20/7/09

CRANAplus
Submission to the Senate Inquiry Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two other Bills

Recommendations
CRANAplus recommends that the government subsidised indemnity scheme for midwives be extended to include labour and birth care in the home and in other non-Government health centres.

The above recommendation is the subject of this paper, however the following recommendations are also included without discussion:

That teleconsulting also be included as an MBS item
That the future MBS items for Nurse Practitioners and midwives take a 'care over time' approach ie there should be an amount for ante natal and post natal care and for the actual birth.
That there is an opportunity where needed, for an extended consulting time for expectant mothers
That similarly there is a 'care over time' item for chronic disease, child health, and well person health checks
That there is an item for acute presentation and follow up
That Nurse Practitioners and Midwives be able to initiate home medicines reviews

Rationale for the Primary recommendation
CRANAplus believes that people living in Australia's 'remote' areas are entitled to access quality Primary Health Care and care from a 'skilled attendant during pregnancy birth and the postnatal period. The term 'skilled attendant' describes an accredited health professional who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns'[1]. In Australia this includes midwives, GP

obstetricians and obstetricians. The WHO have stated that in order to protect both the public and the practitioners, it is important to regulate and license the skilled attendants themselves, the institutions in which they work and the programs and establishments used in their training[1]. In Australia this must also include indemnity insurance as a protection for the public. It is recognised that skilled attendants, and other key professionals, must be supported by an enabling environment including policy support, access to basic supplies, drugs, transport and relevant emergency obstetric and newborn services for timely management of complications[1].

CRANAplus would like to congratulate the government on the introduction of the maternity reforms that are currently before parliament and believe they are mostly progressive and will benefit people living in remote Australia. However we have several areas of concern that relate to safety, quality and equity for remote Australians.

The two areas of concern are:

The Health Practitioner National Regulation law currently being developed by COAG has the impact of making attendance at a homebirth by a registered midwife (without indemnity insurance) against the Act / Regulation.
The legislation being examined by this Senate inquiry does discuss homebirth however the Minister has specifically outlined that homebirth will be excluded from indemnity cover and funding in her second reading of the legislation (Roxon 2009).

CRANAplus has recent experience regarding these issues and will use the Northern Territory as case study to justify our very grave issues of concern.

The Northern Territory: A Case study
The Northern Territory (NT) is a sparsely populated area with less than 1% of the Australian population (196,300) residing across 674 discrete communities and 1,349,129 square kilometres (17% of Australia) [2-4]. Twenty nine percent of the population is Aboriginal or Torres Strait Islander and 71% of these live in the remote areas [3]. Thirty eight percent of the births in the NT are to Aboriginal or Torres Strait Islander women [5] who have higher fertility rates than other Australians and many of whom live in remote areas. The challenges in service delivery are complex and maternity services have recently undergone review.

The NT Health Practitioners Act, 2004[6], was introduced in February 2005 and clearly states that all health practitioners are required to have adequate professional indemnity insurance in place to practice in the NT. As there was no professional indemnity insurance available at that time, either in Australia or internationally, it became impossible for midwives to practise as Privately Practising Midwives in the NT. To do so would contravene the Act and risk becoming deregistered. As a result the Privately Practicing Midwives who had been running their own business and providing holistic midwifery services, not provided by any other organisation, had to cease to practice. Though based in Darwin and Alice Springs, these professionals had provided services across the NT, travelling to women when requested, including women living in remote areas. Though home birth was accessed by a small number of women the services had been operating for over 25 years across the NT. The

midwives all had professional referral arrangements with general practitioners', some of whom also attended homebirths, and facilitated transfer to hospital if it was needed.

In response to community protests and consumer pressure (some of whom were in advanced pregnancy and had planned a home birth), the NT Health Minister approved the establishment of a publicly funded Home Birth Service (HBS) for low risk women. It commenced operating in Alice Springs (2004) and Darwin (2005). The model employs midwives to provide home births. As employees of the Health Department they have the same indemnity cover as other Health Department employees. Clinical protocols guide their practice and the midwives are able to transfer a woman in labour directly to the hospital. This service was reasonably well received by supporters of home birth and continues to operate today. However some obstetric opposition remains and the models were never established in a sustainable or well integrated way, particularly in Darwin. The funding is insufficient to allow for the critical number of midwives to be employed (there is a good evidence base that informs the sustainability and safety of such models). Thus there has been continued activism and consumer pressure to improve the model with some changes made but more required.

Since the HBS establishment there have been requests by women in Nhulunbuy, Jabiru, Katherine and several remote communities from women wanting to have a home birth. The families have written numerous letters and appeals to the Health Department, their local referral hospitals, the Homebirth Service Coordinator, their local representatives and the Health Minister. Advocacy by CRANAplus and the College of Midwives has also occurred. Families describe the process as lengthy and extremely stressful. In each instance there have been either resident midwives that have been prepared to provide this service (some with many years home birth experience in either the NT or in other States), or members of the HBS have been prepared to travel to provide the service. All but one of these requests has been denied with the decisions being made by bureaucrats rather than clinicians. This has resulted in some women making the difficult decision to 'free birth' (birth without the presence of a skilled attendant). CRANAplus is aware of eight non-Indigenous women who have chosen to 'free birth' in the NT in recent years. It is unlikely any of these births would appear in the routinely collected perinatal statistics without the presence of a health professional to fill out the forms. We therefore have no way of knowing how many women free birth in Australia each year.

The midwives unable to support these women have described feelings of guilt and helplessness; particularly when there has been poor outcomes that they felt could have been avoided. One woman, whose request was denied, was transferred into the hospital following a severe post partum haemorrhage; she almost died. This is described as a 'near miss event'. The World Health Organisation state the lack of a skilled attendant at birth is the greatest cause of maternal death with many of those deaths being due to postpartum haemorrhage – often times an avoidable or treatable condition (if skilled attendant present). If a maternal death did occur under such circumstances then it would be documented as having potentially avoidable factors. How these avoidable cases would be tested in the judicial system is to date unknown.

Data on Indigenous women 'free birthing' in Australia is also not available. However, NT led research (the NHMRC funded '1+1' study) has shown that between 5-22% of

women in the three largest remote Aboriginal communities in Australia chose to birth in their communities each year for the last five years, despite the fact that birthing services are not being provided. Typically these women 'hide' rather than actively refuse to transfer to the regional hospital for birth and will present to the local health facility when labour is so far advanced that transfer is not possible. This situation is not uncommon across rural and remote facilities where birthing is not provided and is a cause of great stress to the locally based health staff who are either not skilled (ie are nurses, not midwives) or are not current (they have not worked in birthing facilities for a long time). Some midwives will work with the women encouraging antenatal care and early care in labour in an effort to ensure the best possible care for women given the choices the women are making.

Under the legislative reforms currently before parliament if women refuse to transfer yet present in labour, the locally available midwifery staff would only be covered by the appropriate insurance protection if they worked for public health services. However many remote health services are provided by Aboriginal Controlled Services. These services are largely unable to get insurance to provide birthing services as, like privately practicing midwives, their numbers are small. Hence, potentially midwives who provide care and support to women who refuse transfer, something they are skilled for and their nationally endorsed competencies support, could potentially be in breach of the Act.

The NT Act has a provision for Health Practitioners that will protect a person from prosecution if they undertake certain practices in an emergency situation. For example, if they need to attend to an emergency birth, they would not be in breach of the Act. But not all of these women are experiencing emergency birth, the research is showing that some are very planned[7]. CRANAplus believe it is better to provide these women, some of whom have the worst maternal and infant health outcomes in Australia, with skilled attendants at birth. The skilled attendants must have the appropriate enabling environment and this includes indemnity insurance. This is a human rights issue which, if not amended, is likely to provide another layer of inequity for remote Australians.

Many countries around the world are increasing access to homebirth services. There is increasing evidence that birth in the home is AS safe (some would argue SAFER) than hospital birth[8-10]. Women who birth at home feel more empowered, more in control and more confident – all important characteristics to begin life as a parent. Australia appears to support a culture of fear around birth in all settings, but particularly birth in the home. Some women will ALWAYS choose to birth at home. To deny them access to a skilled birth attendant is to breach our duty of care. It is only a matter of time that this would be tested in a court of law.

Australia must not be the only country in the world to outlaw home birth and home birth practitioners.

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