Submission to Senate Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills

Name: Teresa Walsh **Date: July 20 2009.**

Dear Sir or Madam,

I am a mother of three and a passionate career midwife with 24 years experience in clinical and research roles in the United Kingdom and Australia. The recent government announcements regarding maternity reform (Federal Budget May 12 [1], and Health Legislation Amendment Bills introduced June 24[2]) are acknowledgement that Australia should provide more maternity care choices for women and their families. Health Minister Nicola Roxon has considered much of the evidence of the maternity services review in 2008[3] and acted positively to extend the current shallow range of care options dominated by medical over-servicing, to include the professional services of midwives. Supporting the choice of safe homebirth services has been excluded from the government's reform plans however, which is worrying and disappointing. The published submissions to the review [3] included many passionate pleas for the government to make it possible for women to safely birth in the privacy and comfort of their own homes.

UK NHS maternity services

I was educated and registered initially as a midwife in Queensland before spending several years working in the UK where I was privileged to be employed in a community group practice of midwives. The care provided by community midwife groups is an integral part of the NHS public health services, and accessible to the majority of women in the UK. The team of midwives provided continuity of care throughout pregnancy, labour and birth, and 4 weeks after birth, to women who chose this style of care instead of standard medical services offered within hospitals, similar to many in Australia. When women chose the community midwifery scheme, they continued to have access to obstetricians and other health professionals if necessary for advice. Midwives communicated and collaborated with their colleagues to provide a safe service for women and babies with the emphasis placed on women's needs being met by the most appropriate professionals and services.

This extended to the place of birth. Only 5 - 10% of women in our community midwifery scheme desired homebirth, the remainder birthed in hospital with their known midwife in attendance. Women choosing homebirths did so after consultations with their midwives and occasionally the obstetrician in order to make the required arrangements for a safe and satisfying experience for the whole family. Within this framework, women understood that their wishes were respected, but also understood that their

midwives and doctors would explain the reasons for recommending one particular setting for birth over another. This included consideration of all factors medical, psychological, social, environmental, etc. If homebirth was planned, women and carers were fully informed and prepared, and the services necessary in case of emergency transfer were accessible. In my experience, the respect shown to women enabled them to reciprocally trust the advice given by health professionals to themselves and their families regarding place of birth, and safety was rarely compromised in their final choice.

This combination of hospital and community services clearly satisfied the majority of women in the UK. A small number of women still preferred to choose and pay for the services of a private midwife for their homebirth, and they knew this option existed if their particular requirements went beyond what the publically funded services were able to offer.

Australian maternity services

Similar services could be made widely available to Australian women. With the exception of rural and remote communities where vast distances to emergency services present particular challenges, the predominantly city-dwelling citizens of Australia enjoy similar culture, lifestyle, good health, education, established road networks, and comprehensive emergency services, comparable to British citizens. Yet Australian maternity services are almost exclusively medically orientated and concentrated in large population centres. Services are dependent on the constant availability of high tech equipment and highly specialised consultant obstetricians and anaesthetists for all women irrespective of their risk of complications. Women must fit into this model, particularly difficult for women in rural and remote Australia.

Both the UK and Australia have good safety records in terms of maternal and neonatal perinatal mortality statistics. There is evidence that the over-use of technology to manage uncomplicated pregnancy and birth can inadvertantly cause physical and psychological harm and erode that record of safety [4]. For example, the current rate of caesarean section, a major surgical procedure carrying post-operative risks and long term implications for women, is 31% and rising. The World Health Organisation recommends that a rate of between 10 and 15% represents a safe level for births by caesarean[5].

In reality most Australian women can expect to experience pregnancy as a healthy life event which requires intermittent professional surveillance by midwives to watch for signs of complications, and guide progress and preparation for labour, birth and mothering. The proposed changes will make it possible for women to access professional midwives with Medicare funding, working in collaboration with other professionals in their communities. Many Australian women have previously seen midwives as attendants within the medicalized hospital model only and have limited knowledge of the full scope of practice of midwives. Midwives are qualified to provide support and care to women throughout normal pregnancy, birth and after birth; and to detect complications and refer to other health professionals if necessary.

Australian homebirth

Less than 0.5% babies born in Australian are born at home [6]. Publically funded homebirth is available to a small number of women in Western Australia, South Australia, New South Wales and Northern Territory. Private homebirth midwives are few in number in all States, and are in high demand. Women have to pay for their services and are not eligible for Medicare refund, and often not able to claim these services from private health funds. Anecdotally many more women state that they would choose midwifery care and homebirth *if* it was available and *if* they could afford it. I know of many midwives currently practising in hospital services who would like to offer this service, which women clearly want, but only a tiny number of midwives actually choose to work in this way. There are several reasons for this an inability to access indemnity insurance since 2001, inability to order normal tests and medications for pregnancy, professional isolation, providing 24 hour 7 day a week on call for all clients with no back-up, the high cost and time of maintaining a business, and concerns about accessing safe referral to hospital for their clients should the need arise.

Recent research in the Netherlands where 30% births are at home concludes that planned homebirth which is provided by a regulated and well qualified midwifery workforce integrated in a comprehensive health system is as safe as hospital birth for women and babies with low risk of complications [7]. The use of interventions is greatly reduced, as is the need for pain-relieving drugs. Women consistently report high levels of satisfaction with the experience. It is also cost effective as women are not using hospital beds and other resources. Contrary to popular opinion, women in Australia and elsewhere often choose homebirth after thorough research has convinced them that home is the safest place for birth, for themselves and for their babies. Midwives carry emergency equipment and plan for all eventualities to ensure the safety of the mother and the baby.

The lack of government support for homebirth services is worrying, because a small number of women will continue to choose to have their babies at home, but will no longer be able to access professional midwifery support to guide and advise them after July 1 2010. Unfortunately the incidence of poor outcomes at unattended births is likely to increase. It is not acceptable to knowingly place mothers and babies at risk by withdrawing the availability of qualified assistance. The other unfortunate truth is that the midwives now in private practice will either leave the profession or leave the country to practice elsewhere, for example in New Zealand where the government supports midwives and acknowledges that they are the professional group chosen as lead maternity carers by the majority of women there. It is difficult to understand why the Australian government supports a system which has excessive unnecessary expenditure on practices and interventions which are unsupported by research, and yet discriminates against homebirth which is a safe, cost-effective and satisfying maternity care option.

A Way Forward

Maternity care choices in many countries with good perinatal outcomes include systems of care that support midwives who are specialized in the care of women experiencing uncomplicated pregnancy and birth. Countries such as Germany, the Netherlands, UK and New Zealand promote the choice of homebirth for well women, and have different health care systems to Australia, but their experience provides evidence that other arrangements are possible. Even in remote areas of Australia, the pregnancy and birth experiences of Aboriginal and Torres Strait Islander women could be modeled on

the successful community midwifery services established among remote Inuit Canadian communities in recent years[8]. The social and health problems in these communities were remarkably similar to those experienced by indigenous Australians, and have significantly improved since safe pregnancy and birth care provided by local well educated midwives was returned to these communities and supported under national health arrangements. I believe that collaborating with Aboriginal communities and adequately funding similar systems to provide accessible culturally appropriate maternity services to Australians in remote areas should be a national "closing the gap" strategy.

In Australia women who seek homebirth should be supported and should be able to access a skilled midwifery attendant both within the system of public health care, and as a private arrangement. Because of the invisibility of community midwifery in Australia in recent years, many women are completely unaware that the choice of homebirth is even possible, and even less aware of the potential safety and benefits to low risk women demonstrated in research for planned and supported homebirths. The numbers of homebirths are small at present, but may rise if the option was supported and more widely available because of an increased number of funded homebirth services and midwives in private practice.

Midwives in private practice should be able to access Medicare funding and indemnity under Federal government reforms. Midwives would practice according to the Australian College of Midwives guidelines [9] , which clearly state when consultation and referral are required. Midwives providing care for homebirth would fulfil the requirements for eligibility set down by the profession. This is expected to be a credentialing process such as the current ACM Midwifery Practice Review process, demonstration of continuing professional development , and current national registration (including indemnity when available) with adherence to an established code of practice. Midwives providing homebirth care would be working in a model where they have visiting rights to a local hospital and can freely consult and refer with other practitioners as required. A further safety requirement likely to be a component of such a model is that two midwives attend all out-of-hospital births. The continuing debate over the contentious issue of indemnity insurance for homebirth practitioners indicates that the Australian government needs to consider the merits of legislation to make provision for a "no blame" compensation scheme administered by the government specifically associated with maternity services. This would be another way to ensure that in the few cases when it is necessary, women and babies have access to a defined fund of compensation without the need for expensive and distressing litigation for families and their maternity carers.

Conclusion

I applaud the government's intention to improve maternity service provision for Australian women. It is important to provide alternative choices to the current dominant medical model. Over-medicalization of all pregnancies and births regardless of risk status leads to excessive unnecessary public health expenditure, rising levels of interventions, birth trauma and post-natal depression, and sometimes jeopardizes the relationship between mother and baby. This in turn contributes to a society which is developing a growing skepticism and lack of confidence in all women's ability to birth unaided.

Importantly, women vividly recall the feelings and events they experienced around the time of birth, and this can have profound effects on self-esteem, breastfeeding and family relationships. This is clearly an important and very sensitive time in women's lives and may impact on the well-being of the family later, which is further cause for society to endeavor to provide care which is physically *and* psychologically safe, and appropriate for all birthing women.

However as the current proposals have been presented, the combination of Health Practitioner National Regulation legislation[9] and the currently proposed Federal maternity reform package will leave women without the option of having a registered midwife provide them with homebirth care. Private practice midwives predominantly provide homebirth care in Australia. Women and families need to be able to access safe and satisfying maternity and birth care in all settings. Restricting this option will limit the ability for women to access safe care in the home. This is not acceptable in a democratic society which places great value on public safety in health care.

Passing the proposed legislation without concomitant provision of professional indemnity insurance for midwives attending out-of-hospital births will, without question, increase the risk of poor health outcomes for mothers and babies in Australia. Prohibiting midwife-attended homebirth is not supported by scientific evidence, will increase poor outcomes and undermines women's autonomy in birth. It is essential to the health and wellbeing of mothers, babies and the broader Australian community that our legislation supports a system of maternity care that is evidence-based and provides optimal safe choices for all. For the reasons stated, I ask that you strongly recommend that the proposed Health Legislation Amendment Bill 2009 and 2 related Bills be amended such that midwives caring for women who choose out of hospital birth in Australia are strongly supported and at the very least are not excluded from subsidized professional indemnity insurance.

Yours sincerely,

Teresa Walsh.

References

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