnatal period with relevant referral to ongoing health services.

General registration is granted to practitioners to practise their profession. Practitioners who hold general registration have graduated from a Board-approved, accredited program of study in the profession and completed any required period of supervised practice or internship, or they have demonstrated equivalence of their overseas qualifications.

Homebirth is where a woman gives birth in their own home under the care of a midwife or another registered health professional.

Midwife is a person who has successfully completed a midwifery education programme and who has acquired the requisite qualifications and competence to be registered as a midwife. In Australia, midwives are registered by the NMBA.

Midwifery group practice is a health service where midwives working together in small groups, carrying a caseload of women and providing all their pregnancy, labour and birth, and postnatal care.

Midwifery placement experiences (MPEs) are components of midwifery education that allow students to put theoretical knowledge into practice within the consumer care environment. Includes, but may not be limited to, continuity of care experiences. May also be referred to as clinical placements.

Nursing and Midwifery Board of Australia (NMBA) is the national body responsible for the regulation of nurses and midwives in Australia.

Nurse practitioner (NP) is a registered nurse endorsed as an NP by the NMBA. The NP practices at a clinical advanced level, meets and complies with the Nurse practitioner standards for practice, is able to practise independently and has direct clinical contact. The NP practises within their scope under the legislatively protected title 'nurse practitioner' under the National Law.

Non-practising registration is granted to practitioners who have previously held general or specialist registration in a profession, who do not wish to practise the profession but wish to remain registered. Some practitioners choose to hold non-practising registration so that they may use a protected title for the profession.

Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a midwife. Practice is not restricted to the provision of direct clinical care, but includes work such as management, education, research, and regulatory roles.

Privately practicing midwives are midwives who provide private midwifery services through their own business or a business owned by another midwife or registered health practitioner (whether paid or unpaid). This can include direct clinical care, education, and/or midwifery advice to women and their families.

Provisional registration is granted to practitioners to enable them to complete a period of supervised practice or internship to be eligible for general registration. This type of registration is intended for practitioners who have completed a Board-approved, accredited qualification in the profession.

Scope of practice refers to the boundaries within which the profession of midwifery is educated, competent and permitted to perform by law. The actual scope of the individual midwife's practice will vary depending on the context in which the midwife works, the health needs of women and the baby or babies, the level of competence and confidence of the midwife and the policy requirements of the service provider.

Appendix F
Author Transparency Statements

Professor Caroline Homer AO

Current

Life member, ACM

Emeritus Professor of Midwifery, Centre for Midwifery, Child and Family Health, Faculty of Health, University of Technology Sydney. (2018-current)

Past

- Various roles in ACM including President and Chair of the Board (elected position) 2014 to 2017.

Associate Professor Zoe Bradfield

Current

- President ACM (since May 2024; previously Vice-President)
- Expert Advisory Group member - Unleashing the Potential of our Workforce: Scope of Practice Review
- Executive Committee Australasian Nursing and Midwifery Clinical Trial Network
- Clinical Fellow, Panel Co-Chair, Living Evidence Australian Pregnancy Postnatal Guidelines
- RANZCOG - Sexual and Reproductive Health Committee
- Associate Professor of Midwifery joint appointment Curtin University and Women and Newborn Health Service, WA

Dr Kirsten Small

Past

- Wrote the prescribing courses at Flinders University and Griffith University. Taught the Griffith University prescribing course 2012 – 2016.

Professor Joanne Gray AM

Current

- Immediate Past President ACM
- Board Member: ANMAC
- Previous Chair of the ANMAC Midwifery Accreditation Committee and for the development of the National Standards for Midwifery Education

Past

- Various roles in ACM NSW including State President

Professor Kathleen Baird

Current

- Executive member of CDNM
- Chair of the CDNM Midwifery Advisory Group
- Head of School Nursing and Midwifery UTS.
- Executive Committee Australasian Nursing and Midwifery Clinical Trial Network
- Adjunct Professor: School of Nursing and Midwifery, Griffith University & Adjunct Professor University of the West of England, Bristol, UK.

Past

- 2018 - 2023 Member of ANMAC Midwifery Accreditation Committee (Chair from 2021 - 23), member of Midwifery Reference Group - Review of Midwifery Education Standards.

Professor Jennifer Fenwick

Current

- Member of ANMAC accreditation committee
- Head of Midwifery, School of Nursing and Midwifery University of Technology Sydney

Past

- Various roles in ACM (Qld and WA branches before unification)

Melanie Robinson

Current

- Director Aboriginal Health Strategy, Child and Adolescent Health Service, WA
- Adjunct Professor and Advisory Board Chair, Ngangk Yira Institute, Murdoch University
- Director on the Board, WA Primary Health Alliance

Appendix G
Governance group membership

GROUP	ORGANISATION	STATE/ TERRITORY	PERSON
Yarning circle	Edith Cowan University	QLD	Lynore Geia
	Murdoch University	WA	Rhonda Marriot
	Broome Hospital	WA	Lilly Collard
	King Edward Memorial Hospital	WA	Shari Pilkington
	Ngangk Yira Institute for Change Murdoch University	WA	Trish Ratajczak
		WA	Melissa Lynch
	Waminda Health Service	NSW	Mel Briggs
	Australian Catholic University	VIC	Doseena Fergie
	University of Melbourne	VIC	Cath Chamberlain
	University of Western Sydney	NSW	Donna Hartz
		WA	Tamara Jones
	Charles Darwin University	NT	Res McCalman
		NT	Stacey Butcher
		NT	Jessica McKenzie
		NT	Cherise Buzzavott
		VIC	Storm Henry
		WA	Sienna Kolatowicz
		QLD	Valerie Ah Chee
	Griffith University	QLD	Tanisha Springall
		SA	Tania Day

GROUP	ORGANISATION	PERSON
Consumer and Lived Experience Experts	Bears of Hope	Kelly Marchant
	Maternity Consumer Network	Jemma Mainwaring
	Perinatal Society of Australia and New Zealand Consumer Advisory Panel	Kylie Facer
	Ahpra Community Advisory panel	Kelly Porter, Aunty Maureen Woodward
	Maternity Choices	Azure Rigney, Catherine Bell, Sally Cusack

GROUP	ORGANISATION	STATE/ TERRITORY	PERSON
Working Advisory Group	ACM		Alison Weatherstone
	CRANAPlus		Amanda Forti, Leonie McLaughlin
	ANMF		Belinda Maier, Michael Whaites, Nicole Allan
	ANMAC		Gayle McLelland
	Bears of Hope		Kelly Marchant
	Maternity Choices		Sally Cusack
	Ahpra		Sarah Fagan
	CATSINaM		Stacey Butcher
	CDNM		Virginia Schultz
	Australian Capital Territory Health Department	ACT	Chanel Connor, Mary Brunton
	New South Wales Health Department	NSW	Kelly Lennon
	Northern Territory Health Department	NT	Genevieve Marie Finey, Cheryl McDonald
	Queensland Health Department	QLD	Gemma MacMillan, Jocelyn Toohill
	South Australia Health	SA	Paula Medway
	Western Australia Health	WA	Klair Bayley

GROUP	ORGANISATION	PERSON
Expert Advisory Group	Executive Officer, NMBA	
	Chief Nursing and Midwifery Officer, Australian Government	Alison McMillan, Kellie Wilton
	Nominee, ANZCCNMZO	Shelley Nowlan, Francine Douce
	Nominee, ACM	Helen White, Amanda Singleton
	Nominee, ANMF	Jasmine Kirk
	Nominee, CATSINaM	Melina Connors, Stacie Murphy
	Nominee, CRANAPlus	Amelia Druhan
	Nominee, CDNM	Fiona Bogossian
	Nominee, NMBA midwifery practitioner	Penelope Marshall
	Chair of the National Notification Committee: Midwifery	Paula Medway
	Consumer	Jemma Mainwaring
	Consumer nominated by Ahpra Community Advisory Council	Aunty Maureen Woodward
	ANMAC	Allan Meritt

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