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Mr Elton Humphery
Committee Secretary
Senate Standing Committee on Community Affairs
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PARLIAMENT HOUSE
CANBERRA ACT 2600
By email: community.affairs.sen@aph.gov.au

Dear Mr Humphery

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

Thank you for the invitation to provide a submission to the above inquiry, which will look at the Government's proposed amendments to the above Bill seeking to clarify the requirement for midwives and nurse practitioners to work in collaboration with medical practitioners. I would emphasise from the outset that the AMA fully supports these amendments.

Background and History

Government

The Minister's second reading speech for these Bills clearly confirms that the government's intention through this legislation is to "*support greater choice and access to health services*" through reforms designed to "*complement and boost the work performed by our doctors and specialists* ***as part of a collaborative, team based environment***".

In her second reading speech, the Minister also reinforced this objective, stating that "*nurse practitioners and midwives wishing to provide treatment or prescribe under the new Medicare and Pharmaceutical Benefits Scheme arrangements will need to* ***demonstrate that they have collaborative arrangements in place****, including appropriate referral pathways with hospitals and doctors to ensure that patients receive coordinated care and the appropriate expertise and treatment as the clinical need arises*".

She further emphasised this later in the speech when she stated that "*new Medicare items for services provided by participating nurse practitioners and participating midwives* ***working collaboratively with doctors*** *will be created*" and specifically indicating that "*for participating midwives, this will include antenatal, birthing and postnatal care and* ***collaborative care arrangements between these midwives and obstetricians or GP obstetricians***".

Further to this, on 5 November 2009, the Minister for Health and Ageing, in announcing the government's intention to move amendments to these Bills while they

are being considered in Parliament, issued a press release highlighting the government's original intention to have the new arrangements supported by clear and robust collaborative care arrangements. In this press release the Minister said that these amendments "*make clear in the legislation something that was articulated both on introduction of the Bill to Parliament and in the explanatory material tabled at that time*". She further stated that the amendment will "***simply clarify in legislation that collaborative arrangements with medical practitioners will be required to access the new arrangements***" and that this will " *ensure these new opportunities for nurses and midwives are implemented in an integrated fashion for the benefit of patients*".

Relevant views in other recent major health reform reports

The government's intention to have transparent and meaningful collaborative arrangements between midwives and nurse practitioners and medical practitioners underpinning the new funding arrangements for MBS and PBS is in line with the three most recent and relevant health review reports that have examined the role of midwives and nurse practitioners and possible government funding to cover the services they provide. The views expressed in each of these reviews are consistent with the government's stated intention to have funding underpinned by meaningful collaborative care arrangements. They are set out below.

1. The National Health and Hospital Reform Commission (NHHRC) recommended that "*the Medicare Benefits Schedule should apply to specified activities performed by a nurse practitioner, midwife or other competent health professional, credentialed for defined scopes of practice, and* ***where collaborative team models of care with a general practitioner, specialist or obstetrician are demonstrated***".[1]

2. The recent report on Primary Health Care Reform in Australia stated that "*research indicates that a healthcare system that supports effective teamwork can improve the quality of patient care, enhance patient safety, and reduce workload issues that cause burnout among healthcare professionals. Evidence shows that for teams to work most effectively, they need to have a* ***clear purpose; good communication; co-ordination; protocols and procedures; and effective mechanisms to resolve conflict when it arises***"[2]

   It also noted that "*the recent Budget decision to provide access to the MBS and PBS to nurse practitioners working in primary health care, and advanced midwives providing care from November 2010, provides opportunities for new models of care to develop* ***in collaborative partnerships***".[3]

3. The Report of the Maternity Services Review noted that, in its extensive consultations, "*a key area of consensus was that maternity care should be*

[1] National Health and Hospitals Reform Commission. A Healthier Future for all Australians. Final Report June 2009. Commonwealth of Australia 2009. Recommendation 99.
[2] Primary Health Care Reform in Australia. Report to Support Australia's First National Primary Health Care Strategy. Commonwealth of Australia 2009. Page 124
[3] Ibid. Page 123.

> *multidisciplinary and involve* ***a collaborative, team-based approach***".[4] The report also clearly stated that "*changes to Commonwealth funding arrangements could support the expansion of collaborative models of care, with an expanded role for midwives. Any new Commonwealth funding arrangements would need to be* ***carefully considered to ensure an expanded role of midwives occurred within collaborative, multidisciplinary maternity care models and maintained appropriate quality and safety***".[5]

The review's final recommendation to government on this issue was that "*the Australian Government gives consideration to arrangements, including MBS and PBS access, that could support an expanded role for appropriately qualified and skilled midwives,* ***within collaborative team-based models***".[6]

View of the AMA

The Australian Medical Association, in previous submissions to this senate committee on these Bills, as well as in public statements and input to government consultation processes, has always stated that any expansion of government funding for services provided by nurse practitioners and midwives, and indeed any other allied health providers, needs to be underpinned by robust, clear and agreed collaborative arrangements between those health professionals and medical practitioners to support the quality, safety and continuity of patient care.

Meaningful collaboration is a fundamental factor that will determine whether or not this policy initiative addresses unmet community needs or simply fragments the delivery of health care. This is well recognised in the health care sector, including by the Australian Commission on Safety and Quality in Healthcare which has included in its draft National Safety and Quality Healthcare Standards (November 2009) an accreditation requirement that a health service organisation provide evidence that the roles, responsibilities and accountabilities for medication management at any level have been defined and assigned to the appropriate health care providers.

In the absence of meaningful collaboration, there are a number of inherent risks to patient care including:

- The potential to detract from safe care via fragmentation by excluding or limiting General Practitioners and other medical specialists from the coordination and/or delivery of patient care,
- Increased risk of misdiagnosis and missed diagnosis,
- The potential for care to become increasingly fragmented via poorer relational and record based continuity of care,
- The increased risk of adverse outcomes from the interaction of different medications and treatments due to fragmentation,

[4] Improving Maternity Services in Australia. Report of the Maternity Services Review. February 2009. Commonwealth of Australia 2009. Page 18
[5] Ibid. Page 52
[6] Ibid. Recommendation 17.

- Increased cost to the health system because of extra tests being ordered and inappropriate referrals,
- Medical intervention being called for at the last minute when things go wrong, and,
- Communication between health professionals breaks down and professional silos worsen.

These risks need to be addressed by ensuring these Bills require collaborative arrangements that are based on best practice standards of medical care.

Patients enjoy better health outcomes when they are treated in a model of care that provides coordinated, continuous and comprehensive patient-centred care – delivered by appropriately trained health professionals.

Recognising this, in the recent past when new funding arrangements have been introduced to expand access to other primary health care services (eg MBS rebates for allied health services), they have been largely implemented within a framework that acknowledges the role of the patient's usual general practitioner. This acknowledges the internationally proven benefits of such an arrangement.

This type of approach still makes eminent sense. These Bills should therefore 'hardwire' the role of general practitioners and other medical specialists in the patient's care and ensure that meaningful collaboration between doctors, midwives and nurse practitioners always occurs in the out-of-hospital setting as it already does in the hospital setting.

Here we use the word "meaningful" in a very deliberate way. A framework, for example, where a midwife or nurse practitioner could simply reach an arrangement to refer patients who are difficult to treat to the local emergency department or have a generic arrangement to refer patients to the "local public hospital obstetrics unit", with the manager of a hospital, a non-medical representative or administrator representing an institution, or a representative from some regulatory body would not be sufficient. This would not address concerns around fragmentation of care and it would inevitably lead to an increased and unplanned load on the other specialists and the hospital sector.

In summary, in the interests of the patient, a collaborative care agreement must be between health professionals who are or may be called on to care for the patient.

It is our understanding that the Government's proposed amendments to these Bills seek to do just this and we therefore fully support these amendments.

Specific comments on terms of reference

(a) 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;

In respect of registration requirements, midwives' and nurse practitioners' licence to practice is currently determined by state registration boards. Neither the current state medical registration boards, individual professional medical organisations nor individual medical practitioners have any involvement in this process. Further, the

AMA is not aware of any proposed new registration standards being considered by the new Nursing and Midwifery Board of Australia that would formally introduce any involvement of the medical profession generally or any individual medical practitioner or professional medical organisation into the registration decisions made in respect of individual midwives or nurse practitioners in the future under the National Registration and Accreditation Scheme. There is therefore no basis to claim that any arrangements or requirements set out in these Bills (and the government's proposed amendments to these Bills) would allow doctors to interfere with the registration board processes to issue and renew licences to practice.

In respect of professional indemnity cover, there are two factors that need to be taken into account.

Firstly, the Report of the Maternity Services Review clearly recommended that the Commonwealth should "*give support to ensure that suitable professional indemnity insurance is available for appropriately qualified and skilled midwives operating in collaborative team-based models*".[7] Consistent with the Review's recommendation, for those midwives who wish to avail themselves of the government's new subsidised professional indemnity cover for midwives, these Bills (and the government's proposed amendments to these Bills) anticipate that the contract of insurance for this cover will stipulate that the policy will cover care provided by midwives working in collaboration with a medical practitioner or medical practitioners.

Secondly, for registered health professionals, it will be a requirement under the National Registration and Accreditation Scheme for individuals to have professional indemnity cover appropriate to the scope of services being provided in order to gain registration. However, Health Ministers have explicitly agreed to include a transition clause in the National Registration and Accreditation Scheme legislation that provides a two-year exemption (until June 2012) from holding indemnity insurance for those privately practising midwives who are unable to obtain professional indemnity insurance for attending a homebirth.

Regardless of whether these Bills are passed or not, the final decision about individual midwives' renewal of licence to practice will continue to rest with the Nursing and Midwifery Board of Australia and the outcome of any further decision that Governments might take after June 2012 in relation to the National Registration and Accreditation Scheme professional indemnity requirements for midwives.

(b) whether the Government's amendments' influence on the health care market will be anti-competitive;

A measure might be considered anti-competitive if it:
(i) reduces the supply of persons providing a service;
(ii) restricts the trade of a particular provider of a service; or
(iii) forces a party to deal with a specified third party.

[7] Ibid. Recommendation 18.

In general, the AMA sees the introduction of the notion of competition between doctors and midwives or nurse practitioners as problematic. If collaborative care is accepted as the basis of safety and quality in maternity care, then it is unhelpful in the extreme to suggest that midwives or nurse practitioners and doctors will be competing with each other. If this notion is accepted by midwives or nurse practitioners and doctors, then true clinical collaboration is essentially dead. If a commercial imperative is placed at the centre of this issue, why would one collaborate with one's competitor, except according to an agreed collaborative arrangement which is in the commercial interests of both parties?

The AMA therefore prefers to reinforce the notion of collaboration as an essential responsibility of doctors and midwives or nurse practitioners, to ensure safety and quality in multidisciplinary maternity care, and strongly cautions against the adoption of a presumption of competition rather than clinical collaboration.

In specifically addressing term of reference (b) above the AMA makes the following comments.

In relation to *(i) reduces the supply of persons providing a service* – there are no provisions in this Bill that regulate to limit the individual nurse practitioner or midwife's right to practice. The regulation of the supply of persons providing midwifery or nurse practitioner services, occurs at state level by state registration boards (by virtue of health profession registration rules and processes) and other state government regulations.

It is also important to note that these existing state-based regulatory arrangements, which are the gateway into practice in each jurisdiction for nurse practitioners and midwives, apply similarly to the medical profession. There is an even more comprehensive range of regulations, registration, other practice requirements and credentialing arrangements in each jurisdiction in order for medical practitioners to practice in the public and private sectors.

In relation to *(ii) restricts the trade of a particular provider of a services* – these Bills qualify nurse practitioner and midwife services to be reimbursed under the MBS and PBS under certain criteria that the Federal Government is specifying. This is no different to the raft of criteria and conditions that medical practitioners must comply with for their services to be reimbursed under MBS and PBS subsidy arrangements e.g. requirements for credentials and training to be endorsed by Medicare Australia in order for a practitioner's services to be able to claimed under the MBS, the need to be working in an accredited practice to claim certain MBS items, requirements to comply with comprehensive government-prescribed lists of clinical activities to benefits to be paid for certain items.

However, these Bills are not restricting or limiting the circumstances in which nurse practitioners and midwives can actually provide private health care services in the market i.e. these amendments do not impact in any way on nurse practitioners' or midwives' ability to practise in the private sector per se.

As stated above, it is the authority provided under professional registration arrangements (currently determined in each state and territory by individual nursing and

midwifery boards) and, in the case of prescribing of medications, by state government regulations about the supply and prescribing of scheduled medicines, that enable these health practitioners to legally practise in the private and public sectors in each jurisdiction.

In the case of prescribing, already these state regulations impose requirements, rules and limits on what medications can be supplied and prescribed by nurse practitioners and midwives. To our knowledge, these have never been claimed to be "anti-competitive" nor challenged in terms of inappropriate restriction of trade in some way. And, there has been no evidence to suggest that the services provided by nurse practitioners or midwives have been restricted in an anti-competitive way by medical practitioners in the past or will be in the future under the proposed new arrangements set out in these Bills and the accompanying proposed amendments.

In contrast, these Bills introduce requirements for the reimbursement to patients under the MBS and PBS but do not stop any practitioner from practising in the private market. They merely seek to recognise the capacity of nurse practitioners and midwives to practice privately that already exists (through the state-based arrangements outlined above) and to determine, where appropriate, under what circumstances these arrangements will be recognised for the purposes of MBS and PBS reimbursement.

A recent decision by the High Court of Australia in the case of Wong v The Commonwealth of Australia: Selim v Lele, Tan and Rivett Constituting the Professional Services Review Committee No 309 [2009] HCA3 (2 February 2009) in which the high court similarly described the relationship between the requirements under the MBS as set out in the Health Insurance Act 1973 and the practise of medicine by individual medical practitioners.

In this case, the High Court concluded that the requirements under the MBS, as set out in the Health Insurance Act don't impose either a legal or a practical compulsion "to perform particular medical ... services, or to perform medical ... services at a particular place". That is, requirements for MBS reimbursement do not compel or require a doctor in any way, nor do they restrict the provision of health care in any way, they are merely requirements that need to be met in order for the patient to receive government funding for these services.

Similarly, it cannot be argued that any new requirements imposed by the government for MBS reimbursement for services provided by nurse practitioners or midwives will compel or restrict their ability to provide health care.

In relation to *(iii) forces a party to deal with a specified third party* – the AMA believes that a meaningful collaborative care arrangement should be between health professionals and ideally, in the interests of patient care and safety, with the patient's usual treating GP in the case of nurse practitioners or an agreed obstetrician or GP obstetrician in the case of midwives.

However, we note that the government's proposed amendments to these Bills have been drafted to enable the government to specify the "kind of medical practitioner" that must be involved in collaborative arrangements allowing a fair degree of flexibility in terms of the definition of an acceptable "kind of medical practitioner".

From the AMA's perspective, our advocacy for collaborative care arrangements is based on the need to ensure continuity of care for patients. Therefore the participation by the medical profession can reasonably be assumed to be based on what will be in the patient's best interest, consistent with the ethical framework that doctors work under.

However, we accept that there are some circumstances where the patient doesn't want, doesn't have or can't have a usual GP. In these situations we believe that the patient should be able to dictate that the agreement could be with another doctor nominated by the patient – so long as the patient agrees and that there is meaningful collaboration between health professionals.

As that the final decision about who the collaborating doctor would be will lie with the patient, and not any individual doctor, there can be no reasonable basis for claiming that this would introduce anti-competitive arrangements between health professionals.

In summary, given the analysis of *(i)-(iii)* above, we do not consider that there is any basis to claim that the government's amendments will be anti-competitive in any way.

(c) whether the Government's amendments will create difficulties in delivering intended access and choice for Australian women;

These Bills and the government's proposed amendments to these Bills do not impact on patients' ability to access services provided privately by nurse practitioners and midwives. These services can currently be provided in the private sector by registered practitioners and will still be able to be provided by registered practitioners in the same way after the commencement of this legislation.

However, as stated by the government at the time the measures were announced, and reinforced when these Bills were introduced, while not changing patients' ability to access these services, these Bills do support *greater* choice and access to health services by providing *additional* financial reimbursement for services that are not currently subsidised under the MBS or the PBS. These Bills ensure that this reimbursement is provided in appropriate circumstances in accordance with the principles of safety, continuity of care and collaboration.

Therefore, while the Bills do not have a prima facie impact on access to services, they do introduce *additional* reimbursement arrangements for patients – clearly expanding existing access options, not limiting them. This is further reinforced in the Minister's second reading speech for these Bills that stated "the Rudd government is implementing these reforms for a simple reason. We want to *expand the level of health services, and access to health services,* in the community" (second reading speech of the Bills, Hansard 24 June 2009, p. 6951).

(d) why the Government's amendments require 'collaborative arrangements' that do not specifically include maternity service providers including hospitals;

As stated above, these Bills introduce additional MBS and PBS reimbursement for patients, with requirements in respect of collaborative arrangements to protect safety, quality and continuity of care. These requirements are entirely consistent with the

recommendations made by the three expert reviews and reform reports that have been recently been provided to government, previously mentioned.

In order to appropriately support the quality, safety and continuity of patient care, it is imperative that collaborative agreements are between the health professionals who are involved in patient care – those health professionals who are in a position to consider the actual clinical needs of the patient – not generic agreements with institutions or administrators or regulatory bodies who are not in a position to consider the clinical evidence and best practice and needs and circumstances of individual patients. The AMA is therefore strongly of the view that it is unacceptable to have collaborative care agreements with "institutions" or non-clinicians representing institutions. *Meaningful collaborative care arrangements need to be between health professionals.*

For example it would be acceptable for an individual medical practitioner who might be the lead clinician in a maternity unit of a hospital to enter into a collaborative care agreement with a midwife on behalf of the other clinicians working in the hospital maternity unit. We note that the wording of the government's proposed amendment to these Bills, which allows the government to define the "kind of medical practitioner" with whom a nurse practitioner or midwife should collaborate, would allow this scenario to be included as an acceptable collaborative arrangement.

However in our view, it would *not* be acceptable for a collaborative agreement to be with a non-clinician or administrative representative of the hospital because such a person would clearly not have the clinical skills and expertise to ensure that the agreement was clinically appropriate and able to be followed by other medical practitioners working in the hospital maternity unit concerned.

This is entirely consistent with existing clinical collaboration that already takes place extensively in the hospital setting and occurs between health professionals, not between one a health professional and a hospital administrator.

(e) whether the Government's amendments will have a negative impact on safety and continuity of care for Australian mothers

It is worthwhile noting that midwives are currently able to provide primary care services for women during uncomplicated pregnancy and birth and in the postnatal period. However, in the event of the emergence of complications or risk factors, it becomes necessary for midwives to consult with and/or refer patients to doctors. It is obvious that such an arrangement needs to be well thought-out and established in advance, rather than having no agreed plan, or one arrived at in haste at the time that problem(s) occur. The requirement to establish collaborative care agreements as a prerequisite for eligible midwife practice underpins the necessity of such arrangements and provides a platform for prospective, rather than reactive, planning in the interest of safety and continuity of care.

Therefore, the AMA does *not* consider that the Government's amendments will have a negative impact on the safety and continuity of care, rather the opposite. As the reports cited above clearly indicate (in particular the maternity services review p. 2), collaborative care arrangements, appropriately drawing on the expertise of health professionals, would continue to provide Australian women with safe, high-quality

maternity care but would support an expanded role for appropriately qualified and experienced midwives and increase the range of collaborative models of maternity care available.

It is widely accepted that team based arrangements can improve patient access to primary health care services and, in this regard, doctors have been working effectively with other health care professionals for generations. The Government's amendments clearly support this approach and are sufficiently flexible to allow different team based models to be developed, based on local circumstances and the clinical needs of patients.

Any move to reject or water down the Government's amendments would be at odds with the policy direction being taken in Australia and overseas to embrace team based care arrangements and would only serve to fragment care – which is the enemy of quality care. The AMA believes that the proposed amendments will not only clarify the Government's original policy intent, but that they will also significantly improve the operation of the legislation.

Yours sincerely

Dr Andrew Pesce
President