11/12/09

To: Elton Humphery
Committee Secretary
Senate Community Affairs Legislation Committee
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Dear Senate Community Affairs Committee,

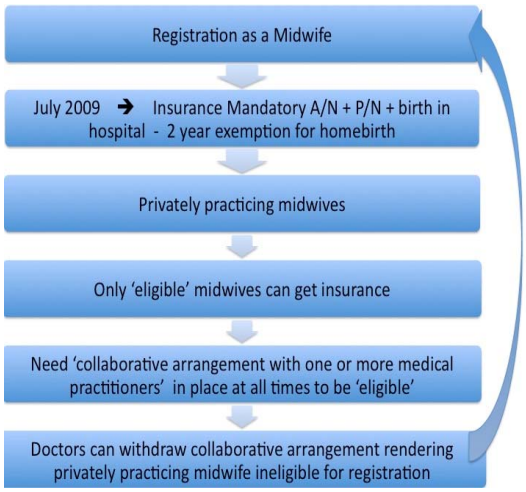
Re: Senate Community Affairs Committee Inquiry into:

- Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009
- Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009
- Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009

CRANA*plus* would like to congratulate the government on the introduction of the maternity reforms that are currently before parliament and believe they are mostly progressive and will benefit people living in remote Australia. However we have several areas of concern that relate to safety, quality and equity for remote Australians. We have addressed these concerns through the Committee's Terms of Reference as described below:

a) Whether the consequences of the Governments amendments for professional regulation of midwifery will give doctors veto over midwives ability to renew their licence to practice.

We believe the amendments MUST NOT be accepted as they WILL result in doctors' veto over midwives practice. This is shown in the diagram below:



For private midwives to practice they will need to be registered and to hold insurance for providing care (homebirth is exempt for 2 years), to gain insurance they will need to meet the eligibility criteria, to be eligible they will need collaborative arrangements which are at the discretion of doctors, without collaborative arrangements they cannot buy insurance and therefore cannot practice or register. This sequential cycle must not be written into legislation.

b) Whether the Governments amendments influence on the health care market will be anticompetitive

The intent of the maternity reforms was to increase choice and access to continuity of care from midwives by consumers. These reforms will introduce competition into the marketplace. In Australia, Midwives, GP Obstetricians and Specialist Obstetricians are all trained as skilled attendants as per the World Health Organisation (WHO) definition:

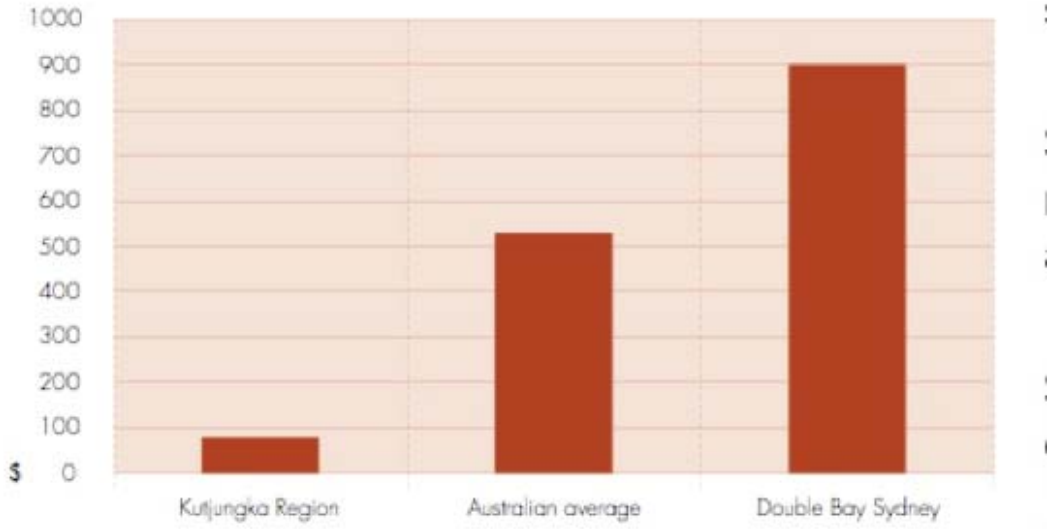
> *The term 'skilled attendant' describes an accredited health professional who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns' [1].*

However, uncomplicated pregnancies are the specialised area of midwives whose training is based on around providing care, identifying when things are not going normally and referring to other practitioners as needed (this includes doctors, allied health personnel and complimentary medicine practitioners) [2]. As private midwives have never had access to Medicare women requesting their services have had to pay full fees. This has resulted in a **lack of these services in rural and remote Australia** where incomes are lower and many families are simply unable to afford such services. If women will be able to access midwives' services and have this subsidised by Medicare this will result in **greater choice, competition and access to care. If doctors can prevent midwives from accessing Medicare this will result in anticompetitive incentives by one provider over another.**

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

CRANA*plus* believes that people living in Australia's 'remote' areas are entitled to access quality Primary Health Care and care from a 'skilled attendant' during pregnancy birth and the postnatal period. We were very pleased with the proposed reform agenda that should result in increased numbers of midwives and nurse practitioners in rural and remote areas where we are simply unable to attract doctors. We can see that this has a very real potential to increase rural and remote access to skilled health professionals' and could result in more Medicare and PBS funding flowing to remote areas where there has for many years been inequitable health funding. Five estimates examining funding for Indigenous Australians highlight a $350-500 million shortfall per year (see diagram below):

Figure 9.3: In 2003, Australians used Medicare-funded primary health care from less than $80 per person in remote WA to more than $900 per person in metropolitan Sydney



Source: G Mooney (2003), 'Inequity in Australian health care: how do we progress from here?', Australian and New Zealand Journal of Public Health, 27 (3):267–270.

The suggested amendments are now linking access to Medicare to signed agreements with doctors. Given we rarely have doctors on site in remote, we are provided with locum services that can change every week and we often have referral doctors who we have never met and are covering call from the cities (eg. a midwife in Maningrida in Arnhem may need to ring a different doctor every night for referral advice, the doctors may have never worked in Arnhem Land and may live in Sydney). **This introduces structural barriers that are unlikely to be overcome. The amendments will create difficulties in delivering the intended access and choice for Australian women.** Preventing the amendments offers opportunities to increasing midwives and nurse practitioners in remote Australia, as there will be financial incentives for the non-Government Health Services (eg. Aboriginal Medical Services) to contract the services of these providers. Thus, access to health services for Aboriginal and Torres Strait Islander Australians would be increased.

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

CRANA*plus* believe all health practitioners need collaborative arrangements and do not believe they should be tied to legislation. To maintain registration midwives and nurses in Australia must work to the nationally recognised competency standards that include working in collaboration with others. The professions have Codes of Ethics, Scope of Practice and Decision Making Frameworks and the Australian College of Midwives have Consultation and Referral Guidelines that have been developed with Obstetricians. There are already structures in place for collaboration with other health

professionals. This is clear in the Australian National Competency Standards for the Midwife:

> *The competency standards are underpinned by primary health care principles. These principles encompass equity, access, the provision of services based on need, community participation, collaboration and community based care. … When women or babies have complex needs and require referral, the graduate midwife will provide midwifery care in collaboration with other health professionals [2].*

We ask why one professional group would require these arrangements when no others do?

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

It is recognised that skilled attendants, and other key professionals, must be supported by an enabling environment including policy support, access to basic supplies, drugs, transport and relevant emergency obstetric and newborn services for timely management of complications [1]. Structures and processes for the transfer and referral of care must be seamless for the woman and neonate if we are to provide a safe environment for maternity care. They must not be dependent on individual providers but instead must be embedded in the system and must be easily available to any practitioner working anywhere in Australia. The proposed amendments are likely to **ADD HEALTH SYSTEM RISK.** We have an example of this that is already occurring in the public health system in Australia and have described it below with the other related matter of homebirth.

f) any other related matter

Homebirth in Australia

The WHO have stated that in order to protect both the public and the practitioners, it is important to regulate and license the skilled attendants themselves, the institutions in which they work and the programs and establishments used in their training [1]. In Australia this should also include indemnity insurance as a protection for the public. The Minister has specifically outlined that homebirth will be excluded from indemnity cover and funding for a two year period in her second reading of the legislation (Roxon 2009). Consumers seeking homebirth should not be excluded from this protection that will be mandatory for all health providers from 1st July 2010 and will be available for all other provision of maternity care.

CRANA*plus* would like to highlight a case study that demonstrates what can occur when homebirth is marginalised and not accepted as a legitimate health service. We believe it results in **Adding Health System Risk** and must be avoided.

Homebirth in the Northern Territory: A case study highlighting the unintended consequences resulting from regulation aimed to protect the public.

Issue:
The Health Practioner National Regulation Law [1] currently being developed by the Council of Australian Governments (COAG) is due to come into force in July 2010. The law states *'that the registered health practitioner must not practise the health profession unless professional indemnity insurance arrangements are in force in relation to the practitioner's practice of the profession'* [1]. The Health Minister has said that homebirth services will be exempt for a two-year period and that the government will provide insurance for antenatal and postnatal care to 'eligible midwives accessing Medicare and working in collaborative arrangements with doctors'. As professional indemnity insurance is currently unavailable worldwide for midwives this will mean that women who have a homebirth are not afforded indemnity insurance.

The Northern Territory Practitioners Act:
The NT Health Practitioners Act, 2004 [3], was introduced in February 2005 and clearly states that all health practitioners are required to have adequate professional indemnity insurance in place to practice in the NT. As there was no professional indemnity insurance available at that time, either in Australia or internationally, it became impossible for midwives to practise as Privately Practising Midwives in the NT. To do so would contravene the Act and risk becoming deregistered. As a result the Privately Practicing Midwives who had been running their own business and providing holistic midwifery services, not provided by any other organisation, had to cease to practice. Based in Darwin and Alice Springs, these professionals had provided services across the NT, travelling to women when requested, including women living in remote areas. Although home birth was accessed by a small number of women the services had been operating for over 25 years across the NT. The midwives all had professional referral arrangements with general practitioners', some of whom also attended homebirths, and facilitated transfer to hospital if needed.

In response to community protests and consumer pressure (some of whom were in advanced pregnancy and had planned a home birth), the NT Health Minister approved the establishment of a publicly funded Home Birth Service (HBS) for low risk women. The model employs midwives to provide home births. As employees of the Health Department they have the same indemnity cover as other Health Department employees. Clinical protocols guide their practice and the midwives are able to transfer a woman in labour directly to the hospital. This service was reasonably well received by supporters of home birth and continues to operate today. However some obstetric opposition remains and the models were never established in a sustainable or well integrated way, particularly in Darwin where **the obstetricians refused to collaborate with the homebirth service despite it being a publically funded service sitting in the public health service.** The funding is insufficient to allow for the critical number of midwives to be employed (there is a good evidence base that informs the sustainability and safety of such models). Thus there has been continued

activism and consumer pressure to improve the model with some changes made but more required.

Since the HBS was established the Australian College of Midwives NT Branch and CRANA*plus* have had requests from women in Nhulunbuy, Jabiru, Katherine and several remote communities to lobby government to provide support for a home birth. The families have written numerous letters and appeals to the Health Department, their local referral hospitals, the Homebirth Service, their local representative, the Health Minister, the NT Midwives Association branch and CRANA*plus*. Families describe the process of trying to gain support as lengthy and extremely stressful. In each instance there have been either resident midwives that have been prepared to provide this service (some with many years home birth experience in either the NT or in other States), or members of the HBS have been prepared to travel to provide the service. All but one of these requests has been denied. This has resulted in some women deciding to 'free birth' (birth without the presence of a skilled attendant). *CRANAplus* are aware of eight non-Indigenous women who have chosen to 'free birth' in the NT in recent years and it is unlikely this is all the women and unlikely any of these births would appear in the routinely collected perinatal statistics. We therefore have no way of knowing how many women free birth in the NT each year.

The midwives unable to support these women have described feelings of guilt and helplessness; particularly when there has been poor outcomes that they felt could have been avoided. One woman, whose request was denied, was transferred into the hospital following a severe post partum haemorrhage; she almost died.

The World Health Organisation state the lack of skilled attendant at birth is the greatest cause of maternal death with many of those deaths being due to postpartum haemorrhage – often times an avoidable or treatable condition (if skilled attendant present). If a maternal death did occur under such circumstances then it would be documented as having potentially avoidable factors. How these avoidable cases would be tested in the judicial system is to date unknown.

Many countries around the world are increasing access to homebirth services. There is increasing evidence that birth in the home is AS safe (some would argue SAFER) than hospital birth [4-6]. Women who birth at home feel more empowered, more in control and more confident – all important characteristics to begin life as a parent. Australia appears to support a culture of fear around birth in all settings, but particularly birth in the home. Some women will ALWAYS choose to birth at home. To deny them access to a skilled birth attendant is to breach our duty of care. It is only a matter of time before this is tested in a court of law.

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Authorised by the Board of CRANA*plus*

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