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Enabling the context for Aboriginal and Torres Strait Islander Community Controlled Birthing on Country services: Participatory action research

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ABSTRACT

Problem: Establishment of Birthing on Country services owned and governed by Aboriginal and Torres Strait Islander Community Controlled Health Services has been slow.
Background: Birthing on Country services have demonstrated health and cost benefits and require redesign of maternity care. During the Building On Our Strengths feasibility study, use of endorsed midwives and licensing of birth centres has proven difficult.
Question: What prevents Community Controlled Health Services from implementing Birthing on Country services in Queensland and New South Wales?
Methods: Participatory action research identified implementation barriers. We conducted iterative document analysis of instruments to inform government lobbying through synthesis of policy, economic, social, technological, legal, and environmental factors.
Findings: Through cycles of participatory action research, we analysed 17 documents: 1) policy barriers prevent Community Controlled Health Services from employing endorsed midwives to provide intrapartum care in public hospitals; 2) economic barriers include lack of sustainable funding stream and inadequate Medicare-billing for endorsed midwives; and 3) legal barriers require a medical practitioner in a birth centre. While social barriers (e.g., colonisation, medicalisation) underpin regulations, these were beyond the scope; technological and environmental barriers were not identified.
Discussion: Findings are consistent with the literature on barriers to midwifery practice. Recommendations include a national audit of barriers to Birthing on Country services including healthcare practice insurance, and development of a funding stream. Additionally, private maternity facility regulation must align with evidence on safe birth centre operation.
Conclusion: Government can address barriers to scale-up of Aboriginal and Torres Strait Islander Community Controlled Birthing on Country services.

Statement of significance

Problem or issue

Aboriginal and Torres Strait Islander Community Controlled Health Services experience barriers to establishing Birthing on Country services.

What is already known

There is growing evidence that Birthing on Country services are

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acceptable, effective, and cost-saving models for women having First Nations babies.

What this paper adds

Synthesis of the policy, economic, and legal barriers to Birthing on Country services in two jurisdictions. Actionable recommendations to address barriers and enable scale-up of Birthing on Country services owned and governed by Aboriginal and Torres Strait Islander Community Controlled Health Services.

Data availability

All documents are publicly available.

Introduction

Prior to colonisation, and for generations, Aboriginal and Torres Strait Islander (First Nations) women in Australia experienced birthing together through deep connection to Country, cultural practices, community connection and healthy families. The colonial disruption negatively impacted birthing systems, imposing the current dominant, biomedical model. First Nations Communities are fighting for birthing sovereignty to ensure the best start to life for First Nations babies [1].

Australian maternity services policy recommends woman-centred care that is culturally and clinically safe; where women have choice of care provider, as close to home as possible [2]. Despite this policy, maternity services are inequitably distributed with some women having no choice but to travel long distances from home; First Nations women and babies are disproportionately affected [3]. Together, the Australian health and social service systems fail First Nations women and infants. Arguably, these systems continue to harm through inaction to address health inequities and systemic racism [2,4,5]. First Nations women are 3–5 times more likely than non-Indigenous women to die in childbirth; babies are almost twice as likely to be born too soon (preterm), too small (low birth weight), to die during pregnancy (stillborn), soon after birth (neonatal death) or in their first year of life (infant mortality); and First Nations babies are also 10 times more likely to be removed from their families and placed in out-of-home-care (see Fig. 1).

The *National Agreement on Closing the Gap* in health and wellbeing outcomes for First Nations Australians has four Priority Reforms, which aim to change the way governments work with First Nations peoples and communities [5]. These include:

1) Increasing Formal Partnerships and Shared Decision Making.
2) Building the Community Controlled Sector.
3) Transforming Government Organisations (to eliminate racism, be culturally safe, increase accountability).
4) Shared Access To Data and Information at a Regional Level [5].

Aboriginal and Torres Strait Islander Community-Controlled Health Services (ATSICCHS) are primary health care services governed by the local (First Nations) Communities in keeping with the principles of self-determination, and with a holistic and whole-of-life view of health incorporating social, emotional, and cultural well-being [4]. Australian maternity care professionals may be self-employed, or employed in public (government) health services, private health services, or through more than 140 ATSICCHS nationally. In 2022, there were approximately 22,841 registered midwives working clinically in Australia with approximately 1100 endorsed to prescribe scheduled medicines [6]. The 2019 *Department of Health Australia's Future Health Workforce Report – Midwives* reports that in 2017, 73.8 % of midwives work in the public sector and 19.5 % in the private sector [7]. According to the Australian Institute of Health and Welfare, there is no available data on the number

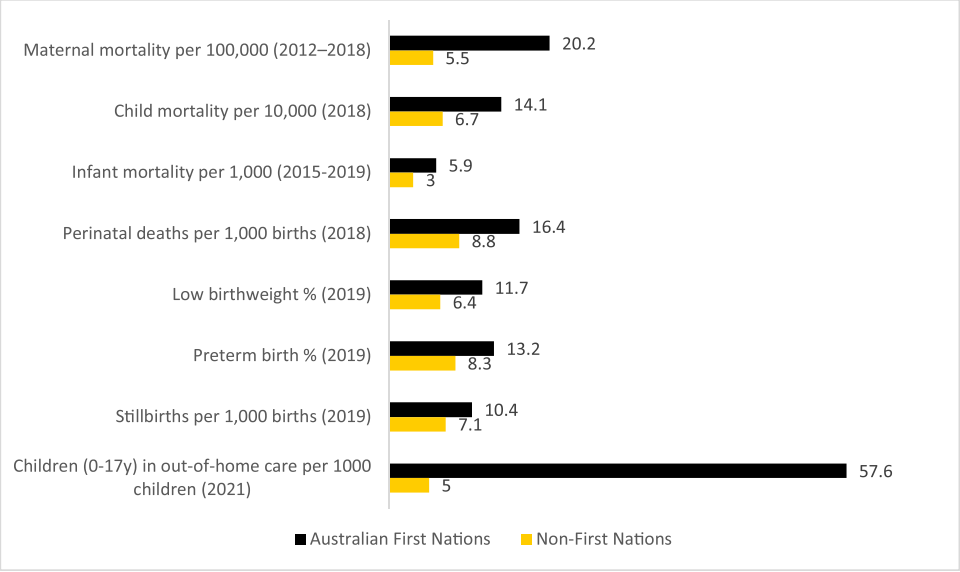

Fig. 1. National Comparison of key maternal and infant health outcomes for First Nations and non-First Nations Australians.
AIHW (2020). Maternal deaths in Australia. Retrieved from: https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-in-australia/contents/maternal-deaths-in-australia.
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AIHW (2022). Australia's mothers and babies. Retrieved from https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies.
Australian Government Productivity Commission. (2022). Aboriginal and Torres Strait Islander children are not over represented in the child protection system. Closing the Gap Information Repository. Retrieved from: https://www.pc.gov.au/closing-the-gap-data/dashboard/socioeconomic/outcome-area12.

of midwives who currently work in ATSICCHS. Yet most already provide some maternity services during pregnancy and the postnatal period. Some ATSICCHS are seeking to expand services to include intrapartum care by establishing Birthing on Country services.

Birthing on Country services

Birthing on Country services are:

> *"Maternity services designed and delivered for Aboriginal and/ or Torres Strait Islander women that encompass some or all of the following elements: are community based and governed; allow for incorporation of traditional practice; involve a connection with land and country; incorporate a holistic definition of health; value Aboriginal and/or Torres Strait Islander and non-Indigenous ways of knowing and learning; risk assessment and service delivery; are culturally competent; and developed by, or with, Aboriginal and/or Torres Strait Islander people."* [8]

Establishing Birthing on Country services is a strategy that aligns with closing the gap between First Nations and other Australians' health outcomes, and the *National Agreement on Closing the Gap* priority reforms and recommendations to support Target 2: "First Nations children are born healthy and strong" [2].

The Birthing in Our Community (BiOC) service (Box 1) demonstrates implementation of an effective Birthing on Country service in Brisbane, Queensland (QLD).

Testing replication and expansion (scaling-up)

Following the success of BiOC, our partners planned to locally customise scale-up in an additional setting (a second urban Queensland site), and we expanded the partnership with a new organisation in rural New South Wales who planned to establish a Birthing on County Service. The Building On Our Strengths (BOOSt) study was developed to assist in the research translation and evaluation of outcomes.

Three key elements are needed for scaling-up:

1) an effective intervention
2) effective implementation methods
3) an enabling context [11].

We referred to the World Health Organizations' *Nine steps for developing a scaling-up strategy* [12] to operationalise scale-up alongside our RISE Framework (see Theoretical Framework below) [13]. This article focusses on the third element of scaling up, the external environment or context for implementation of Birthing on Country services. Furthermore, it analyses the context specifically in relation to Phase 4 Birthing on Country services (see Fig. 2).

Purpose

To analyse barriers to implementation of Phase 4 Birthing on Country services in two Australian jurisdictions and develop recommendations to enable the context for scaling-up.

Methods

Qualitative approach and paradigm

The *Building On Our Strengths (BOOSt): Developing and Evaluating a Birthing on Country Service for First Nations Australians, with integrated Community Hub and Birth Centre* is a mixed methods National Health and Medical Research Council funded Partnership Project (GNT1135125: 2018–2022) [14]. The BOOSt study worked with stakeholders to establish new services within a prospective cohort registered clinical trial (Australia & New Zealand Clinical Trial Registry #ACTRN12620000874910) to evaluate feasibility, acceptability, sustainability, clinical and cultural safety, and cost-effectiveness.

The qualitative approach was participatory action research (PAR), a research approach that is *"grounded in lived experience, developed in partnership, addresses specific problems, works with (rather than simply studies) people, develops new ways of seeing/interpreting the world (i.e. theory), and leaves infrastructure in its wake"* [15]. Key PAR elements that are reflected in our study are: participation, action, research, and social change for social justice [16]. Multiple cycles of PAR were conducted as the services commenced planning for redesign and integration, engagement of stakeholders, identification of barriers and funding sources.

This article reports on the feasibility component of the BOOSt study using PAR, and a critical lens, to identify analyse, and interpret regulation of maternity services focusing explicitly on social justice and equity for First Nations communities [17]. The BOOSt study privileges First Nations knowledges and research methodologies based on principles recommended as good practice:

Box 1
An exemplar Birthing on Country service: BiOC.

A multiagency partnership between the Institute of Urban Indigenous Health, the Aboriginal and Torres Strait Islander Health Service (Brisbane), and the Mater Mothers Hospital provided the context for development of a First Nations led service called Birthing in Our Community. On the foundation of strong First Nations governance, the key components of the model were caseload midwifery continuity of carer, a First Nations workforce including family support workers, midwifery students, drivers and administration staff, a community hub for antenatal and postnatal care, access to onsite wrap around services (e.g., perinatal social worker), weekly community days to connect with each other and with culture through arts, cultural, and health promotion programs. Evaluation of the BiOC service demonstrated cost-savings of (-AUD$4810, [95 % Confidence Interval −7519, −2101]) per mother-baby pair (Gao et al., 2023) and better clinical outcomes for mothers of First Nations babies compared to those receiving standard care:

- Women attending ≥ 5 antenatal visits (adjusted Odds Ratio [aOR] 1·54, 95 % CI 1·13–2·09 p = 0·006)
- Women giving birth to a preterm infant (aOR 0·62, 0·42–0·93; p = 0·019)
- Babies exclusively breastfeed at discharge from hospital (aOR 1·34, 1·06–1·70; p = 0·014) [9].

With increased First Nations control of funding, services, and facilities, including a community-based hub, there was a rapid increase in the First Nations workforce (from 2 to >18 FTE (Full Time Equivalent) staff in four years). The service was expanded after three years and has been sustainable to 10-years. Crucial to success was First Nations leadership by the ATSICCHS, a willing tertiary healthcare service partner, and integration of wrap around care across the primary health care network and broader health services including the tertiary hospital [10]. .

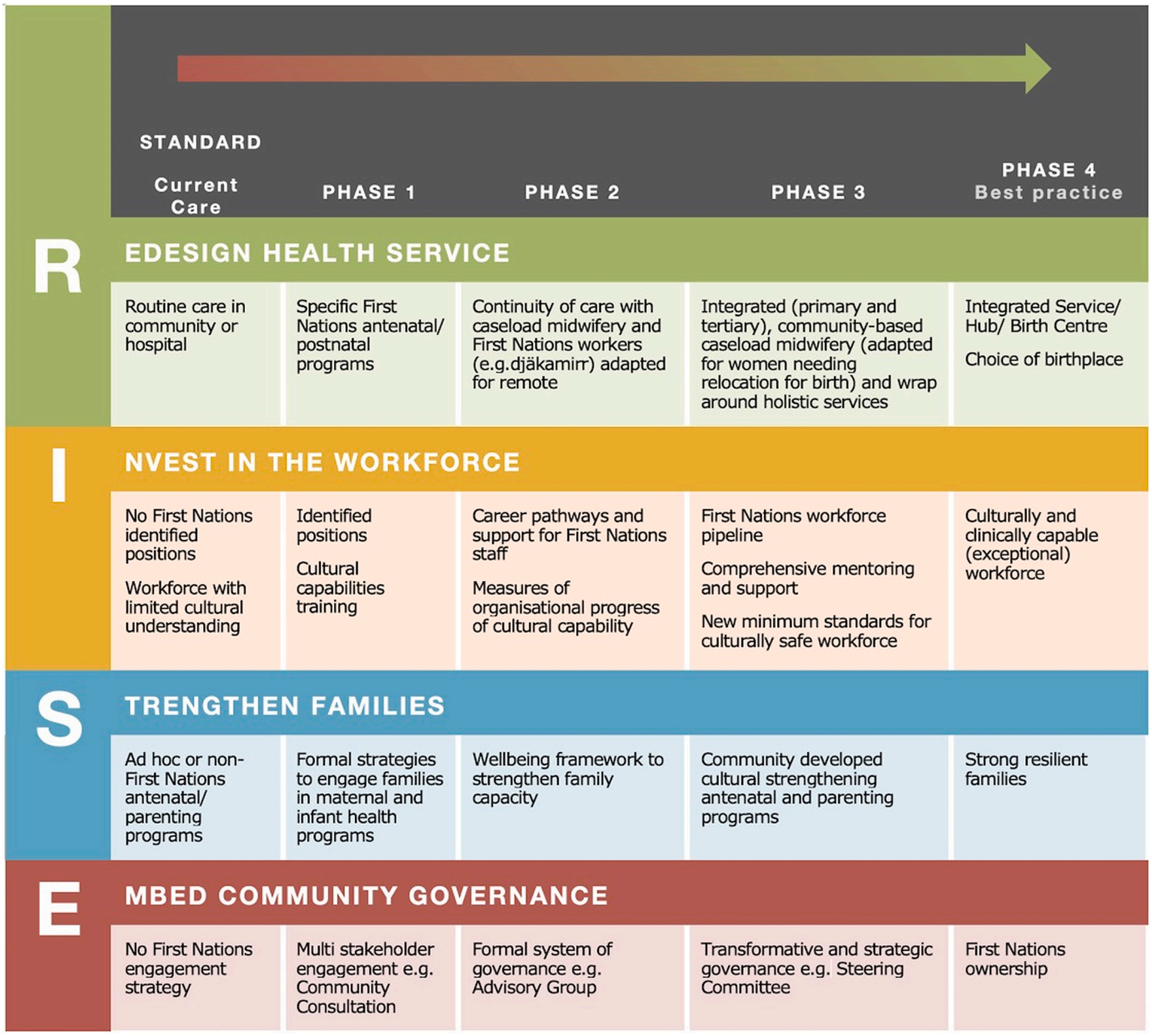

Fig. 2. The RISE Framework. Source: Ireland, S. et al. (2022). Birthing on Country for the best start in life:returning childbirth services to Yolŋu mothers, babies and communities in North East Arnhem, Northern Territory. MJA, 27(1).

1) Recognise First Nations worldviews, knowledges, and realities.
2) Honour cultural protocols.
3) Emphasise social, historical, and political contexts.
4) Privilege First Nations voices and experiences, tailoring responses to each local setting [18].

Researcher characteristics and reflexivity

The PAR team is comprised of four First Nations and nine non-First Nations individuals from the university, Aboriginal Community Controlled Health, and private midwifery sectors. Most of the research team are healthcare leaders, providers (midwives, nurses, doctors) and PhD-qualified mixed methods health researchers. The research team presupposed that Birthing on Country services should be implemented (based on experience either working in these models or researching them). This presupposition influenced how the research problem was framed, how the research question was developed, and how the results were analysed and presented (i.e., focus on solutions to identified barriers in the form of recommendations).

Theoretical framework

The BOOSt study uses the RISE Framework which outlines a phased approach (Phases 1–4) to implementation of Birthing on Country services across four components (Fig. 2).

1) **R**edesign maternity services
2) **I**nvest in workforce
3) **S**trengthen families
4) **E**mbed First Nations engagement, governance and control [13].

RISE is underpinned by concepts of relationality, and connection to Country, Aboriginal values, ways of knowing, being and doing while centring women, babies and families to ensure care that is clinically safe

and culturally safe, and feels safe for participants [13]. Implementation occurs across these four components from routine care provision (Phase 0) to full implementation (Phase 4) (see Fig. 2) where:

1) women can birth close to home with a known midwife and access to a birth centre
2) the workforce is culturally and clinically safe
3) strength-based, cultural activities and holistic services are provided in the community
4) the service has local First Nations community engagement, governance and control [13].

Research partners

Partners specific to this component of the study are the two organisations planning the service redesign:

1) Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation, Nowra, New South Wales (NSW); and
2) the Institute for Urban Indigenous Health (IUIH), Brisbane, QLD.

Both ATSICCHs partners planned to progress to Phase 4 services. Site-specific steering committees include chief executives, medical and services directors, and senior management in partnership with local health service providers. The steering committees provided oversight of service model development and implementation in their communities.

The Molly Wardaguga Research Centre team (Charles Darwin University), provides the research framework and have contributed a literature and scoping review; quantitative and qualitative data collection and analysis; protocol development; trial registration; technical expertise; monitoring, reporting and publication of findings. Additional partners provided advice, expertise, and services [14]. One partner *My Midwives*, a private midwifery organisation, already provided clinical services in multiple settings in two Australian jurisdictions (QLD and Victoria) and provided technical expertise regarding use of the midwifery workforce and professional indemnity insurance considerations.

Context

The ATSICCHS partners work in two Australian jurisdictions, Qld and NSW, where they have taken different approaches to implementing local Birthing on Country services.

Urban Site: Turrbal and Yuggera Nations, Meanjin (Brisbane North), QLD, Australia

In an area where several hundred First Nations families give birth each year, IUIH partnered with My Midwives to provide midwifery continuity of carer for ~120 women birthing in one of three local public hospitals annually. At the time of planning (~2018), there was no affordable insurance product available that would enable the ATSICCHS to employ endorsed midwives and provide insurance cover for professional indemnity. My Midwives had an existing insurance product providing professional indemnity cover for birthing services in relevant hospitals, and existing visiting access agreements with three maternity hospitals in the region. These agreements permit women to be admitted to a hospital facility for labour and birth care as private patients while cared for by My Midwives. Funding is partly supported by a national health insurance rebate scheme named Medicare through the Medicare Benefits Schedule (MBS) which endorsed midwives can claim. IUIH's roadmap for development and expansion of First Nations controlled birthing services includes establishment of a First Nations birthing centre in urban Southeast Queensland.

Rural Site: 13 Clans of the South Coast, Nowra, NSW, Australia

Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation (Waminda) provides services across the Illawarra, Shoalhaven, and Far South Coast districts where approximately 500 First Nations babies are born each year. Waminda currently offers midwifery continuity during antenatal and postnatal periods to an increasing number of women per year (74 women in 2021), aiming for ~120 in the first year of the new service. Waminda have been establishing their own continuity of midwifery carer service (Minga Gudjaga) by upskilling their current midwifery team to become endorsed midwives. Waminda have obtained professional indemnity insurance for the midwives under a Healthcare Companies policy. The Minga Gudjaga service will operate out of a purpose-built birth centre and Community Hub (Gudjaga Gunyahlamai) to incorporate the Birthing on Country program. Minga Gudjaga aims to provide midwifery care to women who plan to birth either at the local hospital (~70 %) or Gudjaga Gunyahlamai Birth Centre (~30 %). Waminda midwives will provide care for women birthing at the local hospital as Visting Endorsed Midwives via an access agreement similar to the arrangement My Midwives have at multiple hospitals in two other Australian jurisdictions.

Ethical considerations

BOOSt has approval through appropriate internal governance as required by our partner First Nations organisations and multisite ethical approvals. Approvals include the Aboriginal Health and Medical Research Council (NSW) Ethics Committee (1448/18), Joint University of Wollongong and Illawarra Shoalhaven Local Health District Health and Medical Human Research Ethics Committee (2019/ETH03796), and the Charles Darwin University Human Research Ethics Committee (H19054).

Sampling and data collection

Early in the PAR process spanning 2018–2022, we became aware of regulatory barriers threatening the feasibility of full implementation of Birthing on Country services, specifically around midwifery workforce and licensing of birth centres. Throughout the PAR process policy briefs with recommendations were prepared for various stakeholders across three of the major political parties including the Minister, Assistant Ministers, and advisors, for Health and Indigenous Health and the broader group known as the Parliamentary Friends of Closing the Gap. We also briefed policy advisors (e.g. insurance branch, Chief Nursing and Midwifery officers) and other stakeholders with two authors participating in the Review of Medicare for Midwives 2018–2022 [19]. Separate briefs were also prepared for the NSW and Qld governments as the barriers differed slightly across jurisdictions.

To better understand these barriers, we performed a desktop review of publicly available information using relevant key terms (e.g., primary maternity unit, private midwifery practice). The search was limited to:

- primary sources authored by Federal or State governments relevant to Qld or NSW;
- documents with current regulatory authority (e.g., policy directives, legislation).

We manually searched relevant documents to find additional, associated regulations. Document analysis is commonly used in qualitative research to provide information about the research context, and corroborate research findings [20]. If barriers were removed briefs were changed to reflect the current issues and advocacy would commence again following local BOOSt meetings where planning and reflection would occur. The regulations were reviewed again in preparation for this article to ensure we included any updated changes.

Data analysis

We conducted a reflexive analysis of identified documents that

involved skimming (superficial examination), reading (thorough examination), and interpretation (synthesis) [20]. We used the *PESTLE Framework* to identify **P**olitical, **E**conomic, **S**ocial, **T**echnological, **L**egal, and **E**nvironmental factors in the external environment [21], relevant to implementation of Birthing on Country services. The analytical process continued, with iterative revision of the PESTLE factors, until consensus was reached by the project team. The project team determined whether each factor was a barrier to implementation or an enabling factor; barriers were assessed as negligible, minor, moderate, or severe with respect to implementation of Birthing on Country services.

Findings

We identified 17 documents relevant to current regulation of endorsed midwifery practice (defined below) or privately licensed birth centres (see Table 1).

A high-level overview of our analysis of the barriers and enablers to full implementation of Birthing on Country services is outlined in Table 2. For the purposes of this paper, we focus on the policy, economic, and legal barriers; discuss the findings within the context of other research; and provide targeted recommendations that will address barriers that prevent ATSICCHS from implementing Phase 4 Birthing on Country services. While social barriers (e.g., colonisation, medicalisation of normal childbirth) may explain or underpin regulations and regulatory frameworks, their solutions were considered more complex, and were deemed beyond the scope of this analysis. No technological or environmental barriers were identified.

Policy barriers

A key policy barrier to Birthing on Country services revolves around the ability of ATSICCHs to both access and employ endorsed midwives to provide continuity of carer.

Midwives do not graduate able to work to full scope of practice

In Australia, *endorsed midwives* are the optimal midwifery workforce because they are authorised to provide services rebated by Medicare, work to full scope of practice across the continuum (pregnancy, labour and birth, and postnatal care), order diagnostic maternity care tests and ultrasounds, and prescribe a limited number of medications. To become endorsed, the Nursing and Midwifery Board of Australia requires midwives to demonstrate 5000 h of post-registration clinical practice and completion of a postgraduate program in midwifery prescribing. The result is < 1000 of the more than 30,000 registered midwives in Australia are ready to work in Birthing on Country services (i.e., have endorsement) [22]. In the short term, a review to either abolish or reduce to the clinical practice hours, which have no evidence base regarding quality and safety, would immediately increase the number of midwives able to apply for endorsement. In the medium term, midwifery prescribing could be required in undergraduate midwifery education so that midwives complete their degrees workforce ready. This change, combined with abolition of post-registration clinical hours, would result in > 10,000 midwives ready to prescribe and claim Medicare by 2033 (based on current >10 % annual increase in midwife-only registrations) [22] and work in Birthing on Country services.

Table 1
Included regulatory documents.

National
1. Health Insurance Act 1973 (Cth)
2. National Health Act 1953 (Cth)
3. National Health (Collaborative arrangements for midwives) Instrument 2022
4. Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010 (Cth)
5. Australasian Health Facility Guidelines (2016)
6. Medicare Benefit Schedule Taskforce report (2019)
7. Participating Midwife Reference Group report (2019)
Jurisdictional
NEW SOUTH WALES
1. New South Wales Health Policy Directive: Private Midwifery Practice
2. New South Wales Private Health Facilities Regulation 2017 – Schedule 2 Licensing standards
3. Private Health Facilities Act (2007) – Part 2 Licensing of private health facilities
QUEENSLAND
1. Queensland Government Access and Collaboration Agreement: For the provision of private midwifery services to private patients
2. Fundamental of the Framework, Clinical Services Capability Framework (QLD)
3. Maternity Service and Neonatal Service Modules - CSCF (QLD)
4. Private Health Facilities Regulation (2016)
5. Private Health Facilities (Standards) Notice 2016 (QLD)
6. Private Health Facilities Act (1999)
7. Private Health Facilities Amendment (2006)

Insurance issues prevent ATSICCHS employing endorsed midwives

Insurance is available for individual endorsed midwives through the Midwifery Professional Indemnity Scheme (MPIS), which includes government support for high-cost claims [23]. However, when organisations (like ATSICCHS) employ endorsed midwives, there is only one insurer who offers a *Health Care Practice policy* which covers professional indemnity insurance for the organisation and their employees. Documents obtained during the PAR process to quote for this insurance product are commercial-in-confidence and cannot be included in this documentary analysis. According to research partners, however, this product is exorbitantly expensive and is not supported through Commonwealth subsidies or offsets if high-cost claims occur. This situation leaves organisations financially vulnerable and drives up the premium price of health care practice insurance to unaffordable levels. This potentially leaves the ATSICCHS and/or the insurance companies at risk in the instance of a high-cost claim (see Fig. 3).

Economic barriers

ATSICCHSs are funded through a mixture of Commonwealth, State and Territory government and non-government expenditure including through Medicare. Medicare is predominantly a fee for service model that enables autonomous funding for the ATSICCHS allowing innovation and growth of their services to respond local Community needs.

Medicare rebates for midwifery services fall short

In 2018, a group of expert stakeholders – the Participating Midwife Reference Group (PMRG) was convened by the Commonwealth government as part of the overall review of the MBS [19]. The multi-disciplinary group reviewed the existing Medicare 'Items' to identify high value care. The PMRG made recommendations through the Medicare Taskforce to continue and expand midwifery Medicare items. Table 3 highlights the difference between the overarching Taskforce Recommendations compared to the expert stakeholder (PMRG) recommendations [19,24]. Despite consensus recommendations from the expert multidisciplinary stakeholders with technical expertise in this area, the Taskforce did not fully endorse the recommendations to strengthen services, increase high value care, and enable economic viability of endorsed midwifery continuity of care services [24].

Lack of sustainable funding for Birthing on Country services

To ensure a culturally safe environment for maternity care provide, ATSICCHSs require planned, recurrent, and sustained funding models that support service delivery and infrastructure requirements. BOOSt ATSICCHS partners have collectively designed and submitted several unsuccessful funding applications to jurisdictional and Commonwealth governments to resource capital investment for purpose-built birthing facilities. After more than 5-years of advocacy Waminda received an

Table 2
Barriers and enablers for full implementation of Birthing on Country services in Queensland and New South Wales, Australia.

	National			Jurisdictional	
Policy	Closing the Gap priority reforms, and Strategic Directions for Maternity Services in Australia align with the model	Existing workforce via Endorsed midwives who provide midwifery continuity of carer	Regulatory framework creates barriers to grow numbers of Endorsed midwives	QLD Government Access and Collaboration Agreement facilitates private midwifery practice in QLD hospitals	NSW Policy Directive creates barriers to private midwifery care in public hospitals
Economic	Model provides education and employment for First Nations workforce, high value care and is cost-effective	ATSICCHS health practice insurance to cover hospital birth expensive, inflexible and without subsidy	ATSICCHS income from MBS midwifery items insufficient without additional funding	Capital works, start up, and ongoing service delivery funding required to build safe birthing spaces (Level 2 private maternity facilities) with community hub and workforce	
Legal	ATSICCHS cannot obtain a PII product to cover out-of-hospital births			QLD regulations require minimum 240 annual births for Level 2 private maternity facility, but provision if throughput <240	Regulations require 24/7 medical practitioner **on-site** (NSW) **or attendance** (QLD) to license Level 2 private maternity facility

Factors have been colour coded according to whether the consequence is considered major, minor, negligible, or enabling.
ATSICCHS – Aboriginal Torres Strait Islander Community Controlled Health Services, PII – Professional Indemnity Insurance

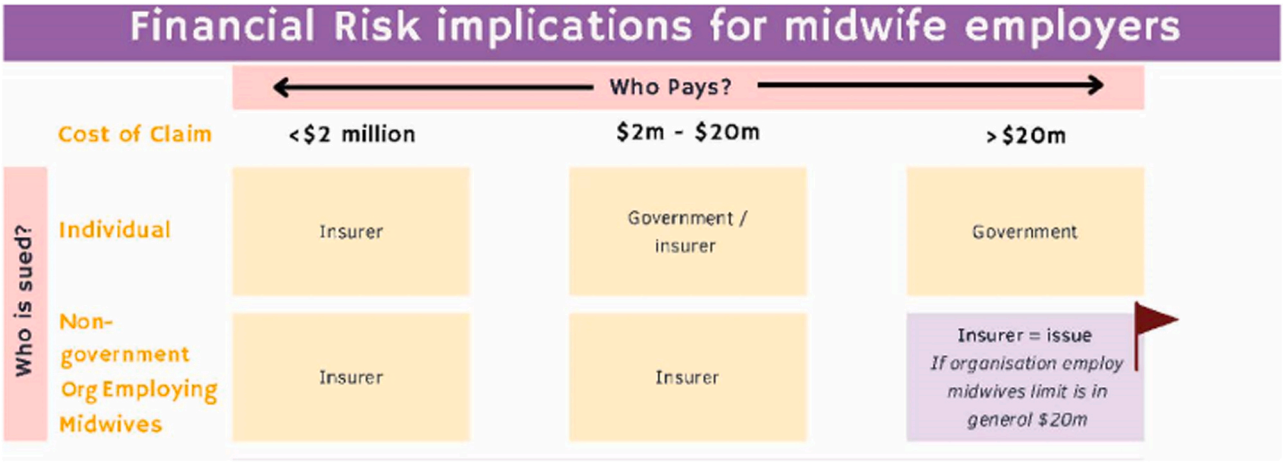

Fig. 3. Insurance barrier for endorsed midwife employers.

approval for $22.5 M in the 2023 Commonwealth budget for capital works for the Gudjaga Gunyahlamai Birth Centre and Community Hub as an identified Community need.

Reduction in hospital funding when endorsed midwives admit patients

Endorsed midwives (employed or engaged by ATSICCHS) who have an access agreement with a public hospital can admit pregnant women for labour and birth care. When this occurs, public hospitals receive a reduction in activity-based funding (ABF) due to private patient accommodation and service adjustments. However, the hospital's reduction in ABF is offset by savings on rostered midwifery staff that are not required for each private patient. Nevertheless, the reduction in ABF acts as a barrier to collaboration between ATSICCHS and public maternity facilities, especially for smaller hospitals.

Legal barriers

Phase 4 Birthing on Country services offer women choice of where to birth, including hospital, birth centre, or at home. Regulatory documents classify birth centres as Level 2 maternity services providing primary health care [25]. Level 2 maternity services must meet maternity facility licensing standards. A Level 2 maternity service provides midwifery care to women and babies with normal clinical needs (babies at least 37-weeks' gestation), including care during normal labour and birth, with seamless transfer procedures to access higher level medical services if required [25]. Level 2 maternity services do not provide onsite emergency surgical or anaesthetic treatment (i.e., caesarean section). Consistent with the national Clinical Services Capability Framework (CSCF) care can be provided by two registered midwives who have skills to work to full scope of practice [25]. A small number of Level 2 services operate in rural Australia with 17 facilities reported in 2016 [26]. A Rural Maternity Services Government Taskforce in Queensland, Australia, recommended bringing rural maternity services closer to home by strengthening, improving and carefully planning for re-establishment of Level 2 and 3 services [27]. In all jurisdictions, birth centres owned and operated by a non-government organisation are considered a private health facility. In Australia, licensing standards for private health facilities are determined by legislation that differs between jurisdictions. Analysis of relevant documents identified barriers that are summarised in Table 4.

Table 3
Differences between Medicare Taskforce Recommendations and Participating Midwife Reference Group recommendations.

Recommendations	Medicare Benefits Schedule Taskforce	Participating Midwife Reference Group (PMRG)
Recommendation 1	Include a minimum duration for initial antenatal attendance	Include a minimum duration for initial antenatal attendances **and align the schedule fee with average attendance duration (90 minute)**
Recommendation 2	Amend the antenatal attendance items to appropriately reflect the time they take	Amend the antenatal attendance items to appropriately reflect the time they take **and introduce a new time tier for long antenatal attendances**
Recommendation 3	Introduce a new item for complex antenatal attendance leading to a hospital admission	Introduce a new item for a complex antenatal attendance leading to a hospital admission
Recommendation 8	None	Include home birthing in intrapartum items. The Reference Group recommends: a. Including birth at home in the intrapartum b. That medical indemnity insurance, for privately practicing midwives be expanded to support a mother's choice regarding place of birth, including birth at home.
Recommendation 9	Amend the postnatal attendance items.	Amend the postnatal attendance items **and introduce a new item for a long postnatal attendance**
Recommendation 10	Include mandatory clinical activities and increase the minimum time for a six-week postnatal attendance.	Include mandatory clinical activities and increase the minimum time for a six-week postnatal attendance
Recommendation 11	None	Include GPs as eligible specialists for existing telehealth items
Recommendation 12	None	Recommendation 12 – Facilitate telehealth consultations between women and midwives in the antenatal and postnatal period. NOTE: Already accomplished during COVID
Recommendation 13	None	Add a new item to the MBS for claiming for participating midwives to conduct ongoing lactation support.
Recommendation 14	None	Addition of a small number of pathology and diagnostic investigation to the MBS rebate schedule for participating midwives as recommended by professional clinical guidelines
Recommendation 15	None	Removal of the need for mandated formal collaborative agreements

***Bold** denotes difference in detail. Recommendations 4-7 have been implemented.*

Table 4
Legislative barriers to First Nations standalone birth centres.

Queensland	The Private Health Facilities Act 1999 (QLD) has subordinate legislation set out in the Private Health Facilities (Standards) Notice 2016 (QLD) which includes the Minimum Patient Throughput Standard (version 5). It states that: *"This Standard is not satisfied unless…Obstetrics: i. 240 births per obstetric facility per year."*[28] However, it includes a provision for facilities with lower birthing numbers: *"If the minimum numbers specified above are not met, a formal affiliation exists with an appropriate health service in accordance with the Queensland Health Clinical Services Capability Framework for Public and Licensed Private Health Facilities to ensure staff maintain skill levels."*[28]
	The Clinical Service Capability Framework (CSCF) for Public and Licensed Private Health Facilities outlines the minimum requirements for a safe service [29]. The CSCF outlines modules that define minimum capability criteria for different services [30]. The *Neonatal Module* now appears to include contradictory requirements, as evidence by the following two statements. The first statement focusses on networked services and **transfer to access medical care** (which is consistent with the CSCF): *"if possible, birth of a high-risk infant should be planned to occur in a hospital with a neonatal service capable of providing the anticipated higher level of care. If birth in a facility without the necessary capabilities cannot be avoided, the infant should be stabilised and transferred to a higher level of care within the service network—one with the required capabilities to ensure the infant's optimal outcome."* [31] The second statement, however, requires **medical attendance to the Level 2 facility**: *"access—24 hours— to registered medical practitioner able to attend within 30 minutes in normal circumstances"*
New South Wales	The Private Health Facilities Regulation 2017 (NSW)[32] has the following requirements for Level 1 or 2 maternity facilities providing intrapartum care, which again undermine the intent of the National CSCF by require **on-site medical access** rather than **access to medical care through transfer** to a higher level services within the network: *"38 Normal risk pregnancies* *(a) obstetricians, anaesthetists, and a paediatrician on call at all times* *(b) a medical practitioner at the facility at all times"*[32]
	The Private Health Facilities Act 2007 (NSW) states that the licensee of a private health facility must ensure that a **registered nurse** is on duty at the facility at all times when a patient is admitted, and that a director of nursing be appointed. These requirements are inconsistent with the legally distinct professional roles of nurse and midwife, and the operational requirements for the Level 2 facility to be staffed by midwives (not nurses).

Discussion

We identified several barriers to the establishment of Birthing on Country services in Australia that are embedded in policy, regulation, funding, and legislation. These barriers highlight broader issues in Australian maternity care including midwives' professional autonomy and scope of practice, ineffective maternity funding models and insurance products, and inconsistent regulation of birth centres between jurisdictions. In some areas, policy or practice is not underpinned by available, high-quality evidence.

Recently, the Commonwealth Department of Health and Aged Care announced that the sole provider of professional indemnity insurance for endorsed midwives (including for healthcare companies like ATSICCHSs) does not cover labour care provided at home prior to hospital birth [33]. Midwives routinely provide advice, assessment and care to women in labour who are planning a hospital birth before they arrive at hospital, and early labour home visiting has been recommended as a way to address women's largely negative experiences of early labour care [34]. The identified gap in insurance cover during early labour poses an unacceptable risk to midwives, who are also risking their professional registration by providing services which are not covered by insurance or exemption; to their employers; and most of all, the women and babies relying on this advice, support and care. This critical issue highlights the urgency of addressing the structural barriers to Birthing on Country services.

The barriers to endorsed midwifery practice identified by our review are consistent with the research literature, including limited access to

the Medicare and pharmaceutical benefits schedules, and lack of support for prescribing in the public sector [35,36]. Few midwives in Australia work to their full scope of practice, which is partially explained by lack of policy and funding models supportive of professional autonomy [37]. Other factors that influence scope of practice include education, legislation and regulatory policies [38,39]. The ability to exercise professional autonomy is critical to midwives' job satisfaction and workforce retention [40].

There is increasing evidence that midwifery graduates would prefer to work in midwifery continuity models of care, including Birthing on Country services, rather than do shiftwork [41]. New graduate midwives transition to practice better in continuity of carer models than non-relationship-based transition programs [42]. Yet few midwives have this opportunity in hospital settings, and no programs are currently offered within Aboriginal and Torres Strait Islander Community Controlled Health Services due to lack of government funding.

In accordance with the evidence supporting the cost effectiveness of Birthing on Country services, funding arrangements should ensure adequate resource allocation to high value maternity care activities [43,44]. The evaluation of the urban Birthing on Country exemplar service, BiOC, demonstrated that, compared to standard care, the BiOC service was associated with better outcomes, and cost less due mostly to a reduction in preterm birth with calculated cost saving of $4810.00 AUD per mother-baby pair [45]. Scale up across the country was estimated to have the potential for reduce the number of babies born preterm by 965 per year at an estimated cost saving of $86,994,021.00 in Australian health expenditure [45]. Australia's maternity data collection systems should be measuring how well maternity care delivers cultural safety, respect, choice and access, *alongside clinical safety*, to provide a comprehensive assessment of value-based maternity care [46]. Medicare services account for almost 80 % of health service usage across the first 1000 days but only 10 % of the overall funding; compared to inpatient services which account for about 4 % of service volume but 75 % of funding [47]. Indeed, significant cost savings could be achieved in Australia if low-risk women planned to birth at home or in a birth centre but this needs to be supported by an affordable insurance product and Medicare funding stream [48].

There is strong empirical high-quality evidence that birth centres provide safe and beneficial perinatal care for women classified as low-risk; [49,50] including in rural and very remote areas [51–53]. Conversely, women who plan to give birth in a tertiary maternity hospital are more likely to suffer physical harm including from medical interventions such as episiotomy and caesarean section, compared to those who plan to give birth in a birth centre [30]. There is no evidence that supports the requirement for on-site or on-call medical practitioners for a Level 2 maternity service. A Delphi study to develop indicators for assessing the quality of birth centre care lists 30 potential indicators under the domains of effectiveness, safety, timeliness, efficiency, equity, and accessibility; none of the indicators measured having a medical practitioner on-site or on-call [54]. Additionally, it is not feasible to have an on-site doctor in many parts of rural and remote Australia where many First Nations women live, and where Birthing on Country services are both urgently needed and demanded by communities [55,56]. There is strong evidence to support scale-up of continuity of midwifery care models [57], including by endorsed midwives, and in rural and remote areas [58,59].

Limitations and trustworthiness

A major limitation of this study is that data were identified and gathered iteratively in response to barriers experienced in two research settings during participatory action research. This process of data collection was therefore purposive (to provide information about a particular problem) rather than systematic, which means there may be additional barriers/documents that were not identified/located as part of the document analysis. Trustworthiness in the results is enhanced by techniques including use of document references and excerpts to evidence claims, and consensus decision-making on how data were interpreted, and policy briefs were designed.

Recommendations

We recommend the Australian Government address significant policy barriers to implementation of Birthing on Country services by:

1. Reviewing educational and regulatory barriers to new graduate midwives working to full scope of practice including prescribing rights and Medicare-billing.
2. Ensuring availability of an affordable professional indemnity insurance product covering all healthcare organisations and maternity care practitioners across the maternity journey; including labour and birth outside hospitals.

We recommend the Australian Government address significant economic barriers to implementation of Birthing on Country services by:

1. Implementing all recommendations from the Primary Maternity Reference Group to the Medicare Taskforce.
2. Working with jurisdictional governments to develop a Birthing on Country funding stream to provide sustainable maternity services and infrastructure; including start-up funding for establishment of new services by ATSICCHSs.
3. Establishing a waiver of private patient adjustments for all women carrying a First Nations baby admitted to hospital for birth by an endorsed midwife.

A coherent and consistent legal and regulatory framework, informed by evidence, would enable the establishment of First Nations owned and operated birth centres. We recommend:

1. Development of an evidence-based national tool to guide the operation of Level 2 maternity services aligned with enabling legislation.
2. Revision of the *Neonatal service, Clinical Service Capability Framework (QLD):* Remove phrase "access—24 h— to registered medical practitioner able to attend within 30 min in normal circumstances." Insert instead "access – 24 h – to registered medical practitioner through a higher level service in the network."
3. Revision of the *Private Health Facilities Regulation 2017 (NSW):* Remove 38a & 38b from Part 10. Insert instead "24-hour access to anaesthetists, obstetricians and paediatricians through a higher-level service in the network."

Conclusion

We recommend privileging the expert knowledge, voices, concerns, aspirations and demands of the ATSICCHS sector when writing policy instruments (including legislation and regulation), that directly affects maternity care for First Nations communities. Despite the evidence that Birthing on Country services, midwifery-led care, and primary maternity units result in better clinical outcomes, are cheaper and safer than hospital-based services, scale up is slow and difficult. This is influenced by entrenched views that reinforce medical domination and control of maternity services. Urgent government action is required to ensure the policy, economic, and legal context enables implementation of Birthing on Country services owned and governed by Aboriginal and Torres Strait Islander Community Controlled Health Services.

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Ethical Statement

Approvals include the Aboriginal Health and Medical Research Council (NSW) Ethics Committee (1448/18) on 5th December 2018, Joint University of Wollongong and Illawarra Shoalhaven Local Health District Health and Medical Human Research Ethics Committee (2019/ETH03796) on 18th December 2018, and the Charles Darwin University Human Research Ethics Committee (H19054) on 10th July 2019.

CRediT authorship contribution statement

Jyai Allen: Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Project administration; Writing - original draft.**Yvette Roe:** Formal analysis; Funding acquisition; Supervision; Writing - review & editing.**Penny Haora:** Formal analysis; Project administration; Writing - review & editing.**Sophie Hickey:** Supervision; Writing - review & editing.**Melanie Briggs:** Formal analysis; Writing - review & editing.**Liz Wilkes:** Formal analysis; Investigation; Visualisation; Writing - review & editing.**Carmel Nelson:** Formal analysis; Supervision; Writing - review & editing. **Kristie Watego:** Formal analysis; Writing - review & editing. **Rebecca Coddington:** Formal analysis; Investigation; Writing - review & editing. **Sarah Ireland:** Methodology; Writing - review & editing.**Sue Kruske:** Formal analysis; Writing - review & editing.**Yu Gao:** Visualisation; Writing - review & editing.**Sue Kildea:** Formal analysis; Funding acquisition; Supervision; Writing - review & editing.

Conflict of interest

None declared.

Data availability

All documents are publicly available.

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