Homebirth Access SYDNEY

Senator Claire Moore
Chairperson
Senate Standing Committee on Community Affairs
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Dear Senator,

Re: Senate Standing Committee on Community Affairs Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills.

I make the following submission on behalf of Homebirth Access Sydney (HAS) in relation to the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009, the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 and the Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009 together with the Government amendments to the bills circulated on 28 October 2009 as referred by the Senate for Inquiry.

As you may recall, HAS is principally a consumer organisation with a focus on supporting homebirth families and increasing access to birthing choices – in particular homebirth - for women in NSW. HAS was established in the 1970s to provide information and support to people interested in homebirth, including parents, midwives, child birth educators and birth support workers.

HAS currently has a membership of around 400 families and birth professionals. We are one of the very few maternity consumer organisations in Australia with a large and active membership of families in their pregnancy and early parenting years.

HAS values the opportunity to put forward the perspective of maternity consumers in relation to the Government's amendments to this legislation and would be pleased to speak further to the Committee about our concerns.

HAS has previously made the Committee aware of our strong concerns about the impact of these Bills on women in Australia seeking to birth at home with a qualified midwife. These concerns have not yet been addressed.

Committee Reference Considerations
(a) A Medical Veto Over Midwives' Practice and Registration; and
(c) Access and Choice for Australian Women

Our organisation is concerned that the Government's amendments which require midwives to demonstrate 'collaborative arrangements' as a condition of registration and practice, will further restrict access to appropriate, professional midwife led care for Australian mothers.

The consequences for midwives as a profession of these amendments are substantial. HAS is of the view that the amendments will give doctors medical veto over midwives' ability to renew their license to practice and as a result restrict competition in the maternity health care market. Professional midwife

groups are in a better position to address the implications for their profession, however HAS believes it is important to emphasise that it is ultimately consumers who will suffer the consequences through the further restriction of midwife led care in Australia.

It is difficult to understand why the Government has put forward these amendments which will operate against the legislation's stated aim of reforming the provision of maternity services in Australia, and expanding the role of midwives by giving them access to the Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS), and by providing a Commonwealth-supported professional indemnity insurance (PII) scheme for eligible midwives.

The Australian Medical Association and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists have specific policy of not supporting homebirth. It is unrealistic to expect that members of these organisations will readily enter into collaborative arrangements with midwives who provide homebirth services to women.

For example the Government's Maternity Services Review notes:

> General practitioners (GPs), medical specialists and their representative organisations identified their highest priority as that of maintaining Australia's excellent record of safety in maternity care and emphasised the need for specialist expertise within the maternity care team. An issue of concern was the loss of skilled professionals and its impact on the provision of maternity care, most noticeably in rural and remote areas. These professional groups also expressed concern about moves towards homebirthing.[1]

Committee Reference Consideration
(e) Collaboration in the context of Safety and Continuity of Care for Australian Mothers

The opposition of some health professionals to homebirth care goes against the overwhelming weight of international evidence and experience.

Homebirth is a minority choice in Australia, as it is in most jurisdictions of the world. Women choose this for a variety of reasons, including:

- to avoid interventions (such as inductions of labour, episiotomy, epidural, forceps or vacuum extraction of their babies and caesarean section deliveries),
- to have a natural, drug-free birth,
- to birth in an environment where they feel safe,
- to have continuous care from a known midwife during pregnancy, birth and the postnatal period,
- to enable the full participation of the woman's partner and children in the birth,
- because they don't see birth as an illness or hospital as necessary,
- to avoid repetition of previous poor hospital birth experiences, and
- because research supports the safety of birthing at home.

Currently, just over 700 women in Australia plan a homebirth each year. Women who choose homebirth are typically well informed about their options for care, the risks of different models of care, the evidence regarding safety of different birth locations, the possible consequences of their decision and the physical and emotional stages of childbirth. Most homebirth families have back-up plans for transfer to hospital if complications arise during labour.

There is a wealth of international evidence to support the safety of planned, assisted homebirth for women with low risk pregnancies[2].

In a study published in April 2009 in *BJOG: An International Journal Of Obstetrics And Gynaecology* of more than half a million women, researchers found no difference in death or serious illness among either mothers or their babies if they gave birth at home rather than in hospital[3]. This study looked at almost 530,000 low-risk births over seven years in the Netherlands where homebirth rates are close to 30% of all births.

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[1] Australian Government, 2009, *Improving Maternity Services in Australia*: The Report of the Maternity Services Review, p 4.

[2] Ackermann-Leibrich et al (1996); Bastian, Keirse, & Lancaster (1998); Campbell R, Macfarlane A (1994); Chamberlain, Wraight, & Crowley (1997); Crotty, Ramsay, Smart, & Chan (1990); Gulbransen, Hilton, & McKay (1997); Johnson & Daviss (2005); Macfarlane A, McCandlish R, Campbell R. (2000); Murphy & Fullerton (1998), Olsen O. (1997); Wiegers, Keirse, & van der Zee (1996); Woodcock, Read, Moore, Springer NP, Van Weel C (1996); Stanley, & Bower (1990)

[3] A de Jonge, BY van der Goes, ACJ Ravelli, MP Amelink-Verburg, BW Mol, JG Nijhuis, J Bennebroek Gravenhorst, and SE Buitendijk *Perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births* BJOG An International Journal of Obstetrics and Gynaecology RCOG 2009 (15 April)

Treating low-risk birth within a highly medicalised model has seen intervention rates rise rapidly, to approximately 30% caesarean section rates across Australia. This contrasts with a World Health Organization recommended caesarean section rate of 10-15%. Among the homebirth population, the caesarean section rate is much lower, approximately 5% (though reliable data is unavailable). Indeed, reversing the trend to high intervention and medicalised birth models is a driving force behind the Government's proposed reforms to give a greater role to midwives in maternity care.

Planned homebirth for low-risk women using certified professional midwives is clearly associated in international research with significantly lower rates of medical intervention and no higher intrapartum and neonatal mortality than that of low-risk hospital births.[4]

In many countries, homebirth is both legal and publicly funded (for example, New Zealand, the United Kingdom, the Netherlands). Indeed, some countries actively encourage the choice to birth at home as explicit policy and as a key element of increasing the rate of normal birth (for example, the United Kingdom[5]).

The World Health Organization has stated that:

> The midwife is the most appropriate and cost effective type of health care provider to be assigned the care of normal pregnancy and normal birth, including risk assessment and the recognition of complications.[6]

Furthermore:

> *a woman should give birth in a place she feels is safe, and at the most peripheral level at which appropriate care is feasible and safe* (FIGO 1992). For a low-risk pregnant woman this can be at home, at a small maternity clinic or birth centre in town or perhaps at the maternity unit of a larger hospital. However, it must be a place where all the attention and care are focused on her needs and safety, as close to home and her own culture as possible. If birth does take place at home or in a small peripheral birth centre, contingency plans for access to a properly-staffed referral centre should form part of the antenatal preparations.[7]

Registered midwives use the Referral Guidelines[8] of the Australian College of Midwives to support informed decision making by their clients when it may be necessary for the woman or baby to be seen by, or transferred to the care of, other health professionals or facilities such as obstetricians and hospitals.

Placing increasing barriers in the way of midwives attending homebirth will put consumers at grave risk of either choosing to birth without the assistance of any health care professional or receiving sub-standard care.

The Government's Maternity Services Review, published in February 2009 and whose recommendations form the basis of the legislation currently before Parliament, concluded that "...while homebirth is the preferred choice for some women, they represent a very small proportion of the total."[9] Though the number of women birthing at home in Australia is small as a proportion of the total births, it is the role of the Government to ensure that *all* consumers in the health system are provided with appropriate protection, not just the majority.

Birthing at home *without* the attendance of a qualified midwife, known as 'freebirthing', can be extremely dangerous and is not supported by our organisation. The very reason attended homebirth is so safe is the same reason that freebirth is not: a midwife is trained and skilled at detecting complications during labour and either addressing them or transferring her client. At an attended homebirth, the midwife observes the birthing woman in a one-to-one situation (unlike in a hospital, where a midwife cares simultaneously for several labouring women) and can act quickly to address any complications. If it becomes illegal for

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4 See footnote 4.

5 See Royal College of Obstetricians and Gynaecologists, Royal College of Midwives and National Childbirth Trust, 2007, *Making normal birth a reality: Consensus statement from the Maternity Care Working Party our shared views about the need to recognise, facilitate and audit normal birth* and UK Department of Health, 2004, *National Service Framework for Children, Young People and Maternity Services.* London.

6 World Health Organization: Care in Normal Birth, 1996, p 6.

7 World Health Organization: *Care in Normal Birth*, 1996, p 12 (emphasis added). The reference within the quote to 'FIGO 1992' is a reference to the publication: Recommendations accepted by the General Assembly at the XIII World Congress of Gynecology and Obstetrics. *Int J Gynecol Obstet* 1992; 38(Suppl):S79-S80.

8 These can be found at http://www.acmi.org.au/text/ corporate_documents/ref_guidelines.htm

9 Australian Government, 2009,*Improving Maternity Services in Australia*: The Report of the Maternity Services Review, p 20.

midwives to attend homebirths, more women will freebirth and there will be no person present who is trained and skilled at recognising and managing the onset of complications.

This was recognised by NSW coroner Nick Reimer in June 2009, when he handed down findings into the death of a baby born at home. Mr Reimer noted that homebirth was a woman's inherent right and a practice that "will not go away" and urged the Federal and State Health Ministers to exercise "great care" in drafting legislation impacting on homebirth, saying homebirths will be driven underground with "disastrous ramifications"[10].

Sections of the press fail to distinguish between freebirth and professionally attended homebirth, so that the dangers of the former taint the safety of the latter. This distinction, so often blurred, is at the heart of the current legislation, which will not stop homebirth, but will prevent or punish those who undertake homebirth safely. Under these Bills as amended, the safe option of attended homebirth will become increasingly difficult to access and the dangerous option of freebirth will be unintentionally promoted.

Other than through small-scale trials and in limited geographic areas, homebirth has never been publicly funded and widely available in Australia. Despite this, a small minority of women have continued to choose to birth at home. We expect that, if access to homebirth were to be made more difficult through these amendments, the number of women birthing without the presence of a qualified midwife will rise, and their births would become immeasurably riskier.

Committee Reference Consideration

(f) Other related matters: Insurance and Collaboration

The current arrangements with regard to PII act as a further disincentive for doctors to enter into collaborative arrangements with independently practising midwives. As the Committee is well aware, PII is currently not available for private midwife practitioners in Australia.

Pursuant to the PII Bills, the Commonwealth aims to contract with an insurer to provide professional indemnity insurance at an affordable price to eligible midwives and will also require the contracted insurer to develop and maintain a database that the wider insurance market will be able to use in developing longer-term products. The insurance is intended to be available so that eligible midwives can be appropriately covered from 1 July 2010, in line with proposed new requirements of the National Accreditation and Registration Scheme.

Under section 5 of the PII Bills, an "eligible midwife":

(a) is licensed, registered or authorised to practice midwifery by or under a law of the Commonwealth, a State or a Territory; and
(b) meets such other requirements (if any) as are specified in the Rules for the purposes of this paragraph; and
(c) is not included in a class of persons specified in the Rules for the purposes of this paragraph.

No draft Rules are currently available, and Rule-making power is vested in the Minister, however, the Minister has repeatedly indicated that homebirth midwives will be excluded from this scheme.

As the committee would be aware, the Australian Health Ministers Conference agreed in September to a transitional clause in the current draft National Registration and Accreditation Scheme legislation to provide a two year exemption until June 2012 from holding indemnity insurance for privately practicing midwives who are unable to obtain professional indemnity insurance for attending a homebirth.

However, while this is a welcome development which aims to prevent the immediate cessation of attended homebirth in Australia, the new amendments to the legislation have created yet further access barriers for women seeking homebirth.

As part of the exemption, the Ministers agreed that Victoria should lead a process of developing a quality and safety framework in which homebirth midwives must participate in order to access the PII exemption and maintain their registration. In general terms HAS is supportive of quality and safety frameworks as a mechanism to provide greater consumer protection and is in contact with Health Victoria about the development of this framework.

However it is crucial that the Committee understands that under the Government's current amendments, medical practitioners will be required to demonstrate collaboration with an uninsured colleague. There is clearly no incentive for a doctor to take on such a financial risk.

If a midwife is not able to secure support from a medical practitioner colleague she will lose her right to practice under the amendments.

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[10] Sydney Morning Herald 30 June 2009

As our organisation has repeatedly pointed out to the Committee, the consequence of reducing the already small number of Australian midwives providing homebirth services, will be an increase in unattended births at home. Such a move is dangerous for mothers and babies, bucks international trends in maternity care, and is inconsistent with the Government's stated policy of providing pregnant women with greater choice and less interventionist maternity care.

Australian women, like those in many countries internationally should have the right to choose the most appropriate health care professional for their needs – not one that is restricted by the availability of another health care professional or that is subject to a right of veto by another practitioner.
We appreciate your time in considering this submission and the importance of providing choice and ensuring safety for pregnant women and their families.

Yours sincerely

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