Maternity Consumer Network

Formal Submission

to the Senate

Standing Committee on Rural and Regional Affairs and Transport

Inquiry into:

Rural, Regional and Remote Medicare Access and Funding

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Summary

This submission addresses enduring barriers in the Medicare Benefits Schedule (MBS) affecting private midwifery care, the need for bundled funding to support evidence-based maternity services, and the disproportionate barriers faced by rural, regional and remote women, particularly in accessing homebirths and continuity-of-care maternity models. Despite recent reforms, key structural and financial impediments remain that limit access, sustainability, and equity in maternity care in non-metropolitan Australia.

1. MBS Access for Private Midwifery Care

1.1 Insufficient Rebates and Operational Barriers

Current Medicare rebates for private midwifery services do not cover the true costs of providing care in primary practice, particularly in rural and remote settings where travel and low population density increase practice costs. This results in midwives charging gap fees and reduces affordable access for women. Medicare rebates are insufficient to sustainably support a private midwifery practice model, especially where travel is required. (Australian College of Midwives, 2024a)

1.2 MBS Item Changes Insufficient for Sustainability

From 1 March 2025, the Commonwealth expanded and upgraded midwifery MBS items, including longer antenatal appointments, more extensive postnatal care, and new complex antenatal services, designed to better reflect the time and complexity of midwifery care. (Australian College of Midwives, 2024b) Despite these enhancements, the remuneration levels remain too low to support a bulk-billing model for private midwives, particularly in rural contexts where caseloads are small and fixed costs (travel, time) are high.

1.3 Legislative Barriers Removed but Structural Barriers Persist

Recent legislative reform to remove the requirement for 'collaborative arrangements' between midwives and medical practitioners removes a red tape barrier that previously undermined access to Medicare rebates for autonomous midwifery care. (Australian College of Midwives, 2024c) However, structural barriers remain in the form of rebate quantum and the narrow range of MBS items, which fail to cover services women seek from private midwives (e.g. intrapartum care at home).

2. Access to Planned Homebirth in Rural and Regional Areas

2.1 Insurance and Regulatory Changes Affect Access

Recent changes requiring both homebirth attendees to be endorsed midwives (previously only the primary midwife) have severely limited feasible homebirth practice models in rural and remote communities where there are insufficient numbers of endorsed midwives to form sustainable practices. This has unintendedly restricted access to safe, regulated homebirths for rural women. (Australian College of Midwives, 2024d)

2.2 Impacts on Rural and Remote Women

The requirement for two endorsed midwives disproportionately affects small rural communities where populations and workforce numbers are low. This effectively eliminates safe, regulated homebirth options for many rural women, driving them either to travel long distances for hospital births or to unregulated options, which is a significant equity issue.

3. Bundled Funding for Maternity Services

3.1 The Rationale for Bundled Funding

The Independent Health and Aged Care Pricing Authority (IHACPA) has established that bundled pricing, a single payment covering pregnancy, birth and postnatal care, could provide clinical, financial and operational benefits.

Bundled funding can encourage integrated, evidence-based models of care, reduce fragmentation, and allow health services greater flexibility to innovate and improve outcomes (IHACPA, 2017).

3.2 Evidence from Midwifery Continuity of Care Literature

MBS Review Taskforce evidence and international studies consistently demonstrate that midwifery continuity-of-care models are associated with:
- Reduced interventions,
- Better maternal and newborn outcomes,
- Higher satisfaction for women, and
- Potential cost savings compared with fragmented care (Sandall et al., 2016).

Bundled funding aligns payment with the clinical pathway of maternity care and would simplify funding mechanisms for women and providers, potentially increasing access and sustainability of continuity models.

3.3 Policy and Economic Rationale

Bundled funding is widely recognised internationally as a pathway to focus funding on outcomes rather than discrete services (WHO, OECD frameworks). For maternity care, a bundled episode payment could meaningfully fund the entire pregnancy trajectory, enabling midwives and multidisciplinary teams to plan and deliver coordinated, preventative care. The current funding model under MBS would be better provided using a Bundled Funding model.

4. Continuity of Care in Maternity Services

Continuity of care in maternity services is an evidence-based model that involves a woman receiving care from the same midwife or small team of caregivers throughout pregnancy, birth, and the postnatal period. In Australia, continuity of carer is associated with improved outcomes and experiences for mothers and babies and is increasingly recognised as one of the "gold-standard" models of maternity care (Prussing 2024 and Dharni 2021). This contrasts with fragmented care where multiple health professionals see a woman at different stages, with evidence suggesting that some outcomes an increase in adverse outcomes; like negative user experience, higher rates of post-partum haemorrhage and an increase in severe perineal tears (Callander 2025).

Health and clinical benefits are among the strongest reasons continuity models are promoted. Women who receive continuity of care from a known midwife tend to have higher rates of spontaneous vaginal birth, fewer interventions (such as inductions or caesarean sections), higher breastfeeding rates and greater satisfaction with their maternity care (Sandall 2024). These outcomes not only benefit individual families but can reduce strain on health systems by reducing unnecessary medical interventions and associated costs (Dahlen 2023).

Despite the strong evidence and demand for continuity of care models, access remains uneven across Australia. According to the Australian Institute of Health and Welfare (AIHW 2025), over one-third of models of maternity care have no continuity of care option. This matters because providing continuity of care improves outcomes for mothers and babies, from an increase in attending check-ups, to lower rates of premature births and small for gestational age babies (Lundborg 2024).

Having continuity of carer (preferably by a midwife) improves outcomes for mothers and babies and meets the strategic directions from the Woman-Centred Care: Strategic Directions for Maternity Services (2019). The NSW Select Committee on Birth Trauma (2024) was an extremely extensive and thorough report that included the lived experiences of over 5000 service users who had experiences within the Australian maternity system. This report was definitive in its findings of a maternity system that has repeatedly failed service users and caused unacceptable levels of trauma to countless women and their families. The report made some key recommendations to improve maternity care; with experts in maternity consulted and evidence considered. With a key recommendation being continuity of carer to be standard care choice, as it is known to be a protective factor that results in less birth trauma (Watson 2021). The findings of this report are a damning indictment on the state of maternity across Australia and demonstrate that we are at a pivotal moment in which progressive and meaningful change that results in better outcomes for mothers and babies must be prioritised.

Implementing culturally safe and evidence-based models of care for the indigenous population are vitally important healthcare objectives. With the aim of reducing health inequalities and poor maternal outcomes, such as pre-term births, also having a significant economic impact on the health service (Gao 2023). Models such as Birthing on Country (https://www.birthingoncountry.com/) integrate cultural safety with healthcare delivery, strengthening trust and connection between caregivers and the indigenous community they serve. Aboriginal and Torres Strait Islander women have reported that continuity contributes to greater cultural respect, communication, and overall satisfaction with maternity care (McEvoy 2024).

These models of care have First Nation governance embedded within it and have been developed with the community, ensuring cultural safety for those accessing it (AIHW 2025). Evidence supports the Birthing on Country model of care, as it improves outcomes for mothers and babies: with an increase in attendance of antenatal appointments, babies less likely to be born prematurely and higher rates of exclusive breastfeeding (McEvoy 2024). This increase in contact gives greater opportunities for public health education, a reduction in premature birth and associated hospital care and long-term complications, it reduces the risk of mother and baby being separated, which can lead to anxiety and perinatal mental health problems, and increases rates of

breastfeeding. (Gao 2023). Increasing rates of breastfeeding is important on a population health level and as it improves long-term health outcomes for mothers and babies; from protection against illnesses; reduced admission for infections; lower rates of obesity; saves money; environmentally friendly; increases bonding with the baby; decreased risk of breast and ovarian cancer for the mother (Australian Breastfeeding Association 2025)

When looking at continuity of carer in maternity care for First Nations people, the numbers are disappointingly low:
Around 125 (11%) models of care across 94 maternity services were designed for those who identify as First Nations, an increase from 117 models in 2024 (AITHW, 2025).

Birthing on Country and continuity care models aim to counter the over-medication of health service by keeping services local and accessible. By having good quality accessible care, from community clinics, health centres, or regional hospitals, it supports family connection, reduces travel burden, and strengthens community wellbeing (Ireland 2021). Continuity of care aims to deliver personalised respectful relationship-based care, which is especially valuable in areas where health services are sparse; ensuring trusting and respectful relationships with caregivers is prioritised and healthcare needs are met in a safe and compassionate way (Prussing 2024).

5. Rural, Regional and Remote Medicare Access and Funding

5.1 Impact of 1 November 2025 Medicare Changes

Expanded bulk-billing incentives and the Bulk Billing Practice Incentive Program aim to improve rural access to primary care, but these changes do not sufficiently address the under-remuneration of critical services, especially midwifery and allied health. Telehealth restrictions also disadvantage rural populations. (Department of Health, Disability and Ageing, 2025; The Australian, 2025)

5.2 Rural Practice Sustainability

Independently owned rural practices remain financially vulnerable under current Medicare structures, with rebates failing to cover real costs of multidisciplinary care, particularly in workforce-limited areas. (National Rural Health Alliance, 2023)

5.3 Preventable Hospital Admissions and Emergency Presentations

Insufficient Medicare investment in multidisciplinary primary care correlates with increased preventable hospitalisations and emergency presentations in areas with limited services. (National Rural Health Alliance, 2023)

5.4 Adequacy of Mixed-Team Models

Current Medicare settings favour GP services over midwifery, nurse practitioners, and allied health providers. Broader MBS support for these roles would better support integrated mixed-team models needed in rural communities.

5.5 Disparity Between Large Providers and Small Clinics

Rules and incentive structures often advantage large corporate providers over small community-embedded rural clinics, which struggle to participate in incentive programs and sustain multidisciplinary services. Most private midwifery practices are sole operators or small businesses.

5.6 Reforms Needed

Recommended reforms include:
1. Bundled maternity funding trials reflecting evidence-based continuity care and reduced fragmentation.
2. Expanded MBS rebates for midwifery services to support bulk billing.
3. Telehealth reform removing initial consultation restrictions.

4. Medicare reform stress-testing for rural, regional, and remote communities.
5. Enhanced incentives for multidisciplinary primary care, including midwifery, nursing, and allied health.

6. Other

In rural and remote Australia, continuity of care intersects with major challenges in maternity services. Many rural maternity units have closed or are under threat due to workforce shortages, low birth numbers, and infrastructure limitations; this has led to "maternity deserts" where women may need to travel long distances for care (Prussing 2024). Since the 1990s, Australia has lost nearly half of its rural maternity services, contributing to workforce challenges and poorer outcomes for rural women and babies (National Rural Health Alliance, 2024).

Workforce shortages rural health services maternity care Midwives, 2023).

and geographic isolation in compound inequities in (Australian College of

Professional reporting midwives nationally has March 2025, indicating midwifery practice (Australian College of

shows the number of private grown to over 1,500 as of a rapid expansion in primary following MBS item reforms Midwives, 2025).

Prior to Medicare participation, the pool of was much smaller, with around 200 2020). Private midwives rural maternity care, distances to reach

reforms expanding midwifery private practicing midwives historical workforce estimates practitioners (Wen et al., provide essential services in frequently traveling long women in their homes or on farms. In rural NSW, the scarcity of local maternity services is such that one private midwife routinely drives approximately 1,000 kilometers each week to deliver comprehensive antenatal, birth, and postnatal care to women across rural regional communities. This is not isolated and many private midwives in rural communities are filling in the important gaps left by State based maternity service closures.

Private midwives play a unique and valuable role in these rural and remote contexts. Private practising midwives provide one-on-one, continuity-oriented care that is tailored to a woman's personal, cultural, and geographical needs. Private midwifery is MBS rebatable in many circumstances, making it more accessible to some rural families.

However, for many there exists a significant paywall that prevents them from accessing this care option, if the Medicare rebate was amended to include rural loading, then this would make their services far more accessible and would lessen the burden on rural and regional communities (Wilkes 2015). In places where hospital services are distant or limited, private midwives may offer antenatal, intrapartum, and postnatal care in community settings or through coordinated arrangements with local hospitals. These arrangements can mean that women receive familiar support even if they must travel for birth, or it may enable models like homebirth or community births where appropriate and safe. This flexibility is invaluable in remote regions, where workforce issues and service closures have reduced options for women (Wilkes 2015). By not utilising private midwives and supporting better MBS rebates, we are disadvantaging these marginalised communities with their care options.

Expanding continuity of care, through private midwifery support, and culturally safe community-based programs, can help ensure that women in rural, and remote Australia alike have access to high-quality, relationship-based maternity care that respects choice, culture, and locality. Especially when we know that continuity of care (particularly midwifery care) is evidence-based and leads to better outcomes for mothers and babies, which is something that we all want to achieve (Sandall 2024).

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