20 July 2009

Ms Claire Moore
Chair, Senate Community Affairs Legislation Committee

By E-mail: community.affairs.sen@aph.gov.au

Dear Senator Moore

Re: Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009, Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 and Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009

Thankyou for the opportunity to comment on this legislation.

I wish to focus my comments on the impact of these bills, and related legislative reforms, on private midwifery practice and the women who employ midwives privately.

I request that the Committee seek assurances from the government in putting these Bills up for enactment that

- **midwives who are currently self employed will be eligible for Professional Indemnity Insurance and other transitional arrangements, such as a 'Grandmother' clause, to ensure safe maternity care options for women in their care.**
- **responsible financial modeling is carried out, in consultation with midwives who are currently self employed, to ensure that private midwifery practice will be possible and sustainable after 1 July 2010.**

The questions and comments that I am putting to the Committee are very important to me. I am a self employed midwife, and have worked independently, referring to and collaborating with other service providers in my community, for the past 15 years. I provide a range of primary maternity services across the childbearing continuum, including prenatal counselling and preparation, attendance at birth, either in the home or hospital, postnatal services, and expert lactation consultant work, as well as teaching and tutoring in the midwifery faculty at Deakin University, and student and midwife support and mentoring.

I rely on my midwifery practice for income and financial security for myself and my family. I understand that these bills will enable Medicare funding, access to the Pharmaceutical Benefits Scheme and professional indemnity premium support for eligible midwives providing care for women to give birth in hospital. If these Acts pass in their current form I will be prevented from doing most if not all of my chosen professional work. It is unlikely that I will be able to transition into new hospital-based midwifery options that have been announced but are not yet in operation. I, and other self-employed midwives, will be disenfranchised in less than a year from now.

It appears that these Bills will open up a new scope of practice for some midwives working in hospitals. This will potentially improve access to basic maternity services for some women, if the payments available, through Medicare, are adequate. While acknowledging the potential for long hoped-for improvements to publicly available maternity services in the long term, I fear that the reforms could further restrict those midwives who are currently practicing privately. These midwives are providing an essential health service, and promoting health in their communities.

I note with concern Clause 21A(3)(c) of the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009, that the midwife is required to charge only the fee stated in the item. I have not found further detail of amounts linked to items. I have concerns that, at least initially as the reforms are being implemented, midwives may find it impossible to attract enough 'business', and carry out enough consultations for which Medicare 'items' apply, to make a living. Is there a particular legal reason why midwives charging under Medicare should be treated differently from doctors charging for the same primary maternity care items with Medicare rebates? Please note that midwives providing primary care usually do so with caseloads, which means that the midwife is committed to attending a specified group of women. The caseload of a midwife is small compared with that of a doctor, as the midwife's work with the woman is more time consuming and woman-

focused, while the doctor does not have the expectation of staying in constant attendance with labouring women, as the hospital provides midwives to do that work.

I understand that under the Health Practitioner Regulation National Law 2009, I and other midwives who are currently self employed will be considered non-practising, and any professional practice we engage in will be unlawful. This is as a result of the Government's decision that no indemnity will be available for midwives who practise privately attending births in the home. I believe this to be an unintended and uninformed consequence and ask that you take steps to include homebirth with a privately employed midwife within the Health Legislation Amendment (Midwives and Nurse Practitioners) and related Bills.

I support a system where competing professions are treated equally, with the same access to funding and the same access to indemnity insurance. In the case of maternity care, midwives do not have access to the same funding or indemnity insurance as doctors who provide basic maternity services for women who are within the scope of practice of the midwife, and whose primary care could well be provided by a midwife.

I understand that in order for State and Federal legislation to be constitutionally valid, all laws passed must be done so as to not discriminate between parts of the state and particular persons of the state. By denying indemnity insurance for homebirth to private midwives, and restricting homebirth practice (a key practice area of privately practising midwives) to certain hospitals, the law discriminates on my right as a midwife to choose my place of employment.

Please note the following points. I would be happy to provide more argument and evidence if requested.

1. This group of Bills is unfairly discriminatory against private midwives
The mandating of professional indemnity insurance (PII) as a requirement for registration is reasonable only if PII is available to all who are required to obtain it. The actual impact of Bill B, as it now stands, will be unfair discrimination against a small minority of midwives, and the women who employ us. The group of Bills in this legislative reform make no provision for the ongoing practice of self employed midwives, or the group of women who have employed us, primarily for homebirth, for generations.

2. The legislation is NOT in the public interest
The exclusion of homebirth from government support is not on any evidence or safety grounds. The report of the Maternity Services Review claimed that supporting homebirth would result in 'polarising the professions', and suggested that the small number of midwives and women were insignificant. This is an unreasonable position to take. With rare exceptions, midwives are the only professional attendants at planned homebirth.

See Attachment 1, which is a summary of homebirth numbers and selected outcomes, over the past five years of reports made by the Victorian government's Perinatal Data Collection Unit. These data demonstrate from an epidemiological perspective, that the great majority of homebirths in this set are uncomplicated and uneventful, as would be expected. Although numbers are small when compared with the total number of births, the births attended by midwives practising privately in communities are not insignificant.

In preventing midwives from attending women privately it is predictable that there would be an increase in the number of women who give birth unattended (sometimes known as 'free-birth'), and an increase in attendance at birth by unregulated individuals who have no professional standards. This, I believe, would greatly increase the risk of harm to mothers and babies.

3. The legislation denies a woman's natural law right to give birth under natural physiological conditions, in the place of her choosing.

The only requirement for physiological birth is that the woman is able to proceed without medical or surgical assistance. Since pregnancy and birth are truly natural states, and are not, *per se*, reliant on outside management, it is reasonable to protect the woman's natural law right to maintain personal control over such decisions, including if and when she goes to hospital. The midwife is the only health professional with a duty of care to 'promote normal birth', a duty that is clearly stated in the international Definition of the Midwife (2005) (a core document of the International

Confederation of Midwives,
http://www.internationalmidwives.org/Documentation/Coredocuments/tabid/322/Default.aspx).

I understand that having a baby at home instead of a hospital is a natural law right which is given by God rather than by the government, and covered under the freedom of religious belief provisions of the Australian constitution. Many religious codes have ancient guidance that can be applied to the birth of a baby. The Christian Scriptures teach that children are a blessing from God, to be valued and protected, and give many examples of people who protected and supported the mother and child, even in defiance of government (eg Exodus 1:17). Section 116 of the constitution says that the parliament shall make no laws to restrict your religious belief, practice, and observance. By denying midwives the same insurance as the government provides for other maternity health professionals, and denying midwives the right to practise privately in any geographic location, the government would deny a right under section 116.

4. The legislation goes against Competition Policy and the Trade Practices Act as it is applied to provision of health services.

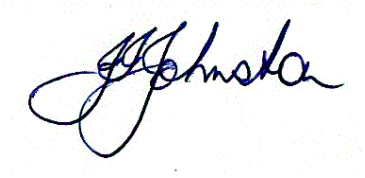
A paper 'The Trade Practices Act and the Health Sector' was presented by Professor Allan Fels, the then chair of the ACCC, in 1998. Prof Fels stated that the role of the ACCC includes "looking at health professionals' conduct to determine whether it promotes or hinders patients' interests in being able to choose among a variety of services and price options according to their needs", and "competition policy is based on the premise that consumer choice, rather than the collective judgment of the sellers, should determine the range and prices of goods and services that are available. Or in other words that the competitive suppliers should not pre-empt the working of the market by deciding themselves what their customers need, rather than allowing the market to respond to what consumers demand."

These principles have not been applied to Government funding for basic maternity care, which is the practice domain for which midwives are registered. Consumers who choose to employ a midwife as their primary carer do so, in most cases at present, without any government support. The medical profession's monopoly of maternity funding and maternity care provision is not in the public interest. There is no evidence that excluding midwives from practice improves outcomes for mothers and babies. The fact that private midwives have continued to hold our place in the maternity market which presents huge professional and financial and social obstacles to our existence, even without professional indemnity insurance since 2001-02, demonstrates the importance of private midwifery practice.

The current restrictions of the scope of practice of Australian midwives, and the further restriction that will be introduced if this legislation is enacted as it is, are regressive and anti-competitive when compared with contemporary standards in developed nations. The Australian consumer has a right, under Competition Policy, to be free to choose the primary maternity care provider, either a midwife or a doctor, with consideration of the ability to each one to provide the service required by the individual woman and her child.

I therefore sincerely recommend that the Senate Community Affairs Legislation Committee do all in its power to ensure that midwives must be able to access indemnity insurance, in the public interest, enabling all midwives to engage in the full scope of midwifery practice, including homebirth.

Yours Sincerely



Joyce Isabella Johnston
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Attachment 1: summary of homebirth numbers and selected outcomes, Victoria 2003-2007

Homebirths Victoria 2003-2007

1	2	3	4	5	6	7	8	9
YEAR	#	#g1p1	3-4TEAR	AP<7@5	SCN-NICU	%SCN-NICU	CF% 100-399	
2003	153	58	1	1	4	2.6	7.1	
2004	181	58	1	2	3	1.7	8.4	
2005	186	51	2	2	1	0.5	0	NOT GIVEN
2006	200	54	2	5	8	4	6.5	
2007	253	60	0	4	7	2.8	6	
TOTALS	**973**	**281**	**6**	**14**	**23**	**2.32**	**7**	

Source: Annual Hospital Profile (Homebirth) Reports from the Victorian Perinatal Data Collection Unit.

Notes:

Column 2: The number of homebirths recorded for that year

Column 3: The number of primiparous mothers (G1P1)

Column 4: The number of serious perineal tears (3rd or 4th degree). The repair of such tears would usually be performed by obstetric specialists in hospital.

Column 5: The number of babies with Apgar score below 7 (0-6) at 5 minutes.

Column 6: The number of babies admitted to Special Care Nursery (SCN) or Neonatal Intensive Care Nursery (NICU) – ie babies requiring transport to hospital and specialist medical attention.

Column 7: The percentage of babies born at home admitted to SCN or NICU. The final value, 2.3%, in Column 7 is the average of the five.

Column 8: The percentage of babies in a comparison group, born at hospitals with 100-399 births annually, admitted to SCN or NICU. This would usually indicate transfer to a larger hospital. The final value, 7%, in Column 8, is the average of the four values available.