SENATE SUBMISSION

AUSTRALIAN PRIVATE MIDWIVES ASSOCIATION

The Australian Private Midwives Association (APMA) http://www.privatemidwives.net/default.html is an organisation representing private practice midwives currently providing midwifery services for women around Australia. This organisation has formed in response to the initiative announced by the Federal government impacting upon the private practice midwifery workforce and through a desire to have an input into the maternity reform agenda commenced by the current Federal government. A number of, state based, organisations have been in existence for over 30 years and the APMA is drawing on the membership of these organisations to ensure national representation. Whilst providing some background in this paper, the APMA would like the opportunity to present to the Senate inquiry and to be available to answer questions regarding the provision of private midwifery services including birth at home.

The APMA views the legislation being examined by this committee with mixed feelings. For many years the practice of midwifery has been limited in its application by many barriers. The legislation being introduced into the parliament does signal a change in maternity services. For the first time some midwives will have access to the Medicare Benefit Schedule (MBS) and will be able to prescribe drugs (subject to state based legislation) under the Pharmaceutical Benefits Scheme (PBS). However, the feelings of most private practice midwives are not optimistic regarding how this might reform maternity services. The Health Ministers definite exclusion of homebirth from the legislated support of both indemnity subsidies and funding (Roxon 2009) may mean the demise of private practice midwifery in Australia. The intersection of this legislation with the Health Practitioner National Regulation law means that midwives will not be able to attend a homebirth as a condition of their registration (Australian Health Workforce Ministerial Council 2009 p47). Most midwives in private practice provide predominantly midwifery services across the full scope of practice in the woman's home, including birthing at home. A further concern is the definition of many of the terms used in this legislation. The most significant of these are the definition of a MBS "eligible" midwife and the definition of working in "collaboration" with doctor.

Midwives in private practice are those most impacted by this reform process. At time of writing this submission, the APMA has been excluded from the Maternity Service Advisory Group developed to

provide stakeholder input to the Federal reform process. The inability to make direct representation in this process is unacceptable.

Australian context and private practice midwives

In Australia currently midwives tend to be employed in hospitals within systemised, fragmented models of care. These midwives work in hospitals, on varying shifts, often in one area such as antenatal or postnatal wards. When a woman enters the system to birth, it is most likely that she has never met the midwife who assigned to look after her at the most intimate moment of her life. The evidence demonstrates that women may encounter 20 to 30 different health care providers (Hastie, 2008; ACM, 2008) during the eight to ten months of their maternity care and sometimes up to ten carers during the course of a 12 hour labour and birth (ACM, 2008) in maternity hospitals. Women in private maternity care may have an obstetrician providing their care, but the obstetrician is only present for a short period of time and is called by the midwife for the birth Therefore women experiencing private obstetric care also have never met the midwives providing their care. There is an assumption that the midwife will be with you all the time. In most hospitals midwives provide care for at least 2 women in labour simultaneously. Sometimes the number is significantly higher, for example: a few women having their labour induced, one or two in labour and some already birthed. Fragmented care such as this leads to fear and impacts on the process of labour. The systemised input, throughput and output for these women means there is no lying in period to recover and establish breastfeeding.

In contrast midwives working in the small number of public hospital continuity of care models across Australia and in private practice provide care for women in across the scope of midwifery care.. Midwives in private practice are self employed. Women self refer to these midwives. As opposed to fragmented models, the women choose the midwife caring for them in the private practice model. Private midwives begin their services caring for a woman in early pregnancy, including as early as preconception advice, these midwives continue to care for the same women until their babies are six weeks old. They are available three weeks before the estimated due date, on call for the labour and birth and they remain with the women providing one-to- one care throughout this process. The entire episode of care lasts an average of 40 weeks per woman.

Continuity of care by a ‘known midwife’ provides superior outcomes to all other models of maternity care (Hodnett E D et al 2003, Homer C et al 2001). A Cochrane review (Hatem et al 2008) concluded that “all women should be offered midwife-led models of care and women should be encouraged to ask for this option.” This review examined midwife-led (midwives providing primary care during pregnancy, labour and birth and postpartum with a high degree of continuity of carer) compared with medical-led care and shared care. Eleven trials, involving 12,276 women were included in the review. Currently in Australia most women seeking care from a private practice midwife are also choosing a homebirth. Homebirth is safe (de Jonge et al. 2009, Symons et al 2009, Bastian et al 1998, Ackermann-Liebrich et al. 1996; Gulbransen et al. 199; Janssen et al. 2002; Johnson & Daviss 2005). Homebirth care in Australia is predominantly provided by midwives in private practice.

In many other countries homebirth care is considered to be a legitimate option for women. In the Netherlands, New Zealand, Canada and the UK far greater numbers of women make this choice in options which are fully funded by the government. Canadian regulation of midwives prevents midwives from registering unless they are "competent and willing to provide care in a variety of settings, including home, birth centre and hospitals" (Canadian Midwifery Regulators Consortium 2008). The option of homebirth is well supported in the UK, including by the Royal College of Obstetricians and Gynaecologists (RCOG and RCM 2007). In direct contrast to their Australian (Royal Australian College of Obstetricians and Gynaecologists – RANZCOG) counterparts the RCOG has developed a position statement in conjunction with the Royal College of Midwives in support of homebirth as a choice that should be offered to all low risk women. (RCOG and RCM 2007). Private midwives are a particularly committed group of practitioners. A midwife who practices private will be available to the Senate committee to provide detail of the model of providing continuity of care across pregnancy, birth and the postnatal period.

Women choose to have a homebirth for an array of reasons. In the current maternity service women generally find it difficult to access this option as there are limited numbers of private practice midwives available. Contrary to most other OECD countries – women in Australia also have to fund homebirth as there is no rebate available for midwife homebirth care. The women making this choice are therefore committed to their choice to homebirth and are therefore unlikely to choose a hospital setting unless transfer is deemed necessary. These women are more likely to choose care at home with an unregistered care provider than to go to hospital if a registered midwife is unavailable.

The Nursing and Midwifery Council in the UK have examined the need for guidance around homebirth and found that there is no research or evidence to indicate specific criteria for birthing at home (Magill-Cuerdin 2005 p5). There does not appear to be a consensus of criteria for booking women in different places of birth (Campbell 1999). Review of the literature suggest that decisions relating to place of birth need to be made in relation to the woman's circumstances as the pregnancy progresses rather than when she first books midwifery care(Magill-Cuerdin 2005 p 5). Women's right to choose their place of birth is recognised as a fundamental right. "The explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment" (United Nation 1995). The Australian Federal government is effectively restricting this choice.

Indemnity Insurance for homebirth

Since 2001 privately practising midwives have been unable to access indemnity insurance. Because of this the number of private midwives has been too small, making it a non-commercial option for insurers. Prior to the collapse of the insurance industry, midwives providing homebirth care, were covered by Guild insurance at a cost of @$800 per annum. Some midwives did not have individual cover, as they were covered as a part of their union membership (i.e. the Australian Nursing Federation in Victoria covered some midwives). Following the collapse of the insurance industry the then Howard government initiated measures to support indemnity for obstetricians in private practice (Caines 2008). This lead to the perception that midwives – still unable to obtain indemnity because of

small numbers and lack of government support - were somehow “riskier” than obstetricians – who had the financial measures initiated by the government to support them. This perception remains today. In a level commercial playing field this myth would be debunked. Midwives provide generally ‘low risk’ care. They do no major surgery, are not responsible for inductions or anaesthesia such as epidurals and they generally provide care for healthy women. In homebirth, as in all birth, midwives are educated to pre empt and to deal with problems and emergencies the same skills required for all registered midwives. As all midwives (public hospitals, private hospitals, birth centre and home) provide nearly all in-labour care, in the absence of direct supervision of obstetricians, it is sensible to conclude that obstetricians consider midwives essential in the detection and referral of problems during labour and birth. It is also a requirement of midwives education and recognised as essential to practice according to the definition of a midwife.

Under the legislation being examined by this committee, the government has provided a subsidy (for high claims) to enable insurers to provide an affordable premium for midwives working in private practice. The Health Minister has been clear that this will not include claims arising out of homebirth care (Roxon 2009). The intersection of the legislation being examined by this committee with the (Bill B) Health Practitioner National Regulation law (Australian Health Workforce Ministerial Council 2009) creates a situation whereby the majority of midwives in private practice will be forced to change the context of their practice (provide no homebirth care), and work outside the conditions of their registration or de-register and work outside a regulatory framework.

A section of the International Confederation of Midwives definition of a midwife, which is accepted by the Australian Nursing and Midwifery Council, states “a midwife may practise in any setting including the **home**, community, hospitals, clinics or health units” (International Confederation of Midwives 2005). The proposed legislation would require an international re-definition of midwifery for Australian midwives to continue to practice, limiting their context of practice. This is completely unacceptable to private practice midwives both within Australia and internationally.

The restriction of provision of indemnity for private midwives to birth care in hospital means that the vast majority of clients for whom private practice midwives now provide services will be unable to access a registered midwife to attend their births. This places midwives in an untenable position. They will be called on by women to attend them at home, and be unable to do so or be forced to work outside the regulatory constraints.

Definitions under the proposed legislation

The word ‘eligible’ has been used throughout the legislation and the Budget to describe midwives who will be able to access both the MBS and indemnity insurance. We recognise that the government wishes to ensure standards in care. Australian private practice midwives have not had input into the definition of “eligibility” – which relates to MBS access or indemnity. Those midwives who fall outside the definition of “eligibility” will be prevented from private practice as they will be unable to secure the professional indemnity insurance required to register. The APMA therefore sees it essential that

private practice midwives have equal opportunity to have input into defining eligibility for their practice.

Midwives are registered professionals who, as a component of registration, state that they are competent to practice to the full scope of midwifery. The APMA considers it reasonable that requirements placed on other health professionals working in private practice, with access to public funding (i.e. physiotherapists, doctors, psychologists etc) be equally required of private practice midwives. These include registration, evidence of continuing professional development and evidence of professional membership. Additional requirements for one professional group are discriminatory.

One example of an additional requirement is that of "collaborative" working arrangements. To be 'eligible' for MBS access and indemnity midwives must be able to demonstrate that the private practice midwife will have to work in a "collaborative" relationship. This is not yet defined. Midwives practising privately have been unable to regain visiting access to hospitals since 2001. Collaboration, consultation or referral often relies on support of individual GP's or obstetricians. The absence of a mechanism that does not enforce a two way process inhibits the collaborative process is likely to prevent midwives continuing to work in consultation and for some it may prevent private practice. The Budget papers state that midwives must have collaborative working relationships to be 'eligible', to obtain insurance and therefore to register. Midwives are professionals responsible and accountable for their own practice. There is no requirement for doctors or health services to collaborate with midwives. This places an extreme amount of pressure on the private practice midwife in two way negotiations. It makes the balance of power in these negotiations weighted very heavily against the midwife.

There is an expectation that these definitions will be developed within stakeholder groups at the Maternity Service Advisory Group meetings. The APMA does not have a place at these meetings and therefore will be unable to provide input into these definitions, this is unacceptable and discriminatory.

The APMA requests that the Senate committee make the following recommendations:

1. Midwives in private practice be directly represented in all negotiations

When in contact with the Department of Health Australia the Australian Private Midwives Association have been told that midwives in private practice will be represented by the Australian Nursing Federation, the Australian College of Midwives and the Royal College of Nursing at the Maternity Services Advisory Group. The RCNA, as a nursing college, has a limited ability to represent midwives. We have approached the RCNA to ask their position on many of the issues being discussed and will await their considered response. It is unlikely that a nurse will have experience or understanding of midwifery practice or homebirth. We have asked the ANF and ACM whether either of their representatives is a current or previous private practice midwife. Whilst we have not received

a written answer we have verbal confirmation that the ANF will be sending a non midwife. At most (if the ACM have a private practice midwife attending) there will be one private practice midwife negotiating with more than 20 other stakeholders. This is not equitable when the recommendations of the National Maternity Service review relate to private practice midwives and when the funding measures and legislation impact a model of private practice midwifery. It is the livelihood of the private practice midwife that will be most impacted by these changes. It is essential to private practice midwives to have representation of our workforce present.

2. That there is an exemption of private practice midwives providing homebirth care from a requirement of professional indemnity insurance.

The APMA recognises that this is outside the jurisdiction of this committee. We ask that in the absence of availability of indemnity, that an exemption be recommended until the insurance problem can be resolved. .

3. That there is an extension of the legislation to include homebirth

The exclusion of homebirth from this legislation impacts on public safety, the livelihood of private practice midwives and rights of women. We ask that support for high claims to subsidise indemnity be extended under this legislation to midwives providing care for women who birth at home.

The APMA recognises that there may be additional requirements from the insurers that may restrict areas of practice. We would like the ability to discuss and negotiate any such restrictions on behalf of Australian private practice midwives. Women have the right to self determine their care and to informed consent and right of refusal. If restrictions apply under indemnity provisions the APMA request recognition of women's rights and protection of midwives who provide self employed services .them. This may require significant negotiation which requires input from private practice midwives.

Summary

The Australian Private Midwives Association recognises and applauds that the government is committed to maternity reform. The Budget measures funding the most significant reform of maternity services in Australian history provide evidence of this commitment. APMA fail to understand that a government committed to such reforms can ignore the hundreds of submissions to the National Maternity Service review calling for access to homebirth care. The exclusion of midwives from providing homebirth in the legislation being considered by this committee, and the consequence of the intersection of this legislation with the legislation supporting national registration, will force homebirth care outside of the conditions of a midwifes registration. We believe that the inability to access a registered midwife for care for birth at home as a direct result of government legislation is a breach of human rights. The livelihood of a group of educated and qualified professionals is impacted to the point where they will be prevented from making a living. Public safety for many women and babies will be negatively impacted to the point where there will be an increase in deaths and serious

morbidity. This is contrary to the government's stated aim of improving choice and access for Australian women to maternity services under a framework of quality and safety.

Liz Wilkes
Spokesperson
On behalf of the committee
Australian Private Midwives Association
217 Bridge St
Toowoomba QLD 4350
0423580585
e.wilkes@griffith.edu.au

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