HEALTH LEGISLATION AMENDMENT (MIDWIVES AND NURSE PRACTITIONERS) BILL 2009 AND TWO RELATED BILLS

THE INQUIRY

1.1 On 25 June 2009 the Senate, on the recommendation of the Selection of Bills Committee (Report No.10 of 2009), referred the provisions of the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills to the Community Affairs Legislation Committee for inquiry and report by 7 August 2009. The Committee presented an interim report on 7 August and indicated that it would table its final report on 17 August 2009.

1.2 The inquiry generated considerable interest and within a very short period of time the Committee had received nearly two thousand submissions, primarily from midwives who provide homebirth services and from parents who described their experiences with, and support for, home birthing. The Committee received 1,958 submissions relating to the Bills and these are listed at Appendix 1. The Committee considered the Bills at a public hearing in Canberra on 6 August 2009. Details of the public hearings are referred to in Appendix 2. The submissions and Hansard transcript of evidence may be accessed through the Committee's website at http://www.aph.gov.au/senate_ca.

1.3 The Committee notes that a predecessor Committee, the Community Affairs References Committee, considered a number of the issues that have been raised during this inquiry, including homebirth and midwife indemnity insurance, during earlier inquiries into childbirth procedures and nursing.[1]

THE BILLS

Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009

1.4 The purpose of the Bill is to amend the *Health Insurance Act 1973* and the *National Health Act 1953* to enable nurse practitioners and appropriately qualified and experienced midwives to request appropriate diagnostic imaging and pathology services for which Medicare benefits may be paid. The Bill will also allow these two

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1 Senate Community Affairs References Committee, *Rocking the Cradle: A Report into Childbirth Procedures*, December 1999, accessed at http://www.aph.gov.au/senate/committee/clac_ctte/completed_inquiries/1999-02/child_birth/report/index.htm and *The Patient Profession: Time for Action*, Report on the Inquiry into Nursing, June 2002, http://www.aph.gov.au/senate/committee/clac_ctte/completed_inquiries/2002-04/nursing/report/index.htm .

groups of health professionals to prescribe certain medicines under the Pharmaceutical Benefits Scheme (PBS). New Medicare items will be created and allow for the referral under the Medicare Benefits Scheme (MBS) from these health professionals to specialist and consultant physicians. The proposed arrangements will be available from 1 November 2010.

1.5 Amendment of the Health Insurance Act will allow a 'participating nurse practitioner' or 'participating midwife' to request or provide certain Medicare services. Under proposed amendments to the National Health Act, an 'authorised nurse practitioner' or 'authorised midwife' will be authorised to prescribe certain PBS medicines. Prescribing under the PBS will only be permitted within the scope of practice of an authorised nurse practitioner or midwife and in accordance with the State or Territory legislation under which they work.

1.6 The proposed arrangements require that the nurse practitioner or midwife be an 'eligible nurse practitioner' or 'eligible midwife'. To be an 'eligible midwife', the Bill requires registration as a midwife and additional requirements specified by legislative instrument must be satisfied. The minimum core requirement of being an 'eligible nurse practitioner' is registration as a nurse practitioner.

1.7 For midwives and nurse practitioners to be eligible to participate in the MBS and PBS arrangements, they will have to demonstrate that they have collaborative arrangements in place, including having appropriate protocols with hospitals and doctors.

1.8 The Pharmaceutical Benefits Advisory Committee will be consulted about the range of medicines that each group can prescribe and the circumstances under which the medicines can be prescribed.

1.9 The Minister commented:

> In short, this Bill removes barriers to the provision of care and will lead to improved access to services for the community. It is a long overdue recognition of our highly skilled and capable nursing and midwifery workforce.[2]

Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009

1.10 The purpose of the Bill is to allow the Commonwealth to provide, via a contracted private sector insurer, affordable professional indemnity insurance to eligible privately practicing midwives. The government supported scheme for eligible midwives will enable the Government to address a market failure which has resulted in privately practising midwives being unable to access professional indemnity

2 The Minister for Health and Ageing, the Hon Nicola Roxon, MP, *House of Representatives Hansard*, 24.06.09, p. 6948.

insurance cover from a commercial insurer since 2002.[3] The implementation date for profession indemnity is 1 July 2010.

1.11 The Bill provides that the Commonwealth will pay certain amounts for claims against an eligible midwife. In the case of practicing eligible midwives, the Bill will provide as follows:

- for each claim, the insurer will pay the first $100,000;
- for each claim over $100,000 the Commonwealth will pay 80 per cent of the cost that exceeds that threshold up to a ceiling of $2 million (these are referred to as Level 1 Commonwealth contribution payments); and
- for each claim that exceeds $2 million, the Commonwealth will pay at the Level 1 rate for the first $2 million, plus 100 per cent of the cost of the claim above that threshold (these are referred to as Level 2 Commonwealth contributions).[4]

1.12 The Bill provides for the $100,000 and $2 million thresholds and rate of subsidy applying to both Level 1 and Level 2 claims to be changed by Rules.

1.13 For Level 1 and Level 2 Commonwealth contributions a claim will only be paid if the claim has been certified as a qualifying claim by the Medicare Australia Chief Executive Officer.

1.14 For the purposes of the Bill, an eligible midwife is one who is licensed, registered or authorised to practise midwifery under a State or Territory law and who meets any other requirements specified in the Rules.

1.15 The Minister, in her second reading speech commented:

> This bill is an important component of the government's maternity reform package. The package will improve the choices that are available to women in relation to maternity care...
>
> Overall, this bill contributes to a new era for midwifery services in this country, by addressing a longstanding impediment that has limited the availability of a wider choice for women.[5]

Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009

1.16 Under the run-off cover scheme eligible midwives claims will be paid out by the Australian Government and the cost of this scheme will be funded by a levy on eligible insurers.

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3 Department of Health and Ageing, *Submission 28*, p. 10.

4 Explanatory Memorandum, pp 1–2.

5 The Minister for Health and Ageing, The Hon Nicola Roxon, MP, *House of Representatives Hansard*, 24.06.09, pp 6953, 6954.

1.17 The run-off cover scheme Bill proposes the levying of a tax on eligible insurers. The tax will ensure that contributions can be made to a pool of funds that will be able to be drawn upon in the future to meet the cost of claims against eligible midwives who leave the midwifery workforce due to retirement, death, disability or maternity.[6]

1.18 The run-off cover scheme Bill provides that the rate of support payment must not exceed 15 per cent with the actual rate to be set on advice from the Australian Government Actuary.

1.19 The Commonwealth will commit $5 million in 2010–11 to assist in covering such claims in the period before sufficient funds are accumulated through the ongoing contribution of support payments.

ISSUES

1.20 The proposed legislation was generally supported by submitters. The Maternity Coalition, for example, stated:

> The reforms promise women the option of employing a midwife of their choice, who is working in private practice (within a range of possible models), who is accredited to receive Medicare funding and subsidised insurance, and has collaborative arrangements with doctors and hospitals. The goal of these reforms is to provide mothers with "safe, high-quality and accessible care based on informed choice" (Maternity Services Review).
>
> This is a historic breakthrough for Australia's health care system. It promises to, over time, improve the accessibility, quality, safety and cost-effectiveness of Australia's maternity services, by building a primary care foundation which is currently missing for most women.
>
> We are particularly aware of the potential in these reforms to improve services and outcomes for rural women, who have significant problems accessing maternity care.[7]

1.21 However, while the proposed reforms were generally welcomed, a number of issues were raised during the inquiry, particularly the issue of midwife support for those who wish to birth at home.

Homebirths

1.22 Under the proposed legislation, the indemnity arrangements will not apply to homebirth midwives. The legislation will then intersect with the National Health Registration legislation which will require all health professionals to hold indemnity insurance. As noted by a number of submitters, privately practicing midwives have been unable to secure indemnity since 2002 and thus 'creates a situation whereby

6 Department of Health and Ageing, *Submission 28*, p. 10.

7 Maternity Coalition, *Submission* 13, p. 1.

midwives providing homebirth care will be acting outside their registration by not holding Indemnity Insurance to cover their practice'.[8]

1.23 Ms Dianna Kidgell of the Australian Nursing and Midwifery Council commented that homebirth midwives were not excluded from the legislation because of lack of qualification or competency:

> I will speak to the exemption of a group of persons who are correctly qualified and registered to practice from their area of practice when there is no issue around competence or conduct and no reason for them to have their practice interfered with other than the fact that it has now come through in the legislation. We are excluding from practice a group of people who have not changed any of the circumstances under which they are practising—they still meet the registration requirements and have not had any reason to come to the attention of the board for conduct or performance issues. That is a concern.[9]

1.24 The Australian College of Midwives stated that it wholeheartedly supported many aspects of the legislation in relation to the expansion of the role of midwives and the development of a private practice midwifery workforce. However, the legislation 'does not enable safe quality of maternity care to be provided for women who choose to have a baby at home'.[10] While there are hospital-based health services in Western Australia, New South Wales, South Australia and the Northern Territory which enable women to birth at home, there services are very limited and operate with strict exclusion criteria.[11] Those women wishing to engage a private midwife for a homebirth outside these arrangements may not be able to do so.

1.25 Many submitters commented that homebirths will still occur but with an unregistered care provider who may or may not have qualifications or without any assistance. As stated in one submission:

> If indemnity insurance is made a requirement for midwives nationally, then the Commonwealth Government should provide such indemnity to independent midwives based on demonstrated competency, as such indemnity is unavailable in the private market. If homebirth is not available through registered midwives, the reality is that many women will still choose to birth at home either unsupported or with the help of non-registered midwives – this will likely worsen outcomes for mothers and newborns.[12]

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8 Midwives in Private Practice Subcommittee of the Australian College of Midwives Qld Branch, *Submission* 7, p. 4; see also Mt Beauty and District Country Women's Association, *Submission* 3, p. 1.

9 Australian Nursing and Midwifery Council, Ms D Kidgell, *Committee Hansard*, 6.8.09, p. 21.

10 Australian College of Midwives, *Submission* 18, p. 1.

11 Homebirth Australia, *Submission* 22, p. 5; see also Australian College of Midwives ACT, *Submission* 16, p. 2.

12 K Weeramanthri & T Weeramanthri, *Submission 1912*, p. 1.

1.26 The Midwives in Private Practice Subcommittee of the Australian College of Midwives (Queensland Branch) also commented:

> Exclusion of homebirth care from Medicare funding is also likely to mean the continuation of the rise in freebirth or doula attended births for economic reasons. Many women are now perceiving that a less expensive doula is an adequate support for birth in the home. They see a doula as a person who has some idea of what is happening through the birthing process. Women may mistakenly view this as "safer" although doulas are not trained to resuscitate mothers or babies, detect complexities or treat them, or to know when there is a need for transfer. In some ways this presents a picture that is even less safe than free-birthing without a doula because women may mistakenly believe that the doula will keep them from harm.[13]

1.27 Concerns were expressed by a number of witnesses that the proposed changes would lead to an increase in free birthing, that is, giving birth without a trained care provider (i.e. a midwife or medical practitioner). Homebirth Australia commented that anecdotal evidence suggests that the incidence of free birthing is increasing and that 'the increase in freebirth is largely an indictment on a broken maternity system that is not based on evidence and is not woman centred'.[14]

1.28 The Australian College of Midwives argued that homebirth falling outside the regulatory framework will result in outcomes being unreported and invisible; those providing services not being required to have professional qualifications; and no compunction to have appropriate collaborative processes, back-up and transfer mechanisms.[15] Mrs Elizabeth Wilkes, Australian Private Midwives Association, commented that 'the disasters of women turning up bleeding, with babies unable to be born or whatever else that people are concerned about will certainly increase if this legislation goes ahead as it stands'.[16]

1.29 The Australian Nursing and Midwifery Council concluded that 'this will make homebirth very dangerous, even for low risk, healthy women for whom homebirth is a safe option'.[17] Ms Justine Caines, Secretary, Homebirth Australia, noted for example, that in Canada after homebirth midwifery was made unlawful, one baby died at home leading to a change in the funding arrangements for homebirth.[18]

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13 Midwives in Private Practice Subcommittee of the Australian College of Midwives Qld Branch, *Submission* 7, p. 7.

14 Homebirth Australia, *Submission* 22, p. 6; see also Griffith University, *Submission* 42, p. 3.

15 Australian College of Midwives, *Submission* 18, p. 5.

16 Australian Private Midwives Association, Mrs E Wilkes, *Committee Hansard*, 6.8.09, p. 52.

17 Australian Nursing and Midwifery Council, *Submission* 20, p. 2.

18 Homebirth Australia, Ms J Caines, *Committee Hansard*, 6.8.09, p. 6.

1.30 It was also argued that midwives currently in private practice may choose to continue to practice either underground or as unregistered caregivers. Such midwives may not seek to update their practice through professional development or may be less willing to transfer women to hospital for fear of prosecution. This will impact adversely on safety.[19] Others may be forced from the workforce altogether 'as working in hospital is not seen as a viable option for these midwives because the fragmented systems of care directly contradict their philosophy of birth and supporting women's choices'.[20]

1.31 A number of submitters noted that the issue of homebirth was mentioned in the National Maternity Service Review. The Review commented that a premature move to a model of care incorporating homebirths risked 'polarising the profession'. The Review also commented that it was likely insurers would be less inclined to provide indemnity for private homebirths and if they did provide cover that the costs would be high.[21]

1.32 During the inquiry, the safety of homebirth was canvassed. The President of the Australian Medical Association (AMA), Dr Andrew Pesce, stated:

> The government was absolutely correct when it decided not to extend these bills to cover home births. The fundamental goal of maternity care must be a healthy mother and a healthy baby. The available Australian evidence on home birth is compelling: it carries significantly greater risk than conventional options for childbirth. While there are people in the community who want this choice, governments must make evidence based decisions. It is not appropriate for the Commonwealth to introduce payment and insurance arrangements that encourage or sanction activities that inherently carry more risk.[22]

1.33 Likewise, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) does not support homebirths.

1.34 However, other witnesses argued that there was ample evidence that homebirths for low-risk women are not unsafe. Professor Hannah Dahlen, Australian College of Midwives, commented that 'what all this evidence tells us again and again is that homebirth for low-risk women attended by competent, networked, integrated midwives within a responsive system is safe'.[23] In addition, it was argued that

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19 Australian College of Midwives, *Submission* 18, p. 5; see also Australian Private Midwives Association, Mrs E Wilkes, *Committee Hansard*, 6.8.09, p. 55.

20 Midwives in Private Practice Subcommittee of the Australian College of Midwives Qld Branch, *Submission* 7, p. 7.

21 Commonwealth of Australia, *National Maternity Service Review*, 2009, p. 21.

22 Australian Medical Association, Dr A Pesce, *Committee Hansard*, 6.8.09, p. 2.

23 Australian College of Midwives, Professor H Dahlen, *Committee Hansard*, 6.8.09, p. 19.

homebirth provided many advantages for both mother and baby, for example low rates of intervention.[24]

1.35 The Maternity Coalition commented that 'despite the science, a heated and ongoing debate continues in Australia about what choices women should make in birth. This tends to be based on raw personal opinion, or at best, "cherrypicked" evidence.'[25] The Queensland Centre for Mothers and Babies also commented that 'the proposed legislation appears to be based on misinformation about the relative safety of in-hospital and out-of-hospital birth, and is reflective of the perspectives and interests of a few groups and organisations with a vested financial interest in hospital birthing'.[26]

1.36 The Australian College of Midwives stated that the impact of excluding homebirth from the regulatory framework is a compromise of public safety. Further, 'it is difficult to rationalize that this is an appropriate decision to appease medical concerns–especially when the RANZCOG position is unable to be substantiated with evidence and is inconsistent with the [Royal College of Obstetricians and Gynaecologists] position statement [supporting homebirth]'.[27]

1.37 In response to the concerns raised about the exclusion of homebirths, Ms Rosemary Huxtable from the Department of Health and Ageing (the department) commented:

> In respect of the maternity services package, that emerged from the maternity services review. It was not the recommendation of the maternity services review that homebirths should be included in new arrangements at this stage. That was taken on board by the government when it made its decisions around access to MBS and PBS. There are then other issues which have emerged through the NRAS legislation and how that intersects with the indemnity arrangements. We are certainly acutely aware of the concerns of many in respect of that intersection. There has been considerable discussion. The minister and the secretary have had discussions with stakeholders in respect of that. There is active consideration of some of the issues that have been raised in that regard now. But I probably cannot say too much more than that, because there has been no final decision on those issues at this stage.[28]

1.38 Ms Huxtable also noted that homebirths are occurring in some States and Territories and that the department is holding discussions with the States and Territories about the services that they provide and how they fit into the matrix of birthing services that are available. Ms Huxtable went on to comment that 'part of this

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24 Homebirth Australia, Ms J Caines, *Committee Hansard*, 6.8.09, p. 11.

25 Maternity Coalition, *Submission* 13, p. 2.

26 Queensland Centre for Mothers & Babies, *Submission* 14, p. 2.

27 Australian College of Midwives, *Submission* 18, p. 3.

28 Department of Health and Ageing, Ms R Huxtable, *Committee Hansard*, 6.8.09, p. 65.

is also about a side-by-side national maternity services plan which is being developed with the states and territories. There are a number of streams of activity occurring.'[29]

1.39 The Committee notes that AAP reported on 11 August 2009 that, in a statement released by her office, the Minister had commented that the Government 'recognised the important role played by qualified midwives in the birthing experience of many Australian women'. The Minister is reported to have stated that 'I recognise that a very small proportion of women would like to have home births and am currently investigating if there is some way that we can provide this as an option without making the proposed midwife indemnity insurance unaffordable'.[30]

Collaborative care

1.40 The AMA commented that whether the legislation succeeds or fails will depend on the requirement for the collaborative care models and the detail of who will be responsible for the development, implementation and monitoring of the models.[31] The AMA also commented on the risks if care is fragmented. Dr Pesce stated:

> If we do not get the arrangements right it will encourage fragmentation of patient care, and fragmentation is the enemy of quality healthcare delivery. We know that, as more people become involved in the care of a patient, the risks of an adverse event increase significantly. This risk is multiplied even further when you open up opportunities for other health professionals to prescribe medications.[32]

1.41 The Rural Doctors Association of Australia (RDAA) voiced the opinion that there is a significant risk associated with the authorisation of nurse practitioner and midwife medication prescribing and ordering of diagnostics as this could result uncoordinated and fragmented care and thereby increasing the risk to the patients and cost to the government and community. The RDAA commented that 'any arrangements that provide for nurses and midwifes to provide additional services should manage this risk and ensure that the quality of care provided to patients is improved and care is coordinated with the patients' general practitioner'.[33] Mr Steve Sant, RDAA, went on to comment that 'we strongly believe that the general practitioner is the main provider and coordinator of medical care–I am not saying health care; I am saying medical care'.[34]

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29 Department of Health and Ageing, Ms R Huxtable, *Committee Hansard,* 6.8.09, p. 66.

30 'Homebirth risks becoming underground practice', *AAP,* 11.8.09.

31 AMA, *Submission* 29, p. 1.

32 AMA, Dr A Pesce, *Committee Hansard,* 6.8.09, p. 1.

33 RDAA, *Submission* 17, p. 2.

34 RDAA, Mr S Sant, , *Committee Hansard,* 6.8.09, p. 39.

1.42 The RDAA also voiced concern about the provisions in the legislation which allow nurse practitioners and midwives to refer patients to medical specialists without the patients being assessed by the patients' general practitioner.[35] Mr Sant stated:

> The other problem with going directly to the specialist is that you will end up with fragmentation of care. We already have big problems with understanding and managing the totality of care that is provided to patients. If we add another source which can be further fragmented, we are only going to disadvantage our patients and cause them to incur additional costs, and the Commonwealth will likely incur additional costs as well.[36]

1.43 In addition, Mr Sant commented that the midwifery services review suggested that midwives should only be able to practise as part of a collaborative team with either a general practitioner or a specialist obstetrician, 'therefore we would argue there is no need for them to be able to refer'.[37]

1.44 RANZCOG also commented that if RANZCOG Fellows are made to work in collaborative care systems that they consider unsafe, a number of obstetricians will cease to practice obstetrics, 'which could have significant workforce implications for Obstetricians and particularly General Practitioner Obstetricians in the country, who underpin the rural obstetric workforce'.[38]

1.45 The Committee received evidence in response to the matters raised by the AMA and possible fragmentation of care. Mrs Wilkes, Australian Private Midwives Association, commented to the Committee that care is already fragmented:

> Frankly, I fail to see how maternity care in Australia can be any more fragmented than it already is. The women who we care for talk to us about having care from 10, 20 or 30 different people. Even if they engage a private obstetrician, which gives them some security around who will attend them in birth, they are still provided with in-labour care from a midwife they have never met before, and that is if they are lucky and get one midwife. Generally they will get more than one—three or four—and generally that midwife will be caring for more than one person at any given time. The only way that a woman in Australia today can guarantee that she will get the same midwife that she has chosen to provide her with care from the beginning of pregnancy to six weeks postpartum is to employ and pay for the services of a private practice midwife.

1.46 The Australian Nursing Federation commented that the AMA's proposals will not result in better care:

> The ANF is of the view that involvement of doctors in the way that is proposed [by the AMA] will indeed fragment care for the community.

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35 RDAA, *Submission* 17, p. 2.

36 RDAA, Mr S Sant, *Committee Hansard,* 6.8.09, p. 39.

37 RDAA, Mr S Sant, *Committee Hansard,* 6.8.09, p. 40.

38 RANZCOG, *Submission* 23, p. 2.

> Finding a doctor to merely rubber-stamp a professional decision is exactly what we are trying to avoid in granting nurse practitioners and eligible midwives access to the MBS and PBS. Nurse practitioners are educated, qualified and regulated and operate under professional standards. They are well placed to know when a doctor or specialist is required. Furthermore, should a nurse practitioner refer, of course all interested and involved health professionals will be forwarded the appropriate information regarding the referral and the client's progress. It is whoever the consumer sees fit to consult in relation to their health care.[39]

1.47 Dr Barbara Vernon, Australian College of Midwives, also responded and noted that the concern appeared to be that if, for example, a midwife has the opportunity to refer a woman directly to an obstetric specialist, in line with the evidence based guidelines, rather than referring the woman to her general practitioner to make that referral, then the general practitioner will not be in the pathway and will not understand what the woman's care involves. The basis for this argument is that the general practitioner is the key coordinator of care and therefore needs to be aware of the women's complete health details even though she may not have chosen that clinician as her primary carer for the maternity episode. Dr Vernon, however put the view that 'the evidence indicates that midwives make safe and responsible decisions for engaging with GP obstetricians or specialist obstetricians and that if you had a woman in labour and something emerged where she would need medical input it is a nonsense to think that we would build in some kind of additional layer of referral before we could bring the doctor in to provide assistance to that woman'. Dr Vernon concluded:

> I think it is seen by some of the medical organisations as being a thin-end-of-the-wedge argument—that if this arrangement was to apply in maternity it might apply more broadly in health, and that would be of concern.[40]

1.48 Dr Vernon also commented on the importance of the discussions on the design of the implementation of the bills as the bills set out only the framework for the proposed changes. Negotiation will be required to ensure that collaboration is 'built-in in a way that is going to facilitate good, respectful working relationships between midwives and doctors' and are focused on the needs of the individual women. Dr Vernon went on to comment:

> It is not about captains of the team or who is in control; it is about good communication, good exchange of information, mutual respect for professional expertise and working alongside one another for the benefit of the women. This is not about midwives substituting doctors or their providing care instead of doctors providing care. Midwives have a scope of practice and expertise in primary midwifery care. They recognise the scope

39 ANF, Ms J Bryce, *Committee Hansard*, 6.8.09, p. 21.

40 Australian College of Midwives, Dr B Vernon, *Committee Hansard*, 6.8.09, p. 22.

> of practice and expertise of doctors. It is essential that the woman has seamless access to both of those things as and when she needs it.[41]

1.49 In relation to prescribing, Professor Sally Tracy, Australian College of Midwives, noted that midwives will be prescribing possibly 10 drugs and commented:

> …far less than is available in the chemist at the moment, and something that midwives have been doing, and have to get signed off, every day in their practice in the hospitals. It is just a bogyman, this idea that ordering and prescribing drugs is going to get absolutely out of hand.[42]

1.50 The department responded to comments about the model of collaborative care envisaged under the legislation. Ms Judy Daniels stated:

> It is not the intention that these arrangements will be highly prescriptive about the model of care that will operate. It will need to be flexible to deal with different circumstances. That said, obviously—and you have heard today—that a key underpinning of the package is a focus on encouraging models of maternity care that involve continuity of midwifery care. But the collaborative arrangements will need to ensure that effective arrangements are in place for referral and escalation of care in circumstances where medical need dictates, making sure that women have access to the appropriate clinical expertise for the conditions that they have.[43]

1.51 In addition, the National Health and Medical Research Council (NHMRC) in developing protocols and guidance as to how collaborative care could operate.[44]

Maternity Services Advisory Group

1.52 The Maternity Services Advisory Group (MSAG) is to be established with representation from 22 key stakeholder organisations with an interest in maternity care. The first meeting of the group took place on 12 August 2009.[45]

1.53 Witnesses commented that MSAG lacked a balance in its membership. Homebirth Australia commented for example, that there no representation of homebirth views.[46] The Australian Private Midwives Association also commented that it was not represented on MSAG.[47]

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41 Australian College of Midwives, Dr B Vernon, *Committee Hansard,* 6.8.09, p. 22

42 Australian College of Midwives, Prof S Tracy, *Committee Hansard,* 6.8.09, p. 24.

43 Department of Health and Ageing, Ms J Daniels, *Committee Hansard,* 6.8.09, p. 62.

44 Department of Health and Ageing, Ms R Huxtable, *Committee Hansard,* 6.8.09, p. 59; see also Department of Health and Ageing, *Submission* 28, Additional Information, p. 1.

45 Department of Health and Ageing, *Submission* 28, Additional Information p. 2.

46 Homebirth Australia, Ms J Cairnes, *Committee Hansard,* 6.8.09, p. 13.

47 Australian Private Midwives Association, Mrs E Wilkes, *Committee Hansard,* 6.8.09, p. 51.

1.54 In relation to membership and the lack of representation of private midwives, Ms Huxtable from the department commented that:

> I believe that group was quite recently formed…It was a question of balancing membership. There are two representatives of both the Australian College of Midwives and the Maternity Coalition on the advisory group. I would also say that the advisory group is one mechanism, and we do not see it as the only mechanism by which consultation will occur. In fact, I think that side by side with the advisory group will be technically focused working groups where we will certainly be seeking to engage with others in respect of the specific elements that are on the table.[48]

1.55 Ms Huxtable went on to note that it was anticipating that there would be working group and technical group structures 'that will advance specific elements of the package'.[49]

1.56 Ms Huxtable outlined the work of MSAG. The work undertaken was seen as being in two phases: a scoping phase and then an actual development of guidelines. In the latter, three items were identified:

- the principles for collaborative maternal care including team learning and review and how to ensure that maternity care is focused on the woman in informing decision making and respecting choice;
- protocols and referral procedures including how effective information sharing and communication referral and consultation arrangements that would underpin transfer of care are put in place, for example, emergency transfers or emergency procedures; and how to undertake professional education to support the collaborative care model; and
- monitoring, evaluation and review of the practical operation of the arrangements.[50]

Eligible midwife

1.57 In evidence, there was discussion around the use of the word 'eligible' in the legislation with 'eligible midwives' having access to both MBS and indemnity insurance. The Australian Private Midwives Association commented that private practice midwives have not had input into the definition of 'eligibility' and that those midwives who fall outside the definition will be prevented from private practice as they will be unable to secure the professional indemnity insurance required to register.

48 Department of Health and Ageing, Ms R Huxtable, *Committee Hansard,* 6.8.09, p. 60.

49 Department of Health and Ageing, Ms R Huxtable, *Committee Hansard,* 6.8.09, p. 61; see also Department of Health and Ageing, *Submission* 28, Additional Information, p. 2.

50 Department of Health and Ageing, Ms R Huxtable, *Committee Hansard,* 6.8.09, pp 61–62.

The Association therefore saw it as essential that private practice midwives have equal opportunity to have input into defining eligibility for their practice.[51]

1.58 Ms Huxtable, the Department of Health and Ageing, commented that in relation to nurse practitioners there is the concept of an advanced practitioner, however in the case of midwives there is the question of 'What is an eligible midwife?' It was noted that work had commenced on the definitions leading up to the budget announcements but 'we are really at the commencement of the implementation and consultation mechanisms around nailing those ideas, and that, as occurs commonly, will occur in very close consultation with the profession'. MSAG is one of a number of mechanisms that will engage with stakeholders around working on the definitional issues.[52]

1.59 Ms Huxtable went on to note:

> On the question of eligible midwives, I think that there has been a degree of consensus in our discussions to date with many of the stakeholders that there are a number of factors that would come to bear in determining what an eligible midwife is. That goes both to the level of qualification and also to the level of experience of a midwife and there may also need to be consideration about how to transition people who have a great deal of experience in the field but who may not have the requisite higher qualifications, and whether there is a way to transition them into the new arrangements.[53]

Rural and remote area nurses

1.60 The RDAA commented on the exclusion of rural and remote area nurses from the proposed arrangements. The RDAA noted that rural and remote areas nurses are highly qualified and may have completed courses of study other than those designed for nurse practitioners. While most remote area nurses do not hold specific qualifications as a nurse practitioner, they practice in isolated communities often with remote medical backup. The RDAA argued that they would be 'ideal candidates to undertaken prescribing of medications and ordering of diagnostic tests under the PBS and MBS'. By extending the ability to prescribe and order a limited range of medications and tests, in accordance with an agreed protocol, patients, who are often indigenous, would benefit. The RDAA also commented that other groups of nurses who are endorsed by their registration authorities and who have undertaken a course such as the Queensland Accredited Rural and Isolated Practice Endorsement for Registered Nurses Program, which enables them to prescribe in accordance with standing orders or local protocol, should also have access to the PBS and MBS

51 APMA, *Submission* 10, p. 5.

52 Department of Health and Ageing, Ms R Huxtable, *Committee Hansard,* 6.8.09, p. 59.

53 Department of Health and Ageing, Ms R Huxtable, *Committee Hansard,* 6.8.09, p. 63.

arrangements. The RDAA concluded that 'unless these nurses are included in the new arrangements little benefit will flow to rural and remote communities'.[54]

1.61 Ms Kerry Flanagan from the department responded:

> No, I do not think remote area nurses are currently part of this legislation. As I understand it, they have prescribing rights at the moment under standing orders. But I do not think there was contemplation that we would be looking at them...We are just looking at nurse practitioners and midwives under this legislation.[55]

Prescribing group

1.62 In its evidence to the Committee, the AMA recommended that the Government establish a new expert committee, the Health Profession Prescribing Committee, to evaluate and advise on proposals to allow other health professionals to prescribe pharmaceuticals.[56]

1.63 The department responded to the AMA's recommendation and stated that:

> The natural development of advice to the PBAC [Pharmaceutical Benefits Advisory Committee] will include the establishment of a group. If you recall, with the optometrist measure there was definitely a process of going through quite a deal of detailed discussion and investigation with stakeholders about drawing up the lists of medicines that the PBAC would then consider. It will be a similar process in this case.[57]

Indemnity for midwives

1.64 Indemnity cover for midwives was canvassed by a number of witnesses. The Medical Indemnity Industry Association of Australia (MIIAA) raised a number of matters in relation to the Midwife Professional Indemnity Bill. These included the inclusion of a number of matters in Rules which are not yet available. The MIIAA argued that some of the proposed Rules should be included into the Bill as potential contracted insurers need to be able to understand the framework that they will have to operate in and the risk to the contracted insurer of Rule changes with the attendant risk of not recovering Commonwealth contributions will be avoided.[58]

1.65 A number of matters were also raised in evidence by the MIIAA's representatives including whether an eligible midwife 'who is deemed a high-risk eligible midwife based on an abnormally high numbers of claims may have imposed

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54 RDAA, *Submission* 17, pp 3–4.

55 Department of Health and Ageing, Ms K Flanagan, 6.8.09, p. 64.

56 AMA, Dr A Pesce, *Committee Hansard*, 6.8.09, p. 1.

57 Department of Health and Ageing, Ms R Huxtable, 6.8.09, p. 64.

58 MIIAA, *Submission* 4, p.3.

upon him or her a deductible or loading on their cover'. Mr David Nathan, MIIAA, noted that such a right would encourage midwives to improve their performance and stated that is the current position with medical practitioners.[59] Mr Nathan also noted that the scheme will insure an eligible midwife, practicing in a manner that an eligible midwife is entitled to practice, but is silent as to precisely what enables a midwife to be an eligible midwife or what it is that an eligible midwife will do.[60]

1.66 In relation to insurance cover for homebirths, Mr Nathan stated:

> …there is not a great deal of compelling data that one can point to as to the relative risks of homebirths versus birthing centres and versus this and that. The devil is often in the detail anyway as to whatever data is available. The sense is that there is more risk associated with homebirthing than there is in terms of the independent midwife model that is being mooted as we speak.[61]

1.67 RANZCOG voiced concern that 'if midwives are indemnified, this could lead to increased costs of indemnity for obstetricians as obstetricians may be called in too late to manage an obstetric emergency and have to face the blame for a poor outcome, when an earlier referral may have averted a crisis'.[62]

1.68 The exclusion of indemnity for private midwives undertaking homebirths was also canvassed. Ms Caines of Homebirth Australia commented that indemnity insurance is a professional requirement but also a consumer right.[63] The Maternity Coalition commented that women and midwives involved in homebirth have been unprotected by professional indemnity insurance since 2001. Midwives working as employees (usually in hospitals) have been unaffected by this, as they work under the cover of their employer. The reason for the withdrawal of insurance cover was given as the small number of midwives purchasing cover. Maternity Coalition went on to state that it is 'unaware of an evidence-based discussion on the cost of insurance cover for homebirth midwifery...It is unclear whether advice provided to Government is rationally informed by a good understanding of midwifery practice and the risks around homebirth.'[64]

1.69 Dr Vernon, Australian College of Midwives, indicated to the Committee that insurers had not provided indemnity for midwives as 'the pool of midwives who would seek a policy has been relatively small and they have therefore seen that that pool has not been large enough for them to make it commercially viable to potentially

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59 MIIAA, Mr D Nathan, *Committee Hansard*, 6.8.09, p. 45.

60 MIIAA, Mr D Nathan, *Committee Hansard*, 6.8.09, p. 46.

61 MIIAA, Mr D Nathan, *Committee Hansard*, 6.8.09, p. 47.

62 RANZCOG, *Submission* 23, p. 2.

63 Homebirth Australia, Ms J Caines, *Committee Hansard*, 6.8.09, p. 11; see also Griffith University, *Submission* 42, p. 3.

64 Maternity Coalition, *Submission* 13, p. 3.

cover off on a $12 million payout, which was the Calandre Simpson case'. Dr Vernon went on to comment:

> We have been hopeful that the government's commitment to extending Medicare benefit schedule access to private midwives would, over time, create a larger pool of midwives seeking a policy and that that commercial barrier would be removed. That possibility was ruled out when the legislation indicated that it would not be an option for midwives to provide care at home. Our preference is to see that the location of care is not the primary driver. We do not have insurance policies for doctors that stipulate the setting in which they must provide their care; the insurance cover is related to their qualifications, their scope of practice and verification of that by their professional organisations.[65]

1.70 Dr Vernon also stated that insurers have indicated that they do not have profound concerns about the safety of midwifery care. Rather:

> What they are telling us is that they are unsure from the documentation the government has currently provided as to what it is that they are being asked to tender for. They are talking particularly about the lack of information at the moment about eligibility—which midwives would provide this care—and there is no information about the collaboration and how that will occur between midwives and doctors and between midwives and hospitals. So they see it very much as the cart before the horse and they are puzzled why it is that the process at the moment is trying to drive the preparation of a request for tender from insurers ahead of those things being worked out.[66]

1.71 The Australian College of Midwives suggested that further consultation with private practice midwives and the College needs to occur to identify the care provided by private practice midwives in the home and to determine the types of risk involved. The College went on to argue that there are significant differences between midwifery and obstetric care with obstetric care involving major surgery, induction of labour and use of epidural anaesthesia. These procedures involve substantial risk but midwives providing care in the home do not perform any of these interventions. The College concluded that 'the actual risk of unpredictable, catastrophic events in the absence of other interventions would need to be examined in the context of healthy women with (generally) uncomplicated pregnancies, in well networked and collaborative systems of care'.[67]

1.72 The Australian Private Midwives Association also called for further consultation on indemnity and stated that the risk profiles should be properly examined. Ms Wilkes commented:

> None of these has really been well explored. Well, if it has all been well explored it has not been well explored in consultation with those that are

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65 Australian College of Midwives, Dr B Vernon, *Committee Hansard*, 6.8.09, pp 24-25.

66 Australian College of Midwives, Dr B Vernon, *Committee Hansard*, 6.8.09, p. 25.

67 Australian College of Midwives, *Submission* 18, p. 4.

> working in private practice. It may have been explored by somebody somewhere along the line but we do not know about it, but if only we could actually actively engage on that and see what that looks like and see what the sorts of insurance products look like and at least do cost comparisons and see whether it is a cost thing and whether it is a safety thing and what the mechanisms are.[68]

1.73 The department's representatives explained the process for the insurance tender to the Committee. The department will conduct a tender process which will select an insurer who is the insurer who offers the policies which are supported by the Commonwealth. A significant range of technical detail will appear in the tender documents and in the contract with the selected insurer. The department noted that many of the technical issues raised by the MIIAA will be answered in the course of the tender process. The policy offered to midwives will cover the scope of their practice.

1.74 Professor Rosemary Calder concluded:

> …the intention is that, as we work towards identifying the insurer that is appropriate for this, we will also be working on the issues around eligibility, noting that it is initially defined by registration and scope of practice. That is an assurance to the insurance industry of where this will go and that, as it reaches the point where insurance products need to be developed, the eligibility criteria will have firmed up.[69]

CONCLUSION

1.75 The Committee welcomes the initiatives contained in the three bills. The recognition of the professional skills and expertise of nurse practitioners and midwives is a significant step. In particular, the changes to allow these two groups of professionals to access the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme will strengthen the health system and the delivery of maternity services in Australia.

1.76 The Committee notes that these three Bills do not take away any current rights and none of these Bills make homebirth unlawful.

1.77 The Committee notes that there is a separate exposure draft Bill for the National Registration and Accreditation Scheme for Health Professionals which has been prepared for all jurisdictions via a COAG agreement. It is the outcome of this legislation that may result in homebirths being outside the scope of practice of registered midwives due to the requirement for indemnity insurance as a condition of registration. The Committee acknowledges the concerns expressed by stakeholders that an unintended consequence of this may be to drive homebirths underground unless an exemption is granted or an insurance product found.

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68 Australian Private Midwives Association, Mrs E Wilkes, *Committee Hansard*, 6.8.09, p. 56.

69 Department of Health and Ageing, Prof R Calder, *Committee Hansard*, 6.8.09, pp 69–70.

1.78 The Committee acknowledges that the minister is currently working with the States and Territories on potential options to prevent this from happening. This will include investigating indemnity options for homebirths that could be progressed without making the insurance unaffordable.

Recommendation 1

1.79 The Committee recommends that the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009, the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 and the Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009 be passed.

Senator Claire Moore
Chair

August 2009