The Maternity Coalition Inc.

Australia's National Maternity Consumer Advocacy Organisation

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The Secretary
Standing Committee on Health and Ageing
Inquiry into Health Funding

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Dear Sir/Madam:

Please find attached our submission to the Inquiry into Health Funding. We used the information from the commonwealth government's following website to guide our presentation: http://www.aph.gov.au/house/committee/haa/healthfunding/tor.htm

Maternity Coalition is a voluntary association that has branches in all Australian States and Territories. It is a non-profit organization made up of consumers, midwives, doctors, researchers and sociologists, working with politicians, CEOs of maternity units, service providers and various other stakeholders to improve maternity care for women, babies, families and our community. Our main focus is to provide all women equity of access to choice, world's best practice and cost-effective maternity care.

Please feel free to contact me should the Standing Committee members require further information or discussion. I can be reached on (03)9817 3118 or 0412 707 001. I look forward to receiving your response to our submission.

Kind regards,

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Submission to the Inquiry into Health Funding

Maternity Coalition Inc
Australia's national maternity advocacy organisation

Recommendation: We recommend that the federal government take funding responsibility for the whole episode of primary maternity care from early pregnancy to six weeks post birth. For the purpose of this paper we will refer to this as a 'Maternity Medicare fund'.

Introduction

In making this submission Maternity Coalition seeks to represent the interests of consumers who are recipients of maternity-related health care.

We speak on behalf of mothers and their babies, as well as fathers, and families. We want maternity services that enhance health for all mothers, babies and families. We believe that our proposed changes to health funding are urgently needed and in the public interest.

It is essential that the federal government leads the reform of basic maternity service provision from a policy perspective, so that change can be effective for the consumer anywhere in Australia.

Normal maternity care spans a pregnancy and the ensuing six weeks, approximately 10 months in total. Maternity care is unique in the spectrum of health care, as most women are not ill, and the condition can not become chronic.

Basic maternity care is guided by the principle that "In normal birth there should be a valid reason to interfere with the natural process." (WHO 1999) This focus on the mother giving birth and nurturing the infant is the basis of primary maternity services. There is no safer way for most births than for the mother to give birth under her own natural power; there is no safer way for most babies to be nourished than for that nourishment to be provided exclusively by the mother at her own breast. The midwife is the most appropriate leading care provider for women with uncomplicated pregnancies and births. Pathways exist in primary maternity services for referral and transfer of care when appropriate. The general practitioner (GP) obstetrician and specialist obstetrician, and hospitals, provide secondary levels of care which, with the midwife, provide safe and effective maternity care options wherever they are available.

All pregnant women require basic maternity care. They may choose either a doctor or a midwife as their primary carer. Both professions are recognised and regulated by statute in all states and territories. Yet the doctor's fees attract a Medicare rebate, while the midwife's fees for the same services do not. The lack of government funding for a basic and essential service such as a midwife's care has resulted in excessive medicalisation of maternity care, and an effective monopoly for the medical profession over the midwifery profession. There is no evidence that the consumer is in any way protected or advantaged by the medical monopoly of funding.

Medicare prevents consumer access to maternity services provided by midwives. We strongly object to this state of affairs.

A few private health insurance plans, such as Australian Unity, give full rebate on a midwife's fees when the rebated service is provided out of hospital and therefore does not include hospital fees.

Specialist medical care is needed only by those who experience illness or complication in pregnancy or birth, or by newborn babies who are ill. This statement is not intended to demean the role of the specialist; rather it is to clarify it. International obstetric experts have

98173118

debated the respective roles of obstetricians and midwives in childbirth, and evidence has led to and underpinned the statement that "It is inherently unwise and perhaps unsafe for women with normal pregnancies to be cared for by obstetric specialists, even if the required personnel were available." (Enkin et al 2000) Yet Australia's Medicare funding, and government support for private medical services through tax rebates and the Medicare safety net has, in the case of maternity services, directed consumers to basic maternity services provided by obstetric specialists - "unwise and perhaps unsafe"! This is unacceptable.

Most consumers who choose a midwife as primary carer do so at their own expense.

We do not recommend that midwives be included in Medicare provisions for Enhanced Primary Care (EPC), for reasons given in Appendix 1 (page 8).

What can the midwife offer?

From the consumer's perspective, the midwife is able to provide a comprehensive primary care service that many healthy women prefer. All women giving birth need midwifery care; only a minority of women need expert medical care in birth. Some of the features of midwife led primary care are:

- Continuity of care from a known midwife who makes bookings with a small number of women, and acts as their leading maternity carer. The midwife works within a small group practice and is able to ensure suitable backup at all times.
- The woman is cared for in labour by the same midwife (or midwives) who have provided prenatal care. The midwife attends the birth as the responsible professional, working within the professional team and personal support situation in the woman's chosen place of birth (hospital, birth centre, home).
- Referral to a medical practitioner or service as required. Referral may lead to collaborative care between the midwife and the doctor or service, or transfer of care to a specialist service. (ACMI 2004)

This ideal of one-to-one midwife led primary care is rarely achievable in Australia, although it is held as a basic model in international childbirth literature. The main impediment in this country is the monopoly, through Medicare, which supports doctors as care providers, and excludes midwives.

Submission to the Inquiry into Health Funding - Maternity Coalition 2005

The following summary of arguments is presented with reference to the Inquiry's Terms of Reference.

TOR consideration 'a.' roles and responsibilities of different levels of government in provision of maternity services

Aspect of service	Government role and responsibility in maternity care	Comment
Prenatal care - most women are well and do not require hospital or medical intervention in the prenatal period	Federal government oversees Medicare and taxation, and funding for state government health arrangements. State government funds hospital services, with payments for birth and other maternity services provided in hospitals. Some hospitals, particularly tertiary and regional Base hospitals, both public, provide in-house prenatal care. The funding in these cases is State. In other situations (smaller public hospitals and private hospitals) prenatal care is provided in the private rooms of the doctors, and Medicare rebates apply. State government statutory Boards regulate medical and midwifery practice. Local government is not usually involved as a provider, except in post-acute maternal and child health services.	Approximately 30% of the 250,000 babies born each year are under private care. Medicare safety net applies to fees charged by obstetricians and other doctors. The federal government has sought to make private health insurance more attractive to the consumer by introducing taxation incentives. Federal government assistance has been provided to ensure doctors are covered by medical defence arrangements for private practice. Midwives have no insurance for private practice, and for this reason have lost hospital visiting rights.
Intranatal care - labour, birth	State government funding arrangements and private hospital fees apply in hospitals.	When women choose to labour and give birth in their own home with a midwife in attendance there is no government funding in most areas (exceptions include programs such as Community Midwifery WA, and South Australia). A few private health insurance companies give full rebate for home based maternity care. (eg Australian Unity, Defence Health). Other insurances give partial rebate for midwife care.
Postnatal care	State government funding as part of the amount claimed by hospitals for each birth or 'confinement'. Medicare for local doctor visits in the postnatal period.	Public and private hospital funding arrangements provide for several days' in-patient care for mother and baby postnatally, and home based care provided by the hospital. Some private health insurances provide rebate for postnatal breastfeeding services provided by private practitioners (midwives and lactation consultants). These services do not attract government funding.

98173118

Submission to the Inquiry into Health Funding - Maternity Coalition 2005

The mix of federal and state funding for basic maternity services results in 'cost shifting' creates an un-even playing field between services provided by midwives and the same services provided by doctors, and has prevented reform at the state government level.

Recommendation: We recommend that the federal government take funding responsibility for the whole episode of primary maternity care from early pregnancy to six weeks post birth. For the purpose of this paper we will refer to this as a 'Maternity Medicare fund'.

Our recommendation, if implemented, will require the federal government to take back some of the funding it currently gives to state governments for acute maternity services that come under the basic maternity service category required by all women in pregnancy and birth.

Our recommendation, if implemented, is unlikely to cost the federal government any more money for the provision of basic maternity services than is currently paid out under Medicare items and basic maternity services under hospital funding arrangements. Instead, the changes resulting from implementation of our recommendation would provide a more equitable choice for consumers, and break down the current monopoly.

Administration of a **'Maternity Medicare fund'** would require a formula that defines the 'items' and payments, and would be consistent for all consumers (private, public, rural, hospital, birth centre, etc). Rebate from the **'Maternity Medicare fund'** would be available for registered providers of basic or primary maternity care, that is midwives and general practitioners (GPs).

Where items within the **'Maternity Medicare fund'** are provided by more than one provider, such as a doctor and a hospital at the time of birth, the fee for that service would be shared according to an agreed formula.

In effect a specific amount of funding would be allocated through the proposed new **'Maternity Medicare fund'** per woman/pregnancy/baby unit.

Specialist obstetric and paediatric care, as well as other specialist medical services, are a separate consideration, and should be accessible with referral. Midwives need to be able to refer to specialist obstetricians. Specialist services are not basic services, and with the implementation of our recommendation will continue to be provided on the basis of need with Medicare and hospital funding.

TOR consideration 'b.' simplifying funding arrangements, and better defining roles and responsibilities of different levels of government in provision of maternity services, with particular emphasis on hospitals

Our recommendation, proving a **'Maternity Medicare fund'** for basic primary maternity care applies to this consideration as outlined above.

As a voluntary organisation Maternity Coalition does not have access to detailed information on maternity funding and hospital management. We consider the consumer interest to be of greater value than financial considerations. However we consider that these proposed reforms would not increase government outlay for maternity services. Instead, the recommended **'Maternity Medicare fund'** would streamline and simplify maternity funding by linking the payment to each woman/pregnancy/baby unit, which is a definable number of care episodes.

Implementation of this recommendation will require systematic reform of maternity funding arrangements. We seek support in principle from this Inquiry, recommending that the government accept at a policy level the need for reform, and set up the appropriate systems to oversee such major reform.

98173118

We believe that our recommendation will break through the current state/federal cost shifting and disagreements on responsibilities. The main beneficiaries will be consumers: mothers, babies, and families.

TOR consideration 'c.' considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and maternity services can be improved

Consumers of maternity services are increasingly expecting that providers of services will be accountable and transparent in all aspects of the care provided, whether public or private, in hospital or in the community.

Maternity Coalition reports on maternity issues to members, and to the wider community, through our journal Birth Matters and our website. Maternity Coalition also provides consumer members to sit on government and hospital maternity committees and inquiries.

An example of recent progress in accountability of maternity services to the consumer is the publication of Victorian Maternity Services Performance Indicators for 2003-2004 (DHS 2005). This report identifies individual public hospitals, and shows how they 'performed' in terms of percentages, and comparison with the other hospitals, in a range of significant indicators such as rate of induction in standard primiparae.

We believe that reliable information and reports should be widely available in maternity care. This should include individual hospitals' outcomes in relation to many aspects of maternity service, for example, a woman being able to find out the percentage of episiotomies performed in the hospital she is to attend. Women wanting to access care must be able to choose where to birth with full disclosure, where possible, of what they are likely to expect.

TOR 'd.' how best to ensure that a private health sector can be sustained into the future ...

Private maternity hospitals are currently the domain of specialist obstetricians. Midwives who are employed to work in private hospitals practise under the supervision and direction of the doctors, and can not act as primary carers. This restriction of the midwife's practice is not in the interest of the consumer, as midwives cannot use their skills to the full scope of practice.

Under current funding arrangements we cannot support the private health sector's role in basic maternity care provision. This is not in the public interest, as caesarean and forceps births, while being life saving for some, are also potentially harmful to women. Major abdominal surgery, such as caesarean, and operative vaginal births (forceps and vacuum), potentially have immediate and long term physical and emotional consequences for the mother and child. The rates of caesarean and other operative births are rising each year, particularly in private hospitals. Reducing these rates would reduce the cost of maternity care and be of benefit to ensuring maternity care continues to be viable in private hospitals.

Since government policy seeks to sustain the private health sector into the future, we contend that reform of access to funding for basic maternity services, providing the same rebates to midwives and doctors for the same services, would enable midwives to engage in their full scope of practice as primary carers, working collaboratively with doctors and achieving better health outcomes for the mothers and babies in their care. This is consistent with our recommendation, providing a **'Maternity Medicare fund'** for primary maternity care.

TOR 'e.' ways to make private health insurance a still more attractive option ...

As mentioned in the comments on TOR 'd.', we cannot support basic maternity services in private hospitals, where midwives are restricted in their scope of practice. The situation also applies to privately insured patients in public hospitals.

Submission to the Inquiry into Health Funding - Maternity Coalition 2005

Appendix 1

Note on Enhanced Primary Care

Since 1 July 2004, the government's new provisions for Enhanced Primary Care (EPC) have enabled some services provided by allied health professionals to be eligible for Medicare rebate. While this program has some features that are similar to our proposed reform in our recommendation, we note the following points for which EPC and our recommendation of a **'Maternity Medicare fund'** not compatible:

- EPC is for people with chronic conditions which have been present for 6 months or more. These requirements exclude basic maternity care from EPC, even if midwives were included as allied health professionals under the EPC rules. Basic maternity care is not a chronic condition, and is required prior to 6 months of pregnancy.
- EPC provides multidisciplinary management of complex care needs, while basic maternity care is suitable for well women, and may be provided by a single midwife or a small team.
- EPC requires a Community Care Plan developed by a GP who refers the patient to allied health professionals. Basic maternity care does not require referral from a GP, as a midwife is able to provide the full service on her/his own responsibility.
- EPC provides five treatments by the allied health professional per year. Basic maternity care must not be restricted in this way.

While GPs provide primary health care in the community, many are not competent in basic maternity care. It would be unreasonable to require a GP to oversee the plan for basic maternity care by a midwife, as the midwife would often be the more skilled person in maternity care provision. A midwife is the ideal professional to provide primary maternity care and therefore direct access to the midwife is essential.

Glossary

Basic maternity care is the essential service that is required by all women in pregnancy birth and post natally. The provider of basic maternity care, referred to as the 'primary' or first level carer, is a midwife or a general practitioner (GP) obstetrician. Basic maternity services may be provided in the community or in a maternity hospital.

Specialist maternity care is provided by medical practitioners with appropriate credentials, such as obstetrics, anaesthetics and paediatrics. Specialist services may be provided in the community by the doctor, or in a maternity hospital.

References

ACMI 2004. *National Midwifery Guidelines for Consultation and Referral*. Australian College of Midwives, ACT.

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