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Dear Mr Humphrey

Thank you for the opportunity to make a submission regarding the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills.

At the outset we would like to commend and to thank Minister Roxon and the Rudd Government for their visionary support for nurses and midwives in Australia. In establishing the Office of the Chief Nurse and Midwifery Officer they recognised for the first time at a national level the contribution that nurses and midwives make to the Australian health system. Then through that Office the government has worked tirelessly to launch far reaching and momentous reforms.

The Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 (to amend the Health Insurance Act 1973 and the National Health Act 1953) will remove barriers to the current provision of midwifery care and will lead to improved access to services for the community wherever there are operational hospitals or maternity units. The new arrangements will permit midwives to request certain diagnostic imaging and pathology services for which Medicare benefits may be paid, as well as make appropriate referrals. In addition to this Bill, the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 and Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009 commencing on 1 July 2010 will allow *eligible* midwives

working in collaborative arrangements with obstetricians or GP obstetricians to access the new government supported professional indemnity scheme.

The reforms are a critical step towards delivering the government's election commitment to develop a national plan for maternity services across Australia. The birth options being sanctioned by the new legislation will support registered midwives to practice to their full capacity in a way that has not been possible in this country before. The maternity reforms are on the whole a sensible and practical response to helping address the workforce shortages that this government inherited.

We would like to bring to the Senate's attention the most notable omission in the new legislation - the lack of recognition of Australian women to have the ultimate responsibility of deciding where to give birth. Medicare benefits and PBS prescribing will not be approved for deliveries outside clinical settings, and the Commonwealth supported professional indemnity cover will not respond to claims relating to homebirths. Our fear is that women who can not access home midwifery care with a registered midwife through any of the proposed hospital based services may be forced into giving birth at home, unattended as the only option they would consider.

As the Minister has pointed out, the plan to provide greater access to maternity care closer to home and reduce family disruption will only be realized where care can be offered in a hospital or birth centre environment. However, many rural maternity hospitals and most birth centres have been systematically closed across Australia in the past decade. In addition to this, the offer of homebirth through a state run area hospital/homebirth service denies those women who live in remote and rural areas the opportunity to give birth closer to home.

There is no doubt a need for change and a need for continuity of care over the spectrum of antenatal, birthing and postnatal services. These changes however, should not occur in either a policy or evidence vacuum.

For example it could be argued that we do not have the evidence that Australian women are safest giving birth in the large hospitals as they currently operate in metropolitan and large rural centres at the moment. There is a level of over intervention in otherwise normal healthy pregnancies that needs to be further addressed. Across the spectrum of industrialized nations Australia does not rank at the forefront with best measures of perinatal, neonatal, and maternal mortality, low birth weight, and caesarean rates. Nonetheless, per capita health expenditure for Australia far exceeds those of many industrialised nations. These outcomes, together with costly, procedure-intensive care, have been called the "perinatal paradox: doing more and accomplishing less."[1]
Many obstetric practices including the universal advice to give birth in hospital were adopted without the availability of best evidence. Following their introduction the implementation of best evidence has proven to be extremely difficult following adequate evaluation. Moving all childbirth out of home and into the current hospital settings is something that has never been well researched in this country. The high 'born before arrival' rates alone suggest that families are not receiving adequate care within their own communities, and having to travel large distances to seek help. The present system also provides strong incentives for inappropriate care of healthy childbearing women. The call for collaborative, multidisciplinary maternity care should not be viewed as midwives working in teams offering women the opportunity to only give birth in hospital. What is lost in translation is the recognition that women themselves are being denied the opportunity to plan to give birth where they feel safest with a registered caregiver.
If the government is truly committed to expanding and improving primary health care services, especially in rural and regional areas alongside access to health services, in the community, it must not block the opportunity for women to choose to give birth at home in the care of a registered practitioner.

Although the government has claimed to have listened to the collective voices of women, the advice that states and territories will agree on a national maternity services plan and make complementary commitments and investments particularly around the provision of

[1] Sakala C Corry MP. 2008 Evidence-Based Maternity Care: What It Is and What It Can Achieve. *Millbank Quarterly* 2008

birthing centres and rural maternity units is a hollow call. In the jurisdictions where we work midwives are only beginning to be recognised for the skills and expertise they offer. Continuity of care by midwives has not yet been embraced fully, and home birth is not on the agenda in the majority of area health services in NSW. The proposed reforms will not improve access and choice for all Australians, particularly Australian mothers. It will not allay the frustration of women faced with limited options available to them. Preliminary outcome data from a NHMRC funded project grant assessing the safety and cost of providing maternity care in primary level units is extremely positive, however, it will take more than good evidence of outcomes to overcome the inherent and entrenched belief that women can only be safe in hospitals with anaesthetics and a caesarean section capacity.

A woman's right to choose her place of birth.

The *tension that exists between maternal* and *medical expertise* is the underlying theme of modern obstetrics.[2] By considering women incapable of deciding for themselves the safest and most appropriate place to give birth demonstrates this tension. Through this aspect of motherhood we can trace the current progress of women's place in contemporary Australian society. The freedoms that have been gained over the past century are virtually undone by depriving women of the ability to make a fundamental choice about their own bodies – where to give birth.

Homebirth is an opposition to hospitalisation. The process of home birth challenges the control of a medically focused establishment. The authority with which we endorse universal hospital treatment and routine interventions for birth is flawed when we consider that nearly 80% of Australian women could potentially give birth safely and without problems. In a national population study published in 2007 we found that less than 2% of Australian women who gave birth during the four years (1999-2002) had a previous medical history of complications and less than 10% had a history of previous obstetric complications. This is the small percentage of women who clearly probably

[2] Oakley Ann 1979 A Case of Maternity: Paradigms of Women as Maternity Cases *Signs,* Vol. 4, No. 4, The Labor of Women: Work and Family (Summer, 1979), pp. 607- 631

require expert medical or obstetric consultation or treatment during pregnancy and therefore the use of a highly specialized workforce.[3] Yet each year more and more women in Australia are having their pregnancies and labours interfered with in hospitals though induction, augmentation, assisted birth via caesarean section. These interventions put them at greater risk of their babies being admitted to special care nurseries. The work we did in this area showed that the admission of babies born at full term or greater than or equal to 2,500 g birth weight is far from a rare event. The finding was especially marked when women did not experience labour before having a caesarean section, where the adjusted odds increased by 12 and 15 times among low risk primiparas and multiparas, respectively.[4]

International studies, and experience in countries such as the Netherlands, Britain and New Zealand have conclusively demonstrated that for uncomplicated pregnancies, home births carried out with proper support are just as safe as hospital births. In the most recent study into the safety of home birth[5] with a sample size large enough to provide the power to detect differences in rare adverse outcomes, researchers showed that planning a home birth does not increase the risks of perinatal mortality and severe perinatal morbidity among low-risk women, provided the maternity care system facilitates this choice through the availability of well trained midwives and through a good transportation and an integrated referral system. The study did confirm that low-risk women who choose to give birth in hospital are more likely to be primiparous and of ethnic minority background; highlighting the fact that some self selection may take place among women who are more likely to need obstetric interventions.

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3 Tracy SK, Wang A, Black D, Tracy M, Sullivan EA Associating birth outcomes with obstetric interventions in labour for low risk women. A population based study. *Women and Birth* 2007;(2):41-48

4 Tracy SK, Sullivan ES, Tracy MB Admission of term infants to neonatal intensive care: A population based study. *Birth* 2007; 34(4):301-307

5 de Jonge A, van der Goes B, Ravelli A, Amelink-Verburg M, Mol B, Nijhuis J, Bennebroek Gravenhorst J, Buitendijk S. 2009 Perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births. *BJOG* ; DOI: 10.1111/j.1471-0528.2009.02175.x.

Advocates of hospital birth for women with low-risk pregnancies argue that the transfer to hospital during labour must be a most disappointing and de-motivating experience and therefore should be avoided. However one of the few studies examining this issue [6] found that amongst those referred to an obstetrician during labour, the ones who wanted to give birth at home but were transferred to hospital were as positive about the experience of childbirth, the appropriateness of the chosen place of birth, the satisfaction with the birth, the midwife's care, and the first postpartum days as the women who wanted to give birth in hospital. This research demonstrated that contrary to expectations, an unplanned transfer from a planned home birth to hospital may have little influence on the experience of childbirth.

An appropriate selection system is needed to ensure that of women who choose to give birth at home, only those women who are really at low risk, not only at the time of booking but throughout pregnancy and up to the onset of labour, are encouraged to give birth at home. Secondly, a good backup system of care is needed to be able to respond adequately to unexpected complications. To meet these requirements, good cooperation between midwives and obstetricians is essential to ensure that all women, regardless of the place of birth, receive the care they need when transferring to hospital for further care. In Australia the College of Midwives have demonstrated leadership in consulting with medical colleagues, midwives and women across Australia to develop a robust set of consultation and referral guidelines that are proving invaluable for midwives working in small primary level maternity units and needing to consistently assess the risk of women who may need to transfer or refer to medical expertise.[7]

Over thirty years ago, in the 1970s Archie Cochrane awarded the wooden spoon to obstetrics partly because 'the specialty missed its first opportunity in the sixties ... to randomise the confinement of low risk pregnant women at home and in hospital'.[8]

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[6] Wiegers TA, van der Zee J, Keirse MJNC. 1998 Transfer from Home to Hospital: What Is Its Effect on the Experience of Childbirth? *Birth*; 25 (1):19-24

[7] ACM National Guidelines for Consultation and Referral. 2nd edition. 2008
http://www.midwives.org.au/ForMidwives/PracticeGuidelines/tabid/308/Default.aspx

[8] AL Cochrane 1979

During the past thirty years there has been a strong and relentless push for women to undergo excessive diagnostic and surgical intervention during childbirth at an 'acute care' environment within hospitals.

Australian women, unlike their counterparts in New Zealand, have not passed the final emancipatory hurdle to be recognised as sentient intelligent human beings capable of making their own decisions about place of birth. The Age published an opinion piece from a woman three days ago who questioned, 'If we truly live in a society where women are granted ownership of their own bodies, and if home births, properly supported, are a safe option, then why shouldn't women have the right to choose that option?'[9]

Homebirth entails the active role of the mother as the person having the baby, and the primacy of her needs, rather than the dependent and inactive role of the mother as medical patient. It denotes birth with the status of an important life event. Homebirth offers possibilities for personal integration.

Hospital birth is justified to society through the conviction that specialist medical education proves to women that "doctor knows best". The knowledge monopoly is developed alongside the control of all resources used to care for women during birth within a medical system, such as hospital beds, machines for monitoring the progress of pregnancy and labour, anaesthetics and drugs for pain management, technology of abnormal deliveries such as induction, caesarean sections, forceps and vacuum extraction.

Three mechanisms work wholly against women having the opportunity to give birth at home - the authoritative knowledge of the experts; the forces of the market (fee for service, litigation); and industry (the quest for the perfect product). In the culture of

[9] Monica Dux July 16 2009 Changes that will effectively outlaw supported home births are paternalistic The Age http://www.theage.com.au/opinion/its-a-womans-right-to-choose-how-she-births-20090715-dlgs.html

childbirth in Australia individual control exercised by each woman is subsumed by the system of maternity care which stresses institutional control.

Our plea to the government is to reconsider the veto against women who choose to have their babies at home.
“Creative childbirth …has significance for a man and a woman which reaches far beyond the act of birth itself and through them has its effects upon society." [10]

With thanks
Yours sincerely,
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[10] Kitzinger SS. 1962 *The Experience of Childbirth* London: Gollancz Services, Ltd.p. 155.