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8 December 2009

The Secretary
Senate Community Affairs Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Sirs

SUBMISSION TO THE SENATE COMMUNITY AFFAIRS COMMITTEE – Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills

Childbirth Australia is a not-for-profit organization that advocates for birthing women and their families.

Childbirth Australia wishes to make the following comments with regard to the proposed amendments to the legislation referred to above, particularly as it impacts on women and their families accessing maternity services.

While we take the view that the proposed amendments were not intended to restrict the practice of midwives, we believe that an unintended consequence of the proposed amendments is that that they have the potential to restrict the practice of a midwife wishing to provide care and subject to this legislation.

We understand that this proposed legislation will require midwives to provide a service "*...in a collaborative arrangement or collaborative arrangements of a kind or kinds specified in the regulations, with one or more medical practitioners of a kind or kinds specified in the regulations..*"

Childbirth Australia believes that all midwives should work in collaboration with other health professionals. Furthermore, the Australian Nursing and Midwifery Council (in their Competency Standards for Midwives) states that:

> "*When women or babies have complex needs and require referral, the graduate midwife will provide midwifery care in collaboration with other health professionals.*"

There would therefore appear to be no further need to legislate for this requirement as midwives already collaborate when required.

The implications behind this requirement are that midwives are not capable of providing maternity care to women without the oversight of another health professional: the medical practitioner. This is simply incorrect. Women choose the care of a midwife as

their lead carer because they understand that midwives are trained to provide this care appropriately and will refer to other health professionals as and when required.

By imposing on midwives a legislative requirement to collaborate with a certain cohort of health professionals – in this case "medical practitioners of a kind or kinds" – there appears to be an unnecessary and onerous restriction on the midwife's practice.

Indeed, where the "medical practitioner" is in direct competition for a women's services such as that of a GP or obstetrician, Childbirth Australia believe that there is a significant risk that this could provide opportunities for anticompetitive practices.

A consequence of this is that women may be denied further choice if midwives cannot access the services of a privately-practicing midwife because midwives in the locality cannot find relevant medical practitioners with whom to enter into the relative collaborative arrangement.

Collaboration is very much a 'two-way' process. We note that there is no requirement for medical practitioners to collaborate with other healthcare professionals, nor is there requirement for other health professionals such as dentists, podiatrists, physiotherapists and so on to collaborate with medical practitioners: there is an understanding that each is an autonomous practitioner that should not be regulated by another profession.

Research supports the delivery of healthcare within collaborative settings and it has been shown to improve outcomes (United Kingdom Department of Health (2009)). Anecdotally, women report benefits from receiving maternity care in a collaborative way: one that delivers seamless and appropriate care with their choices, wishes and views at the centre of the process. Where health professionals display a lack mutual respect for each other's skills and expertise, then care appears fragmented and women report dissatisfaction with their care.

However, legislating for collaboration will not necessarily enable the appropriate outcomes: collaboration requires specific frameworks and elements in which to work.

A Canadian Study on collaboration in healthcare (Way D. Et al, 2001) identified seven key elements to good collaborative practice in healthcare:

- Responsibility & Accountability;
- Coordination;
- Communication;
- Assertiveness;
- Autonomy; and
- Mutual Trust and Respect

Legislating for a collaborative framework will not necessarily mean that these elements would be in place. Furthermore, it could be argued that by imposing a requirement through legislation this could hamper development of true collaborative practices by imposing a hierarchical paradigm. Far better that collaborative arrangements be encouraged and supported through appropriate financial and other support such as training etc. rather than imposing this on one cohort of health professionals. Mutual trust and respect could be facilitated by a clear definition of the roles and responsibilities of each health professional. This could be addressed through training and open dialogue.

There would appear some disincentives and/or obstacles to the collaborative arrangements suggested by the proposed amendments. For an obstetrician with a full caseload of women in their care, there is no incentive to take on an additional support/collaborative role with midwives, requiring obstetricians to set aside more 'on call' time and so on. Financial incentives could potentially be used to resolve this issue.

In many areas obstetric care is provided by locums. As such, there is no named medical practitioner with which to have any collaborative arrangements.

Of some further concern is the link between the requirement for PI cover and registration as a midwife. Access to PI cover will be (through the proposed legislation) contingent on these collaborative arrangements. In turn, registration will be contingent on having PI cover through the new Registration and Accreditation legislation. Thus, the ability to register as a midwife will be contingent on the midwife have a collaborative arrangement and – by extension – the goodwill of a medical practitioner. It is untenable that a midwife should have their ability to register (having been duly trained and deemed competent) determined by another health professional. Rather, a midwife's access to PI cover should be determined by their registration.

All of the above impacts on the availability of midwives to practice privately and thus reduces the ability of women to access this type of care.

We therefore request that:

- the legislation be amended to remove this requirement;
- in the event that this is required, then midwives should be able to have suitable arrangements with institutions such as hospitals;
- all healthcare professionals be encouraged to enter into collaborative arrangements through appropriate work place arrangements, support, and education;
- incentives for health professionals to have collaborative arrangemenst be considered. These may be, for example, financial incentives to counter any financial disincentives to these arrangements.

We would welcome the opportunity to discuss this further should the Committee feels it appropriate.

For and on Behalf of
CHILDBIRTH AUSTRALIA, INC.

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References

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