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

Background

Thank you for the opportunity for providing a submission to your inquiry as a group of senior academic midwives across Australia. We have been most concerned by the nature of the amendment proposed as it appears not only ill-informed, conflicts with current regulation of the practice of midwives but was promoted by a medical union not the craft groups most concerned and knowledgeable about women's needs and safely at birth.

Introduction

We represent midwives who lead research into maternity care in Australia. We currently head and participate in major NHMRC funded research projects designed to add to the evidence of safety and efficacy of care. Our research teams reflect the multidisciplinary environment within which we work. Obstetricians, paediatricians and general practitioners are our practice, research and teaching colleagues. We are surprised, and disturbed, that pressure from a union rather than our medical colleagues has persuaded the government to make changes which are not informed by evidence, but appear to be based on protection of income and power.

We support reform of Australian maternity services – an area of long neglected policy by previous governments and health ministers. Indeed many of us are contributing to the evidence base for safe practice, testing innovation and leading clinical improvement and we teach the next generation of practitioners.

We have serious concerns however about the newly proposed amendment to Health Legislation (Midwives and Nurse Practitioners) Bill and the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill as it effects our profession in several important ways.

Substantive problems

A If midwives are required by Commonwealth law to have "collaborative arrangements" with "one or more medical practitioners" before their services are eligible for Medicare rebates, this can effectively institute medical control over individual women's access to Medicare funded midwifery care.

B If midwives are required by Commonwealth law to have "collaborative arrangements" with "one or more medical practitioners" before being eligible for Commonwealth-subsidised professional indemnity insurance (PII); doctors could unilaterally withdraw from collaborative agreements with a midwife. This would mean the midwife was uninsured, and legally unable to practise in a private professional capacity. This could also leave a woman without her known and chosen carer in the middle of pregnancy.

C No current published research supports an arrangement where a medical doctor has the power of veto over the regulated professional practise of a midwife. Doctors, who are trained in a different skill-set, do not have the expertise to safely control midwifery practice.

D We acknowledge the necessity for regulation to maintain safety and standards, however we fail to see how the amendment can provide a net public benefit. The amendment introduces another level of regulation of the profession of midwifery which is unprecedented nationally or internationally. This move contravenes the international definition of the midwife approved by the International Confederation of Midwives, the International Confederation of Gynaecologists and Obstetricians and accepted by the World Health Organisation.

> *"A Midwife is a person who having been regularly admitted to a midwifery education program, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour, and post-partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant.*
>
> *This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the woman, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, health units, clinics, domiciliary conditions or in any other service".* [1]

E International evidence and research data supports midwives working in collaboration with health systems, with medical practitioners and with women themselves. Midwifery care has received the highest scientific endorsement in the past year, with a Cochrane systematic review[2] of eleven randomised controlled trials involving over 12,000 women from around the world demonstrating that outcomes for women receiving continuity of care from known midwives were better than for women who received fragmented care from multiple midwives and doctors.

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[1] *International Confederation of Midwives Definition of the Midwife,adopted by the International Confederation of Midwives, Council Meeting, 19th July, 2005, Brisbane, Australia*

[2] Hatem M, Sandall J, Devane D, Soltani H, Gates S. Midwife-led versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub2.

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F The amendment ignores and throws out advice provided by high level technical working groups drawn together to provide expert advice to the Commonwealth Department of Health & Ageing on Medicare eligibility and access to the MBS for participating midwives. This expert group contributed valuable information around regulatory criteria to be developed through the new National Registration and Accreditation Scheme. All stakeholders in the maternity service contributed to these technical workshops.

G The amendment denies the highly significant consultation process being led by the NHMRC Maternity Collaboration Project Reference Group to which each profession has contributed in good faith. The NHMRC is developing formal guidance to establish and maintain evidence based arrangements for maternity care across the antenatal, birthing and postnatal services by eligible midwives and other members of the maternity care team.

H While restrictions imposed by legislation are not within the power of the Trade Practices Act, we believe the amendment encourages restrictive practices which contravene the anticompetitive working relationships in Australia. Midwifery is a profession and as such has its own standards, guidelines and codes of practice. These ensure the safety of care provided by midwives in any setting.

I 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. A legal commitment preventing midwives from working in competition with doctors negates opportunities for mutuality and collaboration.

J If midwives are required to form collaborative agreements with individual doctors rather than area health services in rural and remote Australia; the reforms will be unworkable. Sometimes there is no doctor available within hundreds of kilometres, and those available are often locums who change frequently. This makes collaboration with a single doctor impossible. Improving access for these women was a key platform of the maternity reforms and may now not be realized. It is unclear whether a hospital, health service district or authority may be included within the definition of “one or more medical practitioners”, but it appears unlikely.

K Well supported homebirth midwifery care has already been marginalised and the proposed amendments are likely to outlaw homebirth. Driving unregulated home birth underground could result in potentially catastrophic covert practices where women will not be able to access the care of a registered midwife. Many women will be frightened to obtain hospital care, should this be necessary, because of fear of retribution. We are aware that this has already occurred in the Northern Territory when the Health Practitioners Act restricted practice to practitioners holding insurance. To prevent this NT government established a publicly funded Homebirth Service. Previously obstetricians in Darwin refused to collaborate with homebirth midwives.

Outside the geographical areas covered by the Homebirth Service, women were unable to be attended at home by a midwife and chose to 'free birth', that is birth without qualified attendance. We are aware of at least one woman who almost died from a post partum haemorrhage following a 'free birth'.

In Summary

It appears that the powerful vested interests of one professional, unionised group has the potential to completely derail the governments long awaited maternity reforms. The amendment gives one group of medical practitioners, without specialised skills or knowledge of the field, control over the registration status of midwives. This is despite midwifery being a discrete, separately regulated profession. Additionally the medical professional organisations could set guidelines for collaborative arrangements, potentially forming defacto regulatory standards for midwives. The medical profession has not had that right in Australia for nurses or midwives since prior to the Second World War.

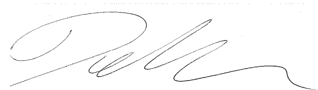
This move, i.e. midwives being forced to enter into a legal and binding association with a privately practicing medical practitioner as a prerequisite to being able to access indemnity and meet their national registration requirements, creates a real risk that qualified, competent midwives will lose their licence to practise. This is at a time when we have acute shortages of qualified midwives in many areas of Australia. This is contrary to the spirit of the reform that has been articulated in recent statements from government; that is to build collaboration across maternity systems and providers. In conclusion this is likely to further reduce access to optimal or even safe care for women and families who are currently disadvantaged and for whom recent reforms offer most promise.

We urge the inquiry to reconsider the amendment in the interests of achieving the long anticipated reforms to Australian maternity services and safer better quality systems of care for women and their families.

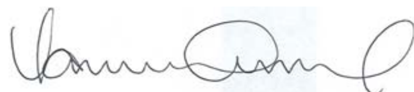
Sally K Tracy

Professor Sally K Tracy, University of Sydney

Professor Lesley Barclay, University of Sydney



Associate Professor Hannah Dahlen, University of Western Sydney



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Professor Sue Kildea, Australian Catholic University

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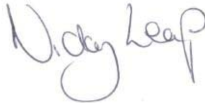

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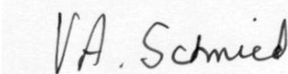

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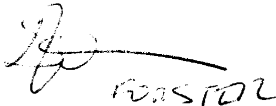

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