Dr. Rebecca Doble PhD

Ms Claire Moore
Chair
Senate Community Affairs Legislation Committee

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

Monday 13th July, 2009

Dear Senator Moore

Re: Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills

I write to express my concern about the above bills. I understand that these bills will enable Medicare funding, access to the Pharmaceutical Benefits Scheme and professional indemnity premium support for midwives providing care for women to give birth in hospital.

Medicare funding for midwifery care is long overdue. It is not acceptable however to exclude homebirth from this funding and indemnity arrangement. By doing this Australia is totally out of step with nations such as the United Kingdom, Canada, The Netherlands and New Zealand. These nations support the rights of women to choose homebirth and fund a registered midwife through their national health scheme. In New Zealand and the U.K women have a legislative right to choose homebirth.

The intersection of this legislation with the national registration and accreditation of health professionals will prevent homebirth midwives from registering. I believe this to be an unintended consequence and ask that you take steps to include homebirth within the Health Legislation Amendment (Midwives and Nurse Practitioners) and related bills.

I am a research scientist and mother of two boys born at home. Despite having had two safe homebirths previously, because of this legislation I will not be able to give birth to any subsequent children at home without risking a $30 000 fine for engaging the services of a homebirth midwife.

Attached follows further discussion of the impact of these bills that details the following points:

1. Homebirth has been shown through many international studies to have as low a perinatal mortality rate as birth in a hospital
2. Homebirth offers significant benefits for mothers, babies and the public health system.
3. Women choose to birth at home for many varied reasons, which can never be fulfilled within the institution of hospitals, despite attempts to make them more women centred.
4. The restrictions that will be imposed on independent midwives through these bills will make homebirth more dangerous.
5. Expecting all maternity hospitals to fill the gap and provide a homebirth service is unrealistic and not a solution to this problem.

As a result I urge you to reject the bills in their current form, unless Government provision is made to allow independently practising midwives to be included on the register with professional indemnity support.

I would like to be involved in any further discussions on this matter, from a consumer perspective. Please contact me using the details above.

Sincerely,

Dr Rebecca Doble PhD, B Eng, Hydrologist

Homebirth safety

International research, including one study which included over 500 000 women, has shown that for low risk pregnancies and trained, professional birth attendants, the neonatal mortality rate for homebirth was found to be identical and in some cases lower than that of hospital births (de Jonge, 2009). Conclusions from the de Jonge 2009 study were:

> *'…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 referral system.'*

The key being that the choice of birthing at home is not the issue for low risk women, but the availability of well trained midwives, backup through a good transportation system to an appropriately equipped hospital, and a referral system to obstetric care during pregnancy if required.

The often quoted Australian study by Bastian H, et al. (1998) which shows a two times higher perinatal mortality rate for homebirth states that this rate includes high risk deliveries, including twins, breech births and post-term births. The inclusion of untrained attendants, births with no attendants (freebirth) and unplanned homebirths in comparative studies will skew statistics to falsely increase the mortality rate in homebirths.

The key requirements for safe homebirth are:

- low risk pregnancies
- trained midwives with appropriate resuscitation equipment
- proximity to maternity hospitals, and
- a good referral system to hospitals and obstetricians if required

Homebirth for low risk women is endorsed by the Royal College of Obstetricians and Gynaecologists UK, and is supported by government health programs in many other European and North American countries. South Australia has recently developed a new policy on 'Planned Birth at Home' and the Women's and Children's Hospital, the premier maternity hospital in that State has recently commenced a homebirth program. Other homebirth programs include St George Hospital in NSW, Darwin and Alice Springs Hospitals and several Midwifery Group Practices within southern Western Australia, NSW, Victoria, and South Australia.

For low risk homebirth, and even including high risk birth statistics, the mortality rate is still lower than that of elective caesarean sections, which have been found to have a 2.5 times higher mortality rate than natural births, which are funded by government and supported by the Australian Medical Association. It should also be noted that by far the biggest causes of perinatal mortality are smoking, drinking and obesity, yet these, though strongly discouraged, are still very legal and considered 'lifestyle decisions'. Government funding is not withheld from women who smoke, drink or are obese to give birth despite the higher costs associated with these cases.

Benefits of homebirth

Benefits of planned birth at home for mothers and babies include:

- Far lower rates of interventions (forceps, vacuum extraction, episiotomies) and caesarean sections
- Fewer birth injuries to babies such as lacerations or broken collar bones
- Better rates of breastfeeding and less postnatal depression
- Lower rates of infections, which is why hospitals were instructed to birth as many babies at home if the SARS epidemic was to enter Australia

For the government, homebirth frees up hospital beds for people who are sick or injured. Homebirth with an independent midwife currently costs the government nothing, as the entire cost is borne by the

families, including pre and post natal care. As the cost of a hospital birth ranges between $6000 and $20000 (Daily Telegraph, June 04, 2009), this is a significant saving for the public health system.

Reasons women choose to birth at home

Women who birth at home are often portrayed by the media and the medical fraternity as being more interested in achieving a self – fulfilling birth than the safety of their babies. Instead, most women are educated, well informed and choose homebirth for a variety of reasons, including the lower rates of intervention and safety statistics. Discussions with women who have birthed at home seem to be almost always positive, and there are very few 'horror stories' that are common for women birthing at hospitals. There is far less fear associated with labouring in a familiar environment, leading to more manageable pain and less need for pain relieving drugs which are known to impact on babies breathing.

Previous hospital birth experiences will often cause women to decide to birth at home, ranging from simply not being listened to, to traumatic experiences often leaving women feeling like they have been sexually assaulted.

The ability to labour without the pressures of systems and protocols designed to attend to many birthing women with limited numbers of staff is an overarching reason for women to birth at home.

Impacts of these bills

If these bills are enacted, it will mean that around 100 professional and highly skilled midwives will lose their careers.

There will be a significant loss of skills associated with facilitating normal and natural birth, and how birth at home differs from birth in hospital. These skills are vital should there be an epidemic such as SARS or avian influenza which would necessitate as many birthing as many women as possible at home to avoid the risks of infection.

Women will continue to choose homebirth, and with no experienced midwives practicing, it is anticipated that there will be an increase in untrained people attending births (just the effect that the legislations is trying to avoid) and freebirthing, that is birthing at home with no attendants or backup.

Above all, this legislation is a violation of a basic human right for all women, by putting birth options under State control rather than allowing women to decide.

Expecting hospitals to fill the void

Whilst homebirth through public hospital systems will still be lawful under the proposed bills, it is unreasonable to expect hospitals to fill the void left by this legislation for the following reasons.

Many women live outside catchments of current hospital run homebirth programs, though are still very close to other maternity hospitals that give backup support to independent homebirth midwives. Some hospitals, whilst happy to give backup support to independent midwives, and indeed have very good relationships between midwives, obstetricians and GPs, do not wish to take on the responsibilities of a homebirth program of their own. It will also take longer than a year (when this legislation comes into effect) to create new programs in other maternity hospitals, leaving a long gap in homebirth services.

Even in hospital run programs, women are still not able to engage a midwife of their choice as they would be with a privately practising obstetrician. When a woman has birthed with an independent midwife, the relationship that has been developed and experience she has with previous labours makes it safer and more desirable to continue to employ the same birth attendant.

Resolution

Subsidisation of professional indemnity insurance is currently offered to obstetricians and general practitioners through taxpayer funding. It is incongruous that the same support is not offered to midwives. As a taxpayer, I would prefer my taxes to also go towards insuring midwives who can facilitate less complicated and far less expensive births. In any case, the funds saved through women birthing out of hospital can surely contribute to this.

Including independent midwives in professional indemnity premium support will ensure that Australian women have the same right to choose where they give birth as do women in the United Kingdom, Europe, New Zealand and many other developed nations.

Over half of all consumer submissions to the Maternity Services Review discussed homebirth and yet the Review does not recommend public funding for homebirth. Indeed these bills make it less accessible than ever before. As they stand, these bills are yet another example of women not being listened to.

References

de Jonge A, et al. Perinatal mortality and morbidity in a nationwide cohort of 529,688 low-risk planned home and hospital births. British Journal of Obstetrics and Gynecology 2009; DOI: 10.1111/j.1471-0528.2009.02175.x

Bastian H, Keirse MJNC, Lancaster PAL. Perinatal death associated with planned home birth in Australia: population based study. *BMJ* 1998;317:384-8

Dr. Rebecca Doble PhD

Ms Claire Moore
Chair, Senate Community Affairs Legislation Committee

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

Thursday 16th July, 2009

Dear Senator Moore

Re: Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills

Since my last letter to you I have realised that I had not included any information about my own experience with requesting a homebirth and the consultation with a GP, obstetrician and the hospital in this process. What follows is a brief account of this.

On discovering that I was pregnant, my husband and I visited my local GP. I told her that if all went well with the pregnancy I would like to have a homebirth. She told me that I seemed very sensible about it and recommended a local midwife who worked part time as a community midwife for the local hospital, who had a good relationship with the GPs and obstetrician there, and in her words, was very safe. Whilst she did not provide backup for homebirth hospital transfers, she referred me to the obstetrician who did. I did, however, continue to see this GP throughout the pregnancy to order necessary ultrasounds. I also had one appointment with the obstetrician, who agreed to provide backup.

I met with the midwife and discussed many details about her practice, including when it would be necessary to transfer to hospital and how many babies had died in her care (two in twenty years – one before labour had started and one with congenitally deformed lungs, so the result from hospital birth in both cases would have been the same). This midwife conducted all of my prenatal care visits in the same way as a GP would.

When labour commenced my husband rang the midwife who arrived with resuscitation equipment and Syntocinon injections in case of haemorrhage. She contacted the hospital to forewarn them that I was in labour. She checked the baby's heartbeat continuously and advised me on the best positions to labour and birth. A second midwife arrived a few hours before the birth so there was an attendant for both myself and the baby if required. My baby was born safely with no assistance and only required a small amount of suction. Bleeding was minimal. My midwife stayed for a further six hours after the birth to observe myself and my baby. She rang to advise the hospital that the birth had gone well. She visited twice the next day, daily for the next week and then weekly until six weeks. We maintained phone contact for months afterwards to help with breastfeeding problems, starting solids and even feeding fussy toddlers. The relationship formed with my midwife, rather than having to repeat medical details at every visit with a new person, has made my following pregnancy and labour easier and more straightforward as well. This process was repeated with my second son twelve weeks ago.

I believe these experiences represent an extremely safe model for homebirth, with extensive collaboration between midwives, GPs, obstetricians and hospitals. Unfortunately, as the local maternity hospital does not have a homebirth program, this model of care will no longer be available to women of the Adelaide Hills. I believe that the proposed bills, which essentially make homebirth with an independent midwife unlawful, will prevent midwives who have good relationships with other medical providers from practising, while having no impact at all on untrained birth attendants. Surely it is better to put policies in place to ensure that all independent midwives operate under a code of conduct to the same standard that I have experienced, than prevent them from practising altogether.

Sincerely,

Dr Rebecca Doble PhD, B Eng, Hydrologist