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To: Community Affairs Legislation Committee

Re: *Health Legislation Amendment (Midwives & Nurse Practitioners Bill 2009)*
The Midwife Professional Indemnity (Runoff Cover Support Payment) Bill 2009
Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is the medical specialty body responsible for the training, assessment, accreditation and reaccreditation of the specialist obstetric and gynaecological workforce in Australia and New Zealand. Since the announcement of the Maternity Services Review by the Health Minister, the Hon. Nicola Roxon, RANZCOG has been actively involved in discussion with Government and other interested stakeholders in the development of changes to the way maternity services are delivered in Australia.

Australia has a safe system of maternity care, and any changes made to the way care is delivered should not have a negative impact on that safety record. That is not to say that the system cannot be improved in various ways, and RANZCOG is committed to working with other professional groups and Government to institute changes in the delivery of maternity care to promote inter-professional collaboration, provide women with increased choice in their care providers, promote continuity of care, promote better perinatal outcomes for mothers and babies and to improve postnatal care.

Since the introduction of the above Bills into the House of Representatives in June 2009, RANZCOG has been involved in various discussion groups, to develop systems of care that will carry out the intent of the above legislation. Given the scope of the changes, and the number of different stakeholder groups who have an interest in the outcome of the Government's proposed changes, there have been predictable objections from different professional groups and consumers about the intent and scope of the legislation. This has been particularly highlighted by the vocal protests over the Government's decision not to fund home birth as part of its Maternity Services reform. RANZCOG strongly supports this Government decision. In this submission, there will be no further mention of Home Birth, as it is outside the scope of the legislation.

The Senate Community Affairs Legislation Committee has outlined some terms of reference for responses, and this document will be consider each of those points.

1. **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 practice.**

   The professional regulation of Midwifery will be carried out by the National Nursing and Midwifery Board. This Board has been convened following the Government's National Registration and Accreditation Scheme for all health professionals. The medical profession, in particular the obstetric and gynaecological part of it, thus has no power to provide professional regulation of midwifery. As part of the Maternity reforms, there will be a class of midwife who will be deemed 'eligible'. These 'eligible' Midwives will be certified and granted practice rights by the Nursing and Midwifery Board, and doctors will have no control over the credentialing of those midwives, though through the committee work that has underpinned the maternity changes, RANZCOG has offered opinions on which midwives, by dint of their training and scope of practice, might be deemed 'eligible'.

   Presumably, there will be a process that eligible midwives will have to go through to renew their licence to practice. This should include Continuing Professional Development (CPD), in particular, practice review, and regular inter-professional audit of outcomes. Whether the individual midwife's licence to practice was renewed would be a matter for the Nursing and Midwifery Board only.

2. **Whether the Government's amendments' influence on the health care market will be competitive.**

   Eligible midwives will have access to the Medicare Benefits Schedule (MBS), if they are involved in collaborative models of maternity care. This means that for the midwife to access MBS Benefits, he/she will have to have an agreement with a medical practitioner to provide backup care, in the event that the pregnant woman under the midwife's care requires a more sophisticated level of care than that which can be provided by the midwife. RANZCOG strongly supports the Government's insistence on midwives having collaborative arrangements with obstetricians, whether specialist obstetricians or general practitioner obstetricians.

   The reason for this is that doctors are keen to avoid the sort of fragmented care that often occurs when a pregnant woman, cared for by a midwife, is taken to a hospital when problems arise in labour. When she arrives there, often a poor clinical handover is made, and the pregnant woman is then cared for by people with whom she has never met, has no rapport with, and has had no opportunity to discuss different aspects of her pregnancy and labour management with them. This often leads to dissatisfaction with care, higher intervention rates and complaints.

   RANZCOG takes the view that it is essential that women, as far as possible, should have known maternity carers, or have, at least, had the opportunity to speak to medical staff in hospital who may be involved in their care, should it be required.

   It is important to realise that assessment of risk in maternity care is a flawed concept. As many as 40% of women who are judged 'low risk' in the early part of pregnancy will need obstetric care in later pregnancy, and in some studies, as many as 50-60% of women are transferred out of 'lower risk' birth centres to mainstream labour wards, because of problems that have arisen.

   Midwives are trained to care for pregnant women through the continuum of pregnancy, and bring essential skills to maternity care. Requiring a midwife to collaborate with a medical practitioner during pregnancy should not be considered anticompetitive, as it is clear that this system of care will ensure that pregnant women can have the opportunity to discuss various risks which may emerge during their pregnancy or labour with an

Obstetrician, and can have the opportunity of having a known medical carer, if she requires transfer from midwifery care. Midwives put great store on having known carers, and it is surprising that they would wish to deny women the opportunity to have a known medical carer as part of the maternity care team.

Maternity care is all about trying to meet an individual pregnant woman's needs, but it principally has to be focused on maternity care outcomes. Current evidence would suggest that the best systems of care involve different professionals collaborating to bring about the best possible outcome for the woman. There should be no place for independent practice within any professional group, and denial of independent practice in the interests of patient safety should not be confused with anticompetitive behaviour.

3. Whether the Government's amendments will create difficulties in delivering intended access and choice for Australian women.

Despite all the discussion that has occurred since the release of the Maternity Services Report, it is still not clear what insurance status a pregnant woman would have if she is cared for by an eligible midwife in the community, and is then taken into a Public Hospital when she is in labour. According to the Medicare Access Agreements for doctors, people having known carers in hospitals are regarded as private patients, which means that they will incur a facility charge while having that particular known carer. A number of women who will be cared for by eligible midwives will have no private health insurance, and will be unable to pay a facility charge for their Public Hospital bed. Thus, their continuity of care with a midwife will be interrupted, unless the eligible midwife is credentialed to work at that particular hospital. This needs urgent clarification from the different jurisdictions.

There have been complaints by midwife and consumer groups that midwives may be not able to practice because they will be unable to obtain a collaborative agreement with an Obstetrician or with a Pubic Hospital Obstetric Service. RANZCOG does not share this view, and in anecdotal discussions with RANZCOG Fellows, most have indicated a willingness to collaborate with eligible midwives, under agreed policies and protocols of care. It seems to RANZCOG that there is some scaremongering in this area, and RANZCOG is of the view that it is up to individual midwives and Obstetricians to work together in sorting out their differences and providing appropriate care for pregnant women.

4. Why the Government's amendments require "collaborative arrangements" that do not specifically include maternity service providers including hospitals.

RANZCOG is keen that collaboration occurs between Health Professionals. It has concerns that if collaborative arrangements are made with hospitals rather than individual doctors, there will be lost opportunities for collaboration, and it will be difficult to document and verify that appropriate collaboration has taken place between midwives and Obstetricians. This will clearly have an impact on the midwives' ability to access MBS payments, and just as clearly, potentially could have a deleterious effect on pregnancy outcome, if necessary collaboration and/or referral did not take place. A collaborative arrangement should require that the various professionals involved in a woman's maternity care discuss each case from time to time, or as often as required. Having an arrangement with a hospital only, and not a known provider will inevitably lead to the sort of fragmented care that the maternity reforms are designed to minimize.

RANZCOG is aware that in a small number of Rural Maternity Units, it may not be possible to collaborate with an individual doctor because of turnovers in staff. It would be then incumbent on those Maternity Care Providers to meet and work out an equitable arrangement that does not compromise safety.

5. Whether the Government's amendments will have a negative impact on safety and continuity of care for Australian mothers.

RANZCOG is firmly of the view that the proposed changes will have a positive impact on safety and continuity of care, provided that the focus on collaborative care continues. Many countries have a proud tradition of midwives and obstetricians working together, for example, Canada and the United Kingdom, and this should remain the focus of the proposed reforms, which will cater for the overwhelming majority (> 99%) of Australian women who have their babies in public or private hospitals.

Given the proposed changes, it is imperative that there is adequate funding of maternal and perinatal data collection, with funding provided to capture maternal and perinatal mortality and morbidity statistics, and to allow audit of different models of maternity care, to ensure that Australia's enviable safe maternity care system is indeed improved and enhanced by the proposed reforms.

Dr Ted Weaver
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