HEALTH LEGISLATION AMENDMENT (MIDWIVES AND NURSE PRACTITIONERS) BILL 2009 AND TWO RELATED BILLS

THE INQUIRY

1.1 On 23 November 2009, the Senate again referred the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills, together with the Government's proposed collaborative arrangements amendments, to the Community Affairs Legislation Committee for inquiry and report by 1 February 2010. In undertaking the inquiry into the legislation, the Senate asked the Committee to consider the following:

- whether the consequences of the Government's amendments for professional regulation of midwifery will give doctors medical veto over midwives' ability to renew their licence to practise;
- whether the Government's amendments' influence on the health care market will be anti-competitive;
- whether the Government's amendments will create difficulties in delivering intended access and choice for Australian women;
- why the Government's amendments require 'collaborative arrangements' that do not specifically include maternity service providers including hospitals;
- whether the Government's amendments will have a negative impact on safety and continuity of care for Australian mothers; and
- any other related matter.

1.2 The inquiry again generated considerable interest and within a very short period of time the Committee received 933 submissions relating to the Bills and amendments. The submissions are listed at Appendix 1. The Committee also received 430 comment letters and 900 form letters. The Committee considered the Bills at a public hearing in Canberra on 17 December 2009. Details of the public hearing are referred to in Appendix 2. The submissions and Hansard transcript of evidence may be accessed through the Committee's website at http://www.aph.gov.au/senate_ca.

THE BILLS AND GOVERNMENT AMENDMENTS

1.3 The Bills were initially considered by the Committee in its report of August 2009.[1] The Committee's report provides an outline of the Bills and the issues raised during the initial inquiry.

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1 Senate Community Affairs Legislation Committee, *Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills [Provisions]*, August 2009, accessed at: www.aph.gov.au/senate/committee/clac_ctte/health_leg_midwives_nurse_practitioners_09/index.htm

1.4 On 28 October 2009, the Government circulated amendments to the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and the Midwife Profession Indemnity (Commonwealth Contribution) Scheme Bill 2009. The amendments are designed to clarify in legislation that eligible midwives and nurse practitioners wishing to access the new arrangements will be required to have collaborative arrangements with medical practitioners. It is intended that the details of the arrangements be specified in secondary legislation.

1.5 On 8 December 2009, the Minister for Health and Ageing, the Hon Nicola Roxon MP, wrote to the Committee Chair indicating that the circulated amendments were intended to clarify in legislation the collaborative intent that had been articulated. The Minister went on to advise that:

> These amendments do not preclude a midwife having a collaborative arrangement with a hospital; however I am advised that the hospital would need to nominate a medical practitioner(s), such as the head of obstetrics or the director of medical services, as being in a collaborative arrangement with the midwife. Accordingly, we intend to proceed with these changes.
>
> However, after further consideration of the issues raised by stakeholders in relation to access to professional indemnity insurance and subsequent registration under the National Registration and Accreditation Scheme, I am persuaded that it is not necessary or desirable to proceed with the collaboration amendments to the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009.[2]

ISSUES

1.6 The proposed legislation aims to improve access and choice for Australian women. The Department of Health and Ageing (the Department) stated that:

> For the first time, patients of eligible midwives and nurse practitioners who have collaborative arrangements with medical practitioners will have the opportunity to access Government-subsidised services and medicines through the MBS and PBS.[3]

1.7 The Department noted that the amendments confirm the original intent of the legislation with collaboration 'being a core concept of the legislation'.[4] It is not envisaged that the new arrangements will be on a 'for and on behalf of basis', rather:

> Collaborative arrangements are intended to support safety and continuity of care by ensuring that, where a patient's clinical situation requires it,

2 The Hon Nicola Roxon, MP, Minister for Health and Ageing, letter to Senator Claire Moore, Chair, Senate Community Affairs Legislation Committee, dated 8 December 2009.

3 Department of Health and Ageing, *Submission* 3, p. 2.

4 Ms R Huxtable, Department of Health and Ageing, *Committee Hansard*, 17.12.09, p. 68.

> consultation, referral or transfer to a medical practitioner can occur as efficiently as possible.[5]

1.8 The government's commitment to increase women's access to midwifery care by providing midwives with access to the MBS, PBS and affordable indemnity insurance was supported by witnesses.[6] The Australian College of Midwives (ACM) stated:

> Evidence confirms that women and babies benefit from continuity of care by a known midwife. We welcome the Minister's recognition of this evidence and commitment to expanding women's access to the choice of primary continuity of care by midwives in both hospital and the community.[7]

1.9 However, a number of witnesses commented on issues related to on-going concerns with the definition of 'eligible midwife' and the impact of the requirement for midwives to have collaborative arrangements with medical practitioners as envisaged under the Government's proposed amendment.

Eligible midwife

1.10 The Australian Private Midwives Association (APMC) commented on the progress towards a definition of 'eligible midwife'. Ms Liz Wilkes, President, APMC, stated that there was still no clarity around this issue although there had been a number of consultations.[8]

1.11 However, Dr Barbara Vernon, Executive Officer, Australian College of Midwives (ACM), indicated to the Committee that all stakeholders had largely agreed upon the issues around eligibility and that:

> The key issue around eligibility that is problematic is whether or not we add this additional requirement of an agreement with a doctor as to whether or not the midwife is going to be a capable, safe and competent practitioner in providing this care, and that is where there is a difference of opinion. But the material on midwives and their qualifications et cetera has been largely agreed upon, and it is likely that the Nursing and Midwifery Board of Australia would have carriage of administering that; they would have some kind of mechanism for identifying these midwives and maintaining their eligibility over time[9]

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5 Department of Health and Ageing, *Submission* 3, p. 3.

6 Australian Private Midwives Association, *Submission* 36, p. 5.

7 Australian College of Midwives, *Submission* 30, p. 4.

8 Ms L Wilkes, President, Australian Private Midwives Association, *Committee Hansard*, 17.12.09, p. 15.

9 Dr B Vernon, Executive Officer, Australian College of Midwives, *Committee Hansard*, 17.12.09, p. 28; see also Ms L Thomas, Assistant Federal Secretary, Australian Nursing Federation, *Committee Hansard*, 17.12.09, p. 28.

1.12 The Department also commented on the progress to establish what is meant by eligible midwife and informed the Committee that a 'very broad consensus' has been reached around that the level of experience that would be expected of an eligible midwife and that the midwife would need to have practised in a number of settings. Ms Kerry Flanagan, Department of Health and Ageing, informed the Committee that it was hoped that the Minister would be provided with advice on this matter by January 2010:

> We intend to have one further meeting just to check with the advisory group that the advice that we will be providing to the minister from them around those broad principles is agreed, or as close to agreement as possible, and then the minister will consider them. Possibly also the intention is to seek advice from the Nursing and Midwifery Board that has been set up under the registration and accreditation legislation. We are intending to get together in January, so we will have what we hope might be sign-off from the advisory group in January in terms of the advice that they will provide to the minister about what an eligible midwife should be.[10]

Collaborative arrangements

1.13 Witnesses supported the concept of collaboration as necessary to ensure appropriate care for women and their babies. The ACM commented that midwifery is a profession committed to the provision of collaborative care and stated that 'there is no argument that women choosing the care of a private MBS funded midwife must have ready access to appropriate medical care if and when the need arises for themselves or their baby'. The ACM saw the issue as how collaboration is ensured.[11]

1.14 The matters raised in evidence in relation to the amendments focussed on the inclusion of collaborative arrangements in legislation; the placing of midwives in a subordinate position to medical practitioners; the need to have a signed agreement with a medical practitioner(s); and problems in rural and regional areas with the proposed arrangements.

1.15 The ACM and other witnesses did not support the inclusion of collaborative arrangements in legislation to ensure that midwives work collaboratively with medical and other health professionals.[12] It was noted that within midwives' core competencies and code of ethics midwives are expected to collaborate with other care providers.[13] The Australian Nursing and Midwifery Council (ANMC) argued that collaborative practice between midwives, nurse practitioners and other health professionals 'is already legislated through the professional framework developed by the ANMC,

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10 Ms K Flanagan, Department of Health and Ageing, *Committee Hansard*, 17.12.09, p. 71, see also p. 74.

11 Australian College of Midwives, *Submission* 30, p. 4.

12 Australian College of Midwives, *Submission* 30, p. 2.

13 Australian College of Midwives ACT, *Submission* 57, p. 1.

'because the status of that professional practice framework in every state and territory is as subordinate legislation to the legislation governing the regulation of nurses and midwives in those states and territories'. The ANMC concluded:

> So our contention is that there is no need for this legislation to have this additional amendment. In fact, there is already legislation that speaks to this issue and which covers the work of nurses and midwives in this area.[14]

1.16 Dr Barbara Vernon, ACM, commented that the proposal supported by the Australian Medical Association (AMA) would allow a midwife to become Medicare eligible on the signing of an agreement between the midwife and one or more medical practitioners. Dr Vernon described the linking of the collaborative agreement as a signed document to the eligibility as the most unworkable part of the proposal.[15] The ACM preference is that the reference to 'collaborative arrangements' is not added to the legislation and that midwives:

> …demonstrate their adherence to safe, collaborative practice through the use of formalised maternity care notes for each woman for whom they provide care, which can be audited by Medicare Australia or the Nursing and Midwifery Board of Australia as appropriate.
>
> The requirement to demonstrate collaborative practice could be implemented as an amendment to the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill, in the definition of a participating midwife. The alternative mechanism, of making collaborative practice a condition of eligibility, risks issues of circularity which could impede midwives access to Commonwealth-subsidised professional indemnity insurance.[16]

1.17 Dr Andrew Bisits, Director of Obstetrics at the John Hunter Hospital which has a freestanding midwifery service, informed the Committee that 'we do not need signed agreements'. John Hunter has 'very clear and sensible guidelines' which are always subject to debate. Dr Bisits went on to state that while the situation always lends itself to tension, 'it is resolvable by reasoned argument and discussion'.[17]

1.18 The AMA supported the requirement for the inclusion of collaborative arrangements in the legislation. Dr Andrew Pesce, President, stated:

> If collaborative care is essential, then it must be enshrined in the legislation. It is simply too risky to say that health professionals can use their discretion as to when, where and in what circumstances they will collaborate—and

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14 Ms K Cook, Chief Executive Officer, Australian Nursing and Midwifery Council, *Committee Hansard*, 17.12.09, p. 25.

15 Dr B Vernon, Executive Officer, Australian College of Midwives, *Committee Hansard*, 17.12.09, p. 24.

16 Australian College of Midwives, *Submission* 30, p. 2.

17 Dr Andrew Bisits, Director of Obstetrics, John Hunter Hospital, *Committee Hansard*, 17.12.09, p. 25.

> that works both ways. It is essential that the primary legislation encapsulates a requirement for collaborative arrangements so that the most important goal, quality and safety of patient care, is achievable.[18]

1.19 The AMA indicated its commitment to work through the advisory bodies to ensure that 'further regulations and guidelines allow different team based models to be developed based on safety and quality, local circumstances and the clinical needs of patients'. The AMA also argued that the amendments will support a flexible approach, particularly in rural and remote areas, and will build on models already in place. Dr Pesce, AMA, concluded:

> This should not be a debate about competition or doctors having the right of veto over our nursing and midwifery colleagues. Collaboration is an essential responsibility of doctors, midwives and nurse practitioners to ensure safety and quality in multidisciplinary patient care.[19]

1.20 It was argued that the requirement for midwives to have collaborative arrangements with one or more medical practitioners before their services are eligible for Medicare rebates may effectively institute medical control over individual women's access to Medicare funded midwifery care and mean that a medical practitioner could have veto over the ability of a midwife to practise.[20] A group of senior midwives argued that the proposed amendment introduces another level of regulation of midwifery which is 'unprecedented nationally or internationally'. The midwives went on to concluded:

> One professional body being given authority to limit the ability of another profession to practise is totally unprecedented and unacceptable, particularly so in this case when there is no guarantee that the generic professional given dominance has relevant knowledge or skill to do so.[21]

1.21 Dr Jennifer Gamble, President, ACM, also commented on the impact of power imbalances on collaborative arrangements and flaws in the amendments. Dr Gamble stated that the amendments were included 'late in the day and under pressure from doctor's groups'. She went on to argue that while collaboration is very important in health care, 'just because some medical practitioners may, do and will collaborate does not actually make for collaboration and to legislate that you have a signed written agreement with a medical practitioner becomes meaningless and unworkable'.[22]

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18 Dr A Pesce, President, Australian Medical Association, *Committee Hansard*, 17.12.09, p. 55; see also Dr A Pesce, *Committee Hansard*, 17.12.09, p. 57.

19 Dr A Pesce, President, Australian Medical Association, *Committee Hansard*, 17.12.09, p. 55.

20 Group of Senior Academic Midwives, *Submission* 1, p. 1; Australian Nursing Federation, *Submission* 40, p. 1.

21 Group of Senior Academic Midwives, *Submission* 1, p. 3.

22 Dr J Gamble, President, Australian College of Midwives, *Committee Hansard*, 17.12.09, p. 23.

1.22 The proposed amendment was not support by the Australian Nursing Federation (ANF), with Ms Julianne Bryce, Senior Professional Officer, commenting that 'the ANF is firmly of the view that the consequence of the government's amendments to the bills will mean that a medical practitioner could have veto over the ability of a midwife to practise'.[23] The ANF also commented:

> The ANF insists that nurse practitioners/eligible midwives and medical practitioners do not need a written contract with each other to make sure that collaboration occurs…Collaborative arrangements do not need to be formalised in legislation. Nurse practitioners/eligible midwives, and their medical colleagues, act ethically, professionally and within a legal framework.[24]

1.23 Ms Liz Wilkes, APMA, commented on the forms of the models that will result from the reforms and their impact on privately practicing midwives. Ms Wilkes argued that:

> …the only midwives that we see as being able to provide continuity of care for women are midwives who are employed by obstetricians or working in an obstetric practice. Obviously, most obstetric practices do not use midwives in that way.[25]

1.24 Ms Wilkes went on to strongly state that position taken by privately practicing midwives: that they are happy to collaborate and work in a collaborative practice with obstetricians and to undertake all the necessary requirements including planning, documenting and audit but:

> …we will not be restricted in our autonomy in our practice because that is fundamental to midwifery. That is part of the ICM definition of a midwife. We will not be restricted...
>
> We want collaborative practice; we do not want collaborative arrangements.[26]

1.25 Ms Wilkes went on to outline what the APMA understood the meaning of 'collaborative arrangement' to be and expressed concern about the attitude of professional bodies to midwifery practise including homebirth which could lead to the medical profession having control and power in what are supposed to be collaborative arrangements:

> [Collaboration] requires that both parties to the arrangement are in equal agreement. We know for a fact that if one party to that agreement are

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23 Ms J Bryce, Senior Professional Officer, Australian Nursing Federation, *Committee Hansard*, 17.12.09, p. 26.

24 Australian Nursing Federation, *Submission* 40, p.5.

25 Ms L Wilkes, President, Australian Private Midwives Association, *Committee Hansard*, 17.12.09, p. 9.

26 Ms L Wilkes, President, Australian Private Midwives Association, *Committee Hansard*, 17.12.09, p. 10.

> medical practitioners—and presumably they are going to have an obstetric qualification; they may not but we will assume that they are medical practitioners—we certainly know that medical practitioners have, on the record in their professional bodies, an opposition to many things that midwives consider philosophically appropriate. For example, they have a position statement that says that they do not support homebirth, they have position statements around freestanding birthing centres, and their own consultation and referral guidelines do not recognise midwives as autonomous practitioners. So we have one party to the collaboration having one viewpoint and then we have midwives on the other side who have a completely different viewpoint. Midwives are going to be mandated to comply with this arrangement, so midwives are going to be on this side of the bench having to find somebody to collaborate with, and we are going to have the collaborators here that we know have a different philosophy, who do not have to participate and can just choose to participate. They are going to be able to say, 'If you want to do this, do it on my terms or else it does not happen at all.'
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> …It does seem to be quite an unequal power balance, and from the definitions around collaboration—and if you look at some of the work that has been quoted in other submissions, for example, the ANF submission—you will see that collaborative arrangements require autonomy and both practitioners to be on equal footing. We do not have that in Australia in maternity services at the moment. We would love to see more collaboration and things working better, but mandating a requirement that one group has control over another is not going to work, is not going to get better collaboration in place.[27]

1.26 Dr Andrew Pesce, AMA, responded to arguments about possible power imbalances between midwives and obstetricians. He argued that a power imbalance emerges because of the different competencies of midwives and obstetricians:

> If there is an imbalance, I suspect that it emerges from the fact that midwives can care for a patient to a certain point and then, if something goes beyond that, they need to enlist the services of a collaborating obstetrician. But that obstetrician obviously is hesitant to just become a technician and say, 'I will just step in when I am asked to.' They would like to step in at the right time. So, if there is a power imbalance, it arises from the different competencies of the people who work in the team, and I do not think it is one which stems from a desire to deal with the competition.[28]

1.27 RANZCOG questioned the contention that RANZCOG fellows did not support collaborative arrangements. The President of the College, Dr Ted Weaver, commented:

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27 Ms L Wilkes, President, Australian Private Midwives Association, *Committee Hansard*, 17.12.09, p. 16.

28 Dr A Pesce, President, Australian Medical Association, *Committee Hansard*, 17.12.09, p. 58.

> In the polling that we have done a lot of RANZCOG fellows have indicated they are very keen to collaborate and are interested in embracing these new systems of care. They honestly believe that working with known midwives and collaborating more closely with their midwifery colleagues will lead to better care for women.[29]

1.28 Midwives also commented on the need to have collaborative arrangements with medical practitioners rather than with health services or hospitals. The ANF commented that the inclusion of health services would provide for 'greater flexibility in working arrangements, and more importantly, accommodates all geographical settings in which maternity services are provided to meet client needs'.[30] Women's Hospitals Australia (WHA) argued that midwives should be able to enter into a collaborative arrangement with public hospitals. WHA noted that public hospitals have a history of collaboration between obstetricians and midwives and have established models of maternity care where collaboration is a vital component.[31]

1.29 Dr Pesce outlined why the AMA supported collaborative arrangements between practitioners rather than health services or institutions:

> Collaboration must also be between health professionals. It cannot be with an institution or agreed to by non-clinicians working in an institution. It must involve those people who understand the clinical needs of a patient and who are ultimately involved in delivery of care to a patient.[32]

1.30 The Department submitted that the amendment would not preclude a midwife or nurse practitioner having a collaborative arrangement with a service provider such as a hospital:

> However, the service provider would need to nominate a medical practitioner(s), such as the head of obstetrics, as being in a collaborative arrangement with a midwife. This ensures that the service will have appropriate clinical arrangements in place in order to enter into a collaborative arrangement with a midwife or nurse practitioner.[33]

1.31 A further concern raised by midwives was the impact of the proposals for those working in rural and regional areas. The senior midwives commented that the reforms may be unworkable in rural areas if midwives are required to form collaborative agreements with individual doctors rather than area health services as distances may make it impossible for collaborative arrangements with a single

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29 Dr T Weaver, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Committee Hansard*, 17.12.09, p. 54.

30 Australian Nursing Federation, *Submission* 40, p. 5; see also Royal College of Nursing, *Submission* 39, p. 3.

31 Women's Hospitals Australia, *Submission* 49, p.2.

32 Dr A Pesce, President, Australian Medical Association, *Committee Hansard*, 17.12.09, p. 56.

33 Department of Health and Ageing, *Submission* 37, p. 3.

doctor.[34] Dr Barbara Vernon, ACM, also noted that the high turnover of doctors in rural areas will make the arrangements difficult.[35] RANZCOG acknowledged that it may not be possible to collaborate with an individual medical practitioner because of turnover of staff. In such cases, RANZCOG stated 'ít would be then incumbent on those Maternity Care Providers to meet and work out an equitable arrangement that does not compromise safety'.[36]

1.32 In relation to the issues raised about the workability of the proposed arrangements in rural and remote areas, Dr Pesce commented that in areas where the workforce is constantly changing it is important that there are protocols, procedures, guidelines and collaborative arrangements to ensure that those practitioners coming into a new area can quickly understand how the system operates.[37] Dr Pesce also stated that the collaborative agreements did not have to be with every individual doctor. Rather there is the possibility that someone representing medical staff, for example a medical director, to be involved in the collaborative agreement and that this 'will make clear that if you work there they have to work within the agreement'.[38]

1.33 The Department provided the Committee with evidence in relation to collaborative arrangements. It indicated that discussions had taken place in MSAG focussing on how collaboration will be defined in the secondary legislation. The Department commented:

> …it is very important to put on the record that, in that group, we have looked at not just what might amount to collaborative arrangements, but also at how Medicare services provided by midwives might be defined and described, the sorts of referrals to Medicare eligible specialist services that should be appropriate for a midwife to make and the sorts of requests for imaging and pathology services that a midwife might legitimately make. That has all been dealt with very constructively and I think there has also been a lot of common ground reached on the issue of collaborative arrangements, although clearly we still have a little way to go.[39]

1.34 Ms Rosemary Huxtable, Deputy Secretary, Department of Health and Ageing, also commented that while a consensus position on collaborative arrangements had not yet quite been reached in the advisory groups 'I think we have made a lot of important steps—and it is not really us; it is more the willingness of the key

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34 Group of Senior Academic Midwives, *Submission* 1, p. 3; see also *Submission* 32, p. 3.

35 Dr B Vernon, Executive Officer, Australian College of Midwives, *Committee Hansard*, 17.12.09, p. 24.

36 Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Submission* 13, p. 3.

37 Dr A Pesce, President, Australian Medical Association, *Committee Hansard*, 17.12.09, p. 61.

38 Dr A Pesce, President, Australian Medical Association, *Committee Hansard*, 17.12.09, p. 62.

39 Mr P Woodley, Department of Health and Ageing, *Committee Hansard*, 17.12.09, p. 69.

stakeholders to actually talk to each other'. Ms Huxtable stated that it was in the hands of those taking part in the discussions to find resolutions to some of the issues:

> In my view, some of the resolution of these issues—and understanding of these issues—is actually in the hands of those who sit there. It is in fact in the hands of those who sit around the table. I think there is quite a significant level of agreement. There is certainly a level of agreement on collaboration and that being a centrepiece to provide safety and quality arrangements. I think that we have made very good progress with the cooperation of both midwives and doctors, to name a few.
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> …At the end of the day the minister will need to come to a view based on the advice that emerges from these [advisory] groups. I would hope that there will be quite a substantial amount of consensus for her to consider by the time we get to that point, which will be in the new year.[40]

1.35 Ms Huxtable went on to comment that the discussions about how collaboration could work had covered 'a real continuum' from a very soft version of collaboration at one end to the signed collaborative agreement at the other end. In relation to signed collaborative agreements, Ms Huxtable stated:

> …a signed collaborative agreement…is certainly not the only option that has been on the table and it is not the only option that has been discussed. It is one of a variety of options that include the idea of having a contemporaneous record in the women's clinical notes, so the more patient centred measure of collaboration.[41]

1.36 Areas where discussions had reached agreement included that collaborative arrangements should be recorded in a patient's clinical notes and that those notes should be comprehensive, contemporaneous and auditable. Matters included in the collaborative agreements included circumstances where a midwife consults with a medical practitioner, refers to a medical practitioner for clinical advice, refers a woman to a medical practitioner or a hospital for treatment or transfers the care of a woman to a medical practitioner or a hospital. There also seemed to be general agreement that the detail would be appropriately defined in secondary legislation. Ms Huxtable stated:

> That is a good, solid start. Everyone who I have spoken to says that all of those things are necessary. There is a difference of view as to whether or not they are sufficient to represent collaborative arrangements. That is where we are trying to continue to work to get some further discussion and more consensus.[42]

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40 Ms R Huxtable, Department of Health and Ageing, *Committee Hansard*, 17.12.09, p. 71.

41 Ms R Huxtable, Department of Health and Ageing, *Committee Hansard*, 17.12.09, p. 72.

42 Mr P Woodley, Department of Health and Ageing, *Committee Hansard*, 17.12.09, pp 72–3.

1.37 Ms Huxtable concluded 'the minister is going to have to make a decision, if there remain areas of difference, on what her views are around how this would be shown in secondary legislation'.[43]

CONCLUSION

1.38 The Committee notes that effective collaborative arrangements amongst health professionals ensures the delivery of safe and high quality care. Collaborative arrangements are at the heart of the midwives and nurse practitioners reforms introduced by the Government and thus the Committee supports the principle of collaborative arrangements in legislation. The Committee considers that the collaborative arrangements as envisaged will enable a flexible approach to meet the different circumstances of practice across Australia, particularly in remote and rural areas. The details of the arrangements will be included in subordinate legislation and will continue to be the subject of consultation with the health professionals and the department. This consultation is critical to the effectiveness of the process and reflects the shared commitment and professional skills focused on safe birth practice.

1.39 The Committee acknowledges that the minister has given further consideration to matters raised by stakeholders in relation to access to professional indemnity insurance and subsequent registration under the National Registration and Accreditation Scheme, and has, as a consequence, decided not proceed with the collaboration amendment to the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009.

Recommendation

1.40 The committee recommends that the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 with amendments, the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 and the Midwife Professional Indemnity (Run-Off Cover Support Payment) Bill 2009 be passed.

Senator Claire Moore
Chair

February 2010

43 Ms R Huxtable, Department of Health and Ageing, *Committee Hansard*, 17.12.09, p. 72.