SENATE COMMUNITY AFFAIRS COMMITTEE

INQUIRY INTO:

HEALTH LEGISLATION AMENDMENT (MIDWIVES AND NURSE PRACTITIONERS) BILL 2009

MIDWIFE PROFESSIONAL INDEMNITY (COMMONWEALTH CONTRIBUTION) SCHEME BILL 2009

MIDWIFE PROFESSIONAL INDEMNITY (RUN-OFF COVER SUPPORT PAYMENT) BILL 2009

SUBMISSION BY THE AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH AND AGEING

JULY 2009

OVERVIEW

This legislation comprising three Bills – the *Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009*, the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009* and the *Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009* – will facilitate new arrangements for nurse practitioners and midwives, announced as part of the 2009-10 Federal Budget *Improving Maternity Services* package and the *Consolidate and Enhance Health Workforce Programs* package.

Under these proposed new arrangements, from 1 November 2010, patients of appropriately qualified and experienced nurse practitioners and midwives working collaboratively with doctors will have access to the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) for certain services provided and PBS-subsidised medicines prescribed.

Also proposed from 1 July 2010, a new government-supported professional indemnity scheme will be available for eligible privately-practising midwives working in collaboration with hospitals and doctors (particularly for obstetricians and general practitioner [GP] obstetricians), covering backup, referral and transition to other care providers as required.

Recognition of the role of appropriately qualified and experienced midwives responds to the national Maternity Services Review, which identified the need for greater choice and access to maternity care for Australian women, while maintaining Australia's strong record of safe, high quality maternity services.

The role of nurse practitioners is not new and nurse practitioners have been providing advanced level care for many years mostly within the public sector. However, these reforms will facilitate more effective use of this workforce and their skills by improving access to health services in non-acute settings, particularly in primary care and aged care and rural and remote locations.

Alongside implementation of these initiatives announced in the 2009-10 Budget, the Commonwealth is working with states and territories, through the Australian Health Ministers' Advisory Council (AHMAC), and with external stakeholders to develop a National Maternity Services Plan to ensure better co-ordination of and improved access to maternity services across Australia. To support this engagement, stakeholder advisory groups are being established.

BACKGROUND

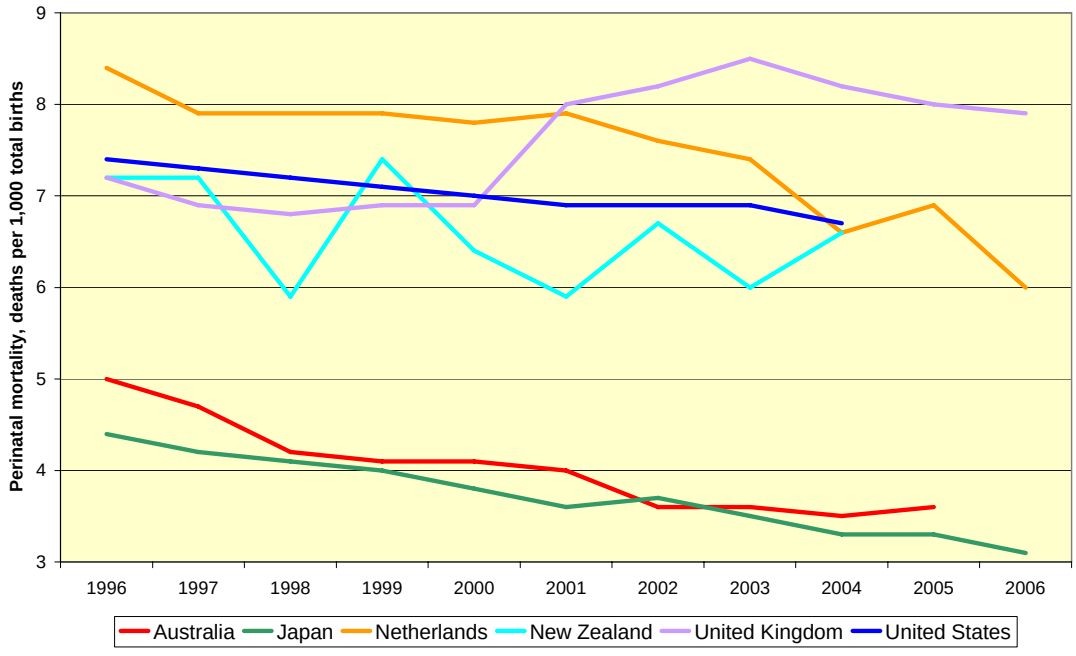
Maternity Services Review

The Government made an election commitment in 2007 to improve maternity services in Australia, including developing Australia's first National Maternity Services Plan. This commitment responded to growing community and professional concerns around some key issues in delivery of maternity care in Australia.

As a first step, in 2008, the Minister for Health and Ageing, the Hon Nicola Roxon, asked the Chief Nurse and Midwifery Officer, Ms Rosemary Bryant, to lead a Maternity Services Review (the Review). The Review process consisted of the release for consultation of the Discussion Paper *Improving Maternity Services in Australia*, a stakeholder consultation process involving over 900 written submissions and a series of Round table forums. The Review Report, *Improving Maternity Services in Australia – The Report of the Maternity Services Review* (the Report), was provided to the Minister for Health and Ageing and publicly released in February 2009[1]. The Review report was informed by stakeholder consultation, as well as other evidence and analysis.

The Report highlighted that Australia has one of the highest quality maternal and child health systems in the world. Data from the Organisation for Economic Co-operation and Development shows that over the past decade Australia has had consistently lower maternal and perinatal death rates than the majority of comparable countries (see Figure 1 for an international comparison of perinatal mortality rates).[2]

Figure 1: Perinatal mortality, international comparison, 1996–2006



Source: Organisation for Economic Co-operation and Development, 2008, *Health Data 2008.*

However, despite these encouraging overall statistics, the Report highlighted that not all Australians have equal access to quality services or achieve the same level of health outcomes in terms of infant and maternal health. The issues for Indigenous and rural women and their babies, particularly, were highlighted to the Review, as well as other disadvantaged groups where poor infant and maternal outcomes can have long term repercussions. The poorer health outcomes of Indigenous mothers and babies are presented in Table 1 below.

[1] http://www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesreview-report
[2] Organisation for Economic Co-operation and Development, 2008, *Health Data 2008*.

Table 1: Poorer health outcomes for Indigenous mothers

	Indigenous	Non-Indigenous
Fetal death rate per 1,000 births	11.7	7.2
Pre-term birth per 1,000 births	7.1	2.8
Low birthweight babies	12.4%	6.4%
Maternal death rate per 100,000 women	21.5	7.9
Contributing factors:		
Smoke during pregnancy	52.2%	15.6%
Aged under 20	20.9%	3.7%

Source: Improving Maternity Services in Australia – The Report of the Maternity Services Review, p 27.

Through the Council of Australian Governments (COAG) and other initiatives, Governments have already recognised the importance of improvements in maternal and child health in closing the life expectancy gap. Rural women contributing to the Review highlighted family disruption and costs associated with travel and accommodation, the physical and other impacts of long travel, and the risks including roadside birthing. Maternity services in rural Australia will be a focus in development of the National Maternity Services Plan, but has also been targeted in the 2009-10 Budget package as discussed further below.

It was also clear from the Review that better utilisation of the maternity care workforce would provide greater choice and access to maternity services for Australian women. Many of the over 900 submissions to the Review were from women sharing their personal experiences. Nearly all of these women expressed frustration at the limited options available to them. Similarly midwives participating in the Review expressed frustration at the constraints to their working to their full scope of practice.

Models of Maternity Care

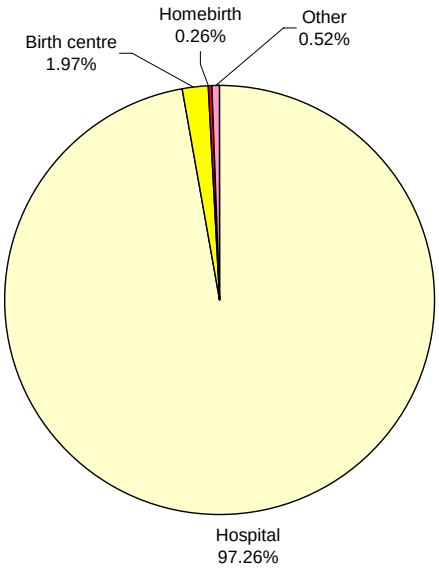
As with many aspects of the Australian health care system, maternity services are a combination of Commonwealth and state/territory government, and privately funded and delivered services. In 2006, 65.9% of women who gave birth in hospital were admitted as public patients and 34.1% as private patients[3]. Data from a Victorian study in 1999 suggests that 85% of women in private hospitals have their birth attended by a private obstetrician compared with 15% of women in public hospitals.[4]

The Review highlighted the need for greater choice in the models of care of maternity care, including increased access to those models where midwives play an enhanced role. The benefits of continuity of care, including maternity models involving a known midwife were presented in the Review. For example, some submissions told of the difficulty of being admitted to birthing centres, referring to 'ballot' systems due to limited availability. Models such as birthing centres are insufficient to meet demand by women to meet these approaches and are virtually non existent outside the public sector. The Review identified that while women can currently access midwives' services outside of the public sector, this is often at their own expense.[5]

Most births in Australia are in the hospital setting in a conventional labour ward setting, illustrated in Figure 2.

[3] AIHW, 2008, *Australia's mothers and babies 2006,* p. 20.
[4] Victorian Department of Human Services, 1999, "Who Usually Delivers Whom and Where", pp 23-24.
[5] Commonwealth of Australia, 2009. *Improving Maternity Services in Australia: The Report of the Maternity Services Review*, p.49.

Figure 2: Place of birth, 2006



Source: Australian Institute of Health and Welfare (AIHW) National Perinatal Statistics Unit, 2008, *Australia's mothers and babies 2006*, Perinatal statistics series no. 22, Cat. no. PER 46, Sydney, p. 20

There are also differences between jurisdictions in access to alternative models of maternity care, with South Australia having a much higher proportion of deliveries in birthing centres.

Table 2: Women who gave birth, by place of birth, 2006

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST
Mothers	(number)								
	91,303	68,547	55,719	28,253	18,518	6,053	5,354	3,689	277,436
Place	(%)								
Hospital	97.3	97.3	98.5	98.0	92.3	97.8	95.8	96.6	97.3
Birth centre	2.0	1.9	0.8	0.9	6.9	1.4	3.8	0.0	2.0
Home	0.1	0.3	0.1	0.7	0.5	0.2	0.2	0.9	0.3
Other	0.5	0.5	0.5	0.4	0.4	0.6	0.2	2.5	0.5

Source: Australian Institute of Health and Welfare (AIHW) National Perinatal Statistics Unit, 2008, *Australia's mothers and babies 2006*, Perinatal statistics series no. 22, Cat. no. PER 46, Sydney, p. 20.

Workforce

The 2005 Nursing and Midwifery Labour Force report found there were 18,297 midwives in Australia: with 67% working in major cities.[6]

The majority of registered midwives work in the public sector. Of the registered midwives in Australia, about 75% work in the public sector and 25% work in the private sector, primarily in private hospitals[7]. There is also a small number of privately practising midwives.

[6] Australian Institute of Health and Welfare (AIHW), 2008, *Nursing and midwifery labour force 2005*, National health labour force series no. 39, Cat. no. HWL 40, Canberra; AIHW, additional spreadsheet *Registered nurses—clinical area by selected characteristics*, table 2.

[7] This estimate is based on 1999 data from the 2002 Australian Health Workforce Advisory Committee Report: *The Midwifery workforce in Australia 2002-2012*.

The Review recommended that the Government consider arrangements, including MBS and PBS access, that could support an expanded role for appropriately qualified and skilled midwives, within collaborative team-based models. While acknowledging home birthing is a preference for some women, the Review did not propose Commonwealth funding for home births as a mainstream option at this time.

The Review emphasised that any reforms needed to maintain Australia's safety and quality record. The Review highlighted the benefits of collaborative care, which draws on the expertise of the range of health professionals involved in maternity care. There was general consensus amongst professional groups participating in the Review about the importance of collaborative, multi-disciplinary maternity care.

Improving Maternity Services Budget Package

The 2009-10 Improving Maternity Services Budget package responds to the Review. Alongside initiatives covered by the changes in legislation, the Budget package delivers a range of measures aimed at providing Australian women with more choice in their maternity care, while maintaining Australia's strong record of safe, high quality maternity services. It recognises the need to improve maternity services for women in rural and remote Australia, to improve access to information, for women and their families, and to build on Australia's strong record of quality and safety.

Alongside the MBS, PBS and professional indemnity insurance for midwives, other measures in the package include:

- more services for rural and remote communities through an expansion of the successful Medical Specialist Outreach Assistance Program;
- more workforce support, with extra scholarships for GPs and midwives, particularly in rural and remote Australia;
- the expansion and enhancement of the existing National Pregnancy Telephone Counselling Helpline to deliver a 24 hour, seven days a week telephone helpline and information service for women, their partners and families, to provide greater access to maternity information and support before and after birth; and
- a small program of targeted research aimed at improving the quality and safety of maternity services; a project to improve national maternal data collections; and national cross-professional guidance to support collaborative maternity care, which will be developed by the National Health and Medical Research Council (NHMRC).

As noted above, the Review did not recommend Commonwealth funding for homebirths at this stage. Accordingly, the Government is not proposing, to extend the new arrangements for midwives to include homebirths.

The reforms that will be facilitated by the proposed legislation will support better utilisation of the maternity care workforce, in particular an enhanced role for appropriately qualified and skilled midwives. They will expand maternity care options available for Australian women without risking the professional relationships that are essential in providing safe, high quality maternity care.

The initiatives supported through this legislation will allow for incremental reform, within a strong framework of quality and safety. While supporting models of care which will allow an enhanced role for midwives, these will need to involve collaborative team work with other members of the maternity care team, most notably obstetricians and GP obstetricians. The arrangements will, while maintaining current choices, support new models as the maternity workforce responds to these new opportunities and as consumers seek them. Effective teamwork is an essential element in ensuring safety and quality and the best outcomes for mothers and babies.

Recognising the important role of external stakeholders in the successful implementation of the *Improving Maternity Services* Budget package, the Australian Government Department of Health and Ageing has established the Maternity Services Advisory Group (the Advisory Group). Members of the Advisory Group include representatives from major organisations with an interest in Australia's maternity services and representation from the Australian Health Ministers' Advisory Council (AHMAC).

The Advisory Group will also provide the Department with advice and comment from a cross-disciplinary perspective on the development of the National Maternity Services Plan to support the Government's commitment to building on its *Improving Maternity Services* Budget package by working with the states and territories to ensure coordination of maternity services across Australia.

Nurse Practitioners

The 2006 ABS Census of Population and Housing reported that there were 334 nurse practitioners in Australia: 68% reported working in hospitals and 70% worked in major cities.[8]

Nurse practitioners are registered nurses who have advanced education and experience and are authorised to function by the relevant state or territory registering authority in an expanded clinical role. As such, the nurse practitioner role involves providing advanced and extended nursing care to patients, including ordering certain diagnostic and pathology tests, prescribing certain medicines and referral to medical practitioners and specialists. The scope of a nurse practitioner's practice is determined by the context in which the nurse practitioner is authorised and registered to practise.

Generally a Masters degree is considered the minimum level qualification required to practise as a nurse practitioner. Nationally consistent requirements for nurse practitioner authorisation will be addressed under the new National Registration and Accreditation Scheme (NRAS), to be implemented by 1 July 2010.

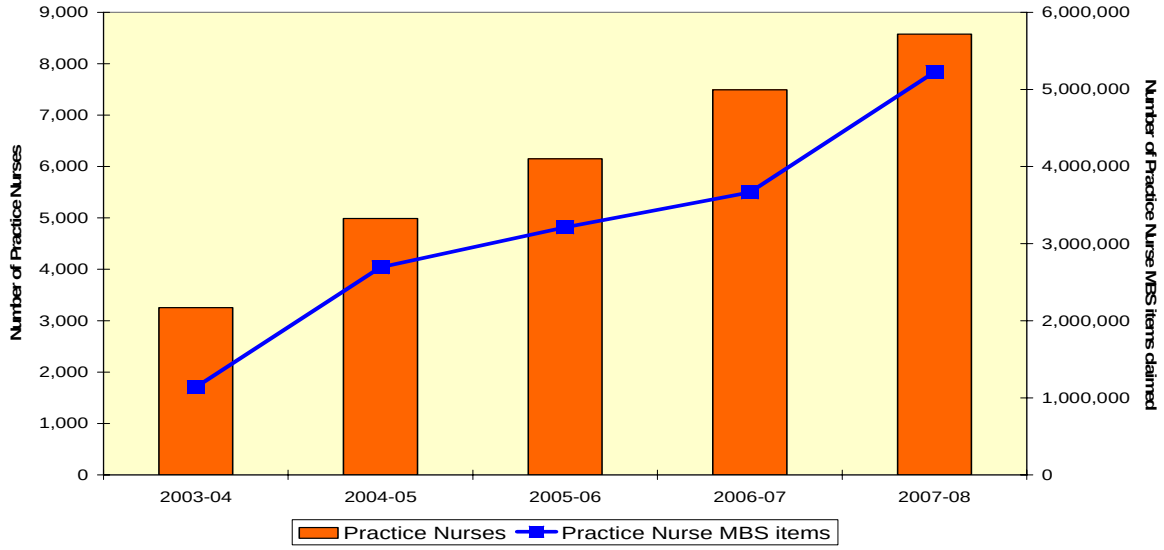
While nurse practitioners have legal rights to prescribe and provide services through relevant state and territory legislation, they have not had access to the MBS or PBS. As a result their role in certain community and private settings has been constrained as their clients cannot access subsidised services or prescriptions.

These new MBS and PBS arrangements will not extend the scope of practice of nurse practitioners, rather they will mean that nurse practitioners wishing to practise in non-acute settings can provide certain Medicare-subsidised services and prescribe certain PBS-subsidised medicines. The reforms will facilitate more effective use of the nurse practitioner workforce, enable nurse practitioners to take a greater role in the provision of health services and improve overall access to health services, particularly in primary care and aged care and in rural and remote locations. The new arrangements will improve access to services for some people in the community, including those who currently have difficulty accessing appropriate primary care services.

[8] Australian Institute of Health and Welfare, 2009. *Health and community services labour force*, National health labour force series number 42. Cat. no. HWL 43, AIHW, Canberra.

Within general practice, the role played by general practice nursing has expanded significantly in recent years with the number of practice nurses more than doubling in the four years to 2007-08. Around 53% of practices reporting to Divisions of General Practice employed practice nurses in 2007-08, up from 39% in 2003-04. Furthermore, in 2007-08 44% of metropolitan practices employed practice nurses compared with 76% of rural and remote practices.[9] This distribution has been encouraged by the availability of Practice Incentive Program payments to employ practice nurses and/or Aboriginal Health Workers in rural and remote areas, and eligible areas of urban workforce shortage. Practices in eligible urban areas of workforce shortage can employ allied health workers instead of, or in addition to, practice nurses. Also, practice nurses are providing an increasing range of MBS-subsidised services 'for, and on behalf of,' a GP.

Figure 3: Number of practice nurses and number of Medicare practice nurse claims



Source: PHCRIS and Medicare

The 2009-10 Federal Budget decision to allow nurse practitioners to access MBS and PBS supports an enhanced career path for practice nurses interested in advanced care at the nurse practitioner level. The fact that the MBS and PBS requirements will emphasise nurse practitioners working in collaboration with other health practitioners means that nurses interested in taking up these roles will practice in their own right rather than under the current 'for, and on behalf of,' arrangements. This career opportunity will help to attract and retain a skilled primary health care nursing workforce.

PART A - HEALTH LEGISLATION AMENDMENT (MIDWIVES AND NURSE PRACTITIONERS) BILL 2009

How the new arrangements will work

The purpose of the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 is to amend the *Health Insurance Act 1973* and the *National Health Act 1953* to facilitate the new MBS and PBS arrangements for appropriately qualified and experienced nurse practitioners and midwives. These proposed arrangements will be available from 1 November 2010.

[9] Primary Health Care Research & Information Service, *Annual Survey of Divisions of General Practice, 2003-04*, pp 68-89, and 2006-07, pp 97-99. Available from http://www.phcris.org.au/products/asd/index.php (accessed May 2009).

Under the *Health Insurance Act 1973*, a 'participating nurse practitioner' or 'participating midwife' will be able to request appropriate diagnostic imaging and pathology services for which Medicare benefits may be paid. New Medicare items will be introduced for services provided by participating nurse practitioners and participating midwives working collaboratively with doctors. Both participating nurse practitioners and participating midwives will be able to refer their patients, under the MBS, to specialists and consultant physicians as appropriate.

The *National Health Act 1953* will be amended to add 'authorised nurse practitioners' and 'authorised midwives' as new prescriber groups. Under that Act, eligible nurse practitioners and midwives will also be able to apply to become authorised to prescribe under the PBS. Prescribing under the PBS will only be permitted within the scope of practice of an authorised nurse practitioner or midwife and in accordance with the state or territory legislation under which they work. Accordingly, this amendment will not extend prescribing rights beyond that specified by the states and territories. Rather it will provide patients with access to certain Commonwealth-subsidised medicines prescribed by these authorised health professionals.

Eligibility requirements will be a core criterion for meeting the definition of a 'participating' or 'authorised' nurse practitioner or midwife. To meet the core requirement of being an 'eligible midwife', the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 requires registration as a midwife, and additional requirements specified by secondary legislation must be satisfied. These are likely to be based on having appropriate advanced qualifications, experience and/or demonstrated competencies. The minimum core requirement of being an 'eligible nurse practitioner' is registration as a nurse practitioner. If required, further eligibility requirements for nurse practitioners may be specified in secondary legislation. The Department will consult with relevant stakeholders – including nursing and midwifery colleges and stakeholder advisory groups - in relation to these eligibility requirements.

Proposed implementation arrangements

Collaborative care underpins the Government's midwifery and nurse practitioner reforms. Midwives and nurse practitioners eligible to participate in the MBS and PBS arrangements will have to demonstrate that they have collaborative arrangements in place, including having appropriate protocols with hospitals and doctors (for example, GPs, medical specialists or consultant physicians), covering backup, referral and transition to other care providers as required. The mechanisms by which Medicare arrangements will support and reinforce collaborative care arrangements will be developed in consultation with medical, nursing and consumer groups in the coming months including through the advisory groups established to support implementation of these initiatives.

The details of the MBS items, the diagnostic imaging and pathology services that may be requested, and the referral rights of these health care providers, will be finalised following consultation with relevant professions (including nursing, midwifery and medical) and specified in secondary legislation. Medicare items for participating midwives will include antenatal, birthing and postnatal care and collaborative care arrangements between these midwives and obstetricians/GP obstetricians. Participating nurse practitioners will be limited to providing services within their authorised scope of practice and level of experience and competency.

Similarly, the details of the range of medicines that nurse practitioners and midwives can prescribe under the PBS, and the circumstances under which the medicines can be prescribed, will be specified in secondary legislation following consultation. The formularies or other prescribing arrangements will be designed to reflect midwife and nurse practitioner practice(s).

Advice will be sought from the Pharmaceutical Benefits Advisory Committee (PBAC), which provides recommendations to the Minister for Health and Ageing in relation to the listing of medicines and other products on the PBS. The PBAC can also provide advice on the PBS medicines suitable for prescribing by different prescriber groups and any restrictions that should apply. Advice will also be sought from midwife and nurse practitioner professional bodies, and medical, health professional and stakeholder advisory groups.

While nurse practitioners already have prescribing rights under state and territory arrangements and have been performing this role for some time, this is not the case for midwives. Accordingly, to support the new PBS arrangements for these health professionals, the Government will be encouraging nationally consistent prescribing approaches across Australia.

Budget Allocation

The MBS and PBS components of the measures that this Bill will enable through secondary legislation, have a total cost of $111.3 million over four years. The budgeted annual costs, which include administrative and Department of Health and Ageing costs, and administrative costs for Medicare Australia to introduce the necessary systems changes and manage the program, are set out in the table below:

2009-10 $(m)	2010-11 $(m)	2011-12 $ (m)	2012-13 $(m)	Total $(m)
$14.8	$17.5	$32.3	$46.7	$111.3

PART B - MIDWIFE PROFESSIONAL INDEMNITY (COMMONWEALTH CONTRIBUTION) SCHEME BILL 2009
- MIDWIFE PROFESSIONAL INDEMNITY (RUN-OFF COVER SUPPORT PAYMENT) BILL 2009

How the new arrangements will work

These two professional indemnity Bills provide the legislative framework for the creation of a new, government-supported professional indemnity scheme for eligible midwives, which will enable the Government to address a market failure which has meant that Australian privately practising midwives have been unable to access professional indemnity insurance cover from a commercial insurer since 2002.

The Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 provides for Commonwealth financial contributions towards the cost of meeting insurance claims that are made against an eligible midwife. The Level 1 Commonwealth contribution provides for an 80 cents in the dollar Commonwealth subsidy for eligible claims above $100,000 but less than $2 million. The Level 2 Commonwealth contribution provides a subsidy of 100 cents in the dollar for eligible claims in excess of $2 million.

The Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009 allows for the levying of a tax on the eligible insurer, so that contributions can be made to a pool of funds that will be able to be drawn upon in the future to meet the cost of claims against eligible midwives who leave the midwifery workforce due to retirement, death, disability or maternity. This allows eligible midwives to be able to leave the workforce without having to continue to pay a premium to keep their professional indemnity cover in force.

Proposed implementation arrangements

The Department of Health and Ageing will conduct a tender process to select a suitable insurer. This process is expected to be finalised by October 2009, with the contracted insurer required to have policies available for eligible midwives to purchase with effect from 1 July 2010.

Eligible midwives will pay around $7,500 annually for a policy. This is roughly equivalent to the point at which Commonwealth assistance with the cost of medical indemnity insurance for doctors becomes available.

Budget Allocation

The measures that these Bills will enable (including through secondary legislation), have a total cost of $25.2 million over four years. The budgeted annual costs, which include administrative and Department of Health and Ageing costs, and administrative costs for Medicare Australia to introduce the necessary systems changes and manage the program are set out below:

2009-10 $(m)	2010-11 $(m)	2011-12 $ (m)	2012-13 $(m)	Total $(m)
$4.7	$8.1	$4.4	$7.9	$25.2