Submission to the Senate Community Affairs Legislation Committee

Inquiry into the Government's proposed amendments to the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009;

and

the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009

December 2009

Executive Summary

The Australian College of Midwives (ACM) supports the government's commitment to increase women's access to primary midwifery care by providing midwives with access to Medicare, the PBS and affordable indemnity insurance. We welcome the Minister's recognition of the evidence that women benefit from access to the choice of primary continuity of care by midwives.

The ACM also welcomes the Minister's advice to us in writing on 27 November 2009 that she has decided not to amend the Midwives Professional Indemnity (Commonwealth Contribution) Bill 2009 to require collaborative arrangements with a medical practitioner(s) as a condition of access to indemnity. The Minister has responded to our concern that this amendment may have had the unintended consequence of affecting midwives' ability to retain a licence to practice.

We are keen to see the passage of the Midwives Professional Indemnity (Commonwealth Contribution) Bill 2009 through the Senate at the earliest opportunity.

The Minister has affirmed her intention to amend the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 to require midwives to have collaborative arrangements with medical practitioners.

ACM acknowledges and supports the Minister's intention that Medicare funded midwives will work collaboratively with medical and other health professionals as needed in the care of women and their babies. ACM does not however, agree that it is necessary to legislate for collaborative arrangements in order to achieve this goal. Collaboration with medical and other health professionals is already encoded in the regulatory framework within which midwives work in Australia. Disciplinary action may be taken by regulatory Boards if midwives are found to practise in a non-collaborative manner.

If the amendment to the Bill is passed, requiring midwives to have "collaborative arrangements with one or more medical practitioners", it appears to us that self-employed midwifery would be unlikely to be broadly workable and that access for women to Medicare funded midwifery care would be greatly diminished.

ACM is strongly opposed to the proposal put forward by some medical organisations that eligible midwives be required to have a signed collaborative agreement with one or more doctors before they could become Medicare providers. This proposal is unworkable for many reasons, as outlined on page 8 and 9.

ACM's preference is that the reference to 'collaborative arrangements'is *not* added to the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 as proposed in the 5 November amendments.

ACM proposes that midwives demonstrate their adherence to safe, collaborative practice through the use of formalised maternity care notes for each woman for whom they provide care, which can be audited by Medicare Australia or the Nursing and Midwifery Board of Australia as appropriate.

The requirement to demonstrate collaborative practice could be implemented as an amendment to the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill, in the definition of a participating midwife. The alternative mechanism, of making collaborative practice a condition of eligibility, risks issues of circularity which could impede midwives access to Commonwealth-subsidised professional indemnity insurance.

The ACM is keen to support the successful implementation of this important legislation, for the benefit of Australian women and their families. We urge the Senate to pass this Bill at the earliest opportunity if Senators are assured that requirements to ensure collaboration will be implemented as suggested here.

Introduction

The Australian College of Midwives (ACM) supports the government's commitment to increase women's access to primary midwifery care by providing midwives with access to Medicare, the PBS and affordable indemnity insurance. Evidence confirms that women and babies benefit from continuity of care by a known midwife. We welcome the Minister's recognition of this evidence and commitment to expanding women's access to the choice of primary continuity of care by midwives in both hospital and the community.

ACM also acknowledges and supports the Minister's intention that Medicare funded midwives will work collaboratively with medical and other health professionals as needed in the care of women and their babies. Midwifery as a profession is committed to providing care in a collaborative way. There is no argument that women choosing the care of a private MBS funded midwife must have ready access to appropriate medical care if and when the need arises for themselves or their baby. At issue is how collaboration is ensured.

Midwives already work collaboratively with obstetricians and other health professionals on a daily basis. They are regulated to provide care on their own responsibility, consulting and referring to secondary and tertiary care as required. A change in funding of their care from state government budgets to the Commonwealth budget via Medicare will not alter the commitment and responsibility of midwives to work collaboratively with doctors to meet the needs of women and babies in their care.

This responsibility to practice collaboratively is encoded in the professional framework for midwifery practice (competency standards, code of ethics and code of conduct) upheld by the regulatory Boards for midwifery. The Australian Nursing and Midwifery Council (ANMC) Competency Standards for the Midwife (2006) require the midwife to consult, refer and transfer care if complex needs arise during pregnancy where the care provided is outside the midwife's scope of practice. The definition of a midwife **on entry to practice** from the ANMC is:

> *The midwife is recognised as a responsible and accountable professional who works in partnership with women to give them necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.* [1]

There are several competency standards within the ANMC Competency Standards for the Midwife that require midwives to work with other health professionals, consulting and referring when required. Midwives' regulatory processes require them to comply with these standards. Disciplinary action may be instigated by the regulatory Board where it is found that the midwife has failed to meet these requirements. ACM does not agree that it is necessary to legislate for collaborative arrangements in order to ensure this is what happens in practice.

The ACM welcomes the opportunity to provide evidence to the Community Affairs Legislative Committee Inquiry into the amendments to the above Bills announced on November 5[2] This submission briefly addresses each of the Inquiry's terms of reference.

We are happy to expand on this submission in person if requested to.

(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;

When the amendments were announced on 5 November 2009, the ACM became concerned that the proposed amendments may inadvertently give doctors the power to influence midwives' ability to maintain their licence to practice.

This concern arose because the definition of eligibility in the Midwives Professional Indemnity Bill was proposed to be amended to require midwives to have collaborative arrangements with one or more medical practitioners. Discussions within the consultative committees looking at implementation of the reforms had at that time been focused on collaborative arrangements being evidenced in the form of a signed agreement between a midwife and one or more medical practitioners. This would mean that, if doctors declined to enter into, or withdrew from such agreements, they could effectively prevent midwives being able to access or maintain a professional indemnity policy and by so doing, cause them to breach the mandatory conditions of their registration with the Nursing and Midwifery Board of Australia.

The College has been in discussions with both the Minister's office and her Department on this issue. The Minister's advisors and the Department have indicated that it is not the Minister's intention to give doctors a de facto regulatory power over midwives' licence to practice. The ACM received written advice from the Minister to this effect on 27 November 2009. The letter advises that the Minister does not plan to proceed with amending the Midwives Professional Indemnity Bill to require collaborative arrangements with one or more medical practitioners.

ACM has sought clarification from the Department that the decision not to amend the Midwives Professional Indemnity Bill will successfully remove the unintended link between the decisions of individual doctors about collaborative arrangements and a midwife's ability to maintain her/his license to practice through holding professional indemnity insurance. At the time of submission we have not received a response, and remain concerned that a link may be retained in conditions within the insurance policies, requiring midwives to have "collaborative arrangements" in place for their insurance to be valid.

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

The AMA is on the public record as supporting the amendment precisely because they evidently believe it will reduce potential competition:

> "*AMA vice-president Dr Steve Hambleton, who sits on the Government's Nurse Practitioner Advisory Group (NPAG), said the crucial amendment* [requiring "collaborative

> arrangements"] *would ensure nurse practitioners [and midwives] were not supported to work in competition with doctors*"

The ACM believes the proposed amendments would be anti-competitive, effectively restricting midwives from the private maternity care market. Professor Alan Fels in 1998 in a paper titled 'The Trade Practices Act and the Health Sector' described the dangers of misuse of market power and exclusive dealing as follows:

> *"Misuse of market power – that is, taking advantage of a substantial degree of power in a market for the purpose of eliminating or substantially damaging a competitor, preventing the entry of a person into any market or deterring or preventing a person from engaging in competitive conduct in any market (Section 46), and*
> *"Exclusive dealing – that is, one person who trades with another imposing restrictions on the other's freedom to choose with whom, or in what, to deal." (Section 47)*

The AMA is proposing that the amendment be implemented so that it is compulsory for midwives to have a signed agreement about collaboration with one or more doctors in order to become Medicare eligible. This would definitely create the opportunity for anti-competitive behaviour by some doctors.

Medical practitioners, including GPs and specialists, provide primary care to women during pregnancy, labour and birth. Midwives provide primary care to women during pregnancy, labour and birth and for up to six weeks post birth. Primary care of well women is a low energy/low time activity with financial reward for obstetricians. There is the real potential that privately practising GP and specialist obstetricians may see a midwife/midwives setting up in private practice in the same community as a source of competition to their own business. Thus perceived competition for a market share may impact doctor's decisions around entering into collaborative arrangements with midwives, even where there is local demand from women to access to private midwifery care.

If midwives are required to have formal, signed collaborative agreements with doctors in place **before** becoming a Medicare provider, and if there is no obligation on medical practitioners to enter into such agreements with midwives, then the potential will exist for doctors to prevent midwives offering private care in their community by declining to sign an agreement. This would limit women's choices as well as those of midwives.

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

If the proposed amendment is passed and implemented in a form where signed collaborative agreements were compulsory, the most likely model of care to emerge from these reforms would be where midwives will work as employees of privately practising obstetricians (GP or specialist). Midwives not employed by a doctor are likely to have difficulty gaining a collaborative agreement to become Medicare eligible.

Private obstetricians employing midwives to provide midwifery care within their practices is a potentially beneficial model for women, provided that any participating midwives are free to practice in accordance with midwifery professional standards and philosophy of practice and not obliged to see women for the same very short duration that is currently typical of pregnancy consultations by doctors. Women choosing private obstetricians may also benefit from the

opportunity to receive labour, birth and postnatal care from a midwife known to them through the doctor's practice, although some obstetricians have already indicated they do not intend to allow midwives in their employ to continue to provide care for birth and beyond.

If employment of midwives by doctors is the only model to emerge from these reforms, women will be disadvantaged, particularly those in rural and remote communities and those who are socio-economically disadvantaged and unable to access private obstetric care. Only one third of women have the resources and/or preference to receive care from a private obstetrician. Further, not all obstetricians will employ Medicare eligible midwives. That leaves approximately 200,000 women who are currently accessing fragmented public maternity care across Australia who must be considered if these reforms are to be successful in enhancing access to primary midwifery care. It is essential that interested midwives have the opportunity to offer care to women in a wide range of communities (rural, remote, urban, socio-economically disadvantaged, Aboriginal and Torres Strait Islander, etc) and that the proposed amendments do not prevent this by making eligibility for midwives contingent upon approval by named doctors.

ACM is also concerned that such a model might give rise to situations where women might not receive evidence based, safe midwifery care if midwives' practice, clinical decision making and referrals are dictated not by professional standards and evidence of best practice midwifery but by the individual preferences of one or more medical practitioners.

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

The ACM has been advised by both the Minister's office and her Department that the wording as presented in the amendment does not preclude a midwife having collaborative arrangement with a hospital – with a hospital's medical director confirming an arrangement with a midwife. We remain concerned that this still provides an opportunity for an individual medical director of a public hospital to refuse to enter an arrangement with a midwife thus limiting access for women to the government's reform package.

If midwives are to be in a position to offer women safe care, they need to be able to consult and refer with a maternity service, whichever obstetric and other relevant personnel it might have available at the time. It is simply unworkable for such arrangements to be contingent upon approval by each individual doctor who might support the service at one time or another. Midwives' consultation and referral pathways are well developed, evidence-based and well accepted by the profession and by existing maternity services across Australia. The Australian College of Midwives National Consultation and Referral Guidelines (2008)[3] are the basis for midwives decision making.

Recent Australian research indicates that the focus should be on developing collaborative care through organisational or systemic pathways rather than focusing on individuals.[4] Midwives provide safe, quality maternity care for Australian women and their babies. They are regulated to provide this care on their own responsibility, consulting and referring to secondary and tertiary care as required. It is not necessary or appropriate to duplicate this regulatory framework by legislating for a "collaborative arrangement" with a medical practitioner to control midwifery practice, and clinical decision making.

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

There is ample evidence that midwives provide safe care on their own responsibility. There is no extension to the scope of practice of a midwife under these reforms. There is a change in funding mechanism.

ACM takes the view that safety for women will be maintained by midwives having clear consultation and referral pathways for women in their care. We do not agree with the view that the only way to provide for clear consultation and referral pathways is to force midwives to have up front collaborative arrangements, such as a signed agreement with an individual medical practitioner.

Effective collaboration does not arise from situations where one health professional has control over the decision making of another health professional. Inter-professional collaboration occurs when two or more experts from different disciplines take joint ownership of decisions and collective responsibility for outcomes when working across professional and functional boundaries, for example, within the hospital setting[5]. A collaboration of health professionals share responsibility for outcomes, see themselves playing a crucial role within a larger social system (heath service) and manage their relationships across organizational boundaries[6]. If safety and quality in care and enhanced access for women to midwifery care are the desired outcomes of these reforms, a one sided arrangement in which the midwife is mandated to comply, whilst the medical practitioner is not, is unlikely to achieve that outcome.

Midwives can demonstrate they provide safe care by providing evidence of care planning, use of guidelines and protocols and appropriate emergency plans. Safe care can further be demonstrated by measuring, reporting and evaluating outcomes and by auditing evidence of appropriate consultation and referral in the woman's records

The way forward: solutions re collaboration

Everyone is in agreement that care for pregnant women and mothers needs to be collaborative to be safe and effective. At issue is how this commitment is translated into law and regulation for the purpose of providing Commonwealth funding for care by appropriately qualified and experienced midwives.

One option that has been put forward for doing this – that of having a signed collaborative agreement between each Medicare midwife and a medical practitioner(s) – is unworkable for a host of reasons:

- Signed agreements would not ensure safety for women and babies because:
    - the doctor with whom a midwife has an agreement may not be available when the woman needs medical care
    - the existence of an agreement would not create an audit trail of the midwife's practice
- Signed agreements may not accommodate the preferences of women, who may prefer to receive care from a medical practitioner other than the one(s) with whom the midwife has an agreement(s).

- Doctors who are already collaborating with private midwives are saying they would be reluctant to sign an agreement because it may have medico-legal implications for their own practice
- Only midwives employed by doctors would be likely to gain agreements.
- If only one health professional (midwives) has to collaborate, and the other can choose whether or not to collaborate, there is potential for anti-competitive behaviour
- Doctors already have busy workloads and may be reluctant to formally take on more responsibilities, particularly given the rising preference within the private obstetrics workforce for greater work/life balance.
- A requirement for agreements could impede equity of access to Medicare funded midwifery care for women across Australia e.g. in many rural areas there is no permanent obstetrician with whom an agreement could be made
- They would effectively make doctors 'de facto regulators' of midwives' ongoing eligibility for MBS provider status and potentially of midwives' ability to retain professional indemnity insurance and therefore their license to practice.

The mechanism for resolving ACM concerns is

1. that the reference to 'collaborative arrangements' is *not* added to the definition of a participating midwife in the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009.
2. Collaboration by midwives is ensured through auditable evidence of collaborative practice, such as the use of formalised maternity care notes.

The ACM has recommended to DOHA the adoption of a set of national midwifery notes which demonstrate evidence of care plans developed with the woman, evidence of the pathways for consultation and referral and communication about consultation and referral when and where it occurs. Women accessing Medicare funded midwifery care will take these notes to any consultations with medical practitioners or bookings with hospitals and therefore the woman's consent to collaboration can be assured and documented by all parties. An example of a similar document has been developed by the Queensland Government in response to requests from private midwives and hospitals for a collaborative document to ensure seamless transition between contexts of care. This collaborative maternity record has triplicate sheets enabling the woman, her midwife and the hospital or medical practitioner to have all relevant information about her care. The Queensland Midwifery Notes could readily be adapted to a national collaborative care record for use by all Medicare provider midwives.

There are a number of distinct advantages to the use of a standardised collaborative care record over that of requiring a signed agreement as evidence of collaborative practice by midwives:

- the woman has access to information about her care at all times and consents to the sharing of her information with any providers involved in her care
- all care providers can access and contribute to the maternity record, and retain a copy of relevant information for their own records

- the record explicitly supports recording by the midwife of all consultations and referral to medical practitioners
- the record does not limit the provision of medical care to an individual with whom the midwife has an agreement, thus ensuring more timely and flexible access for the woman and/or her baby to any medical care required
- the record is auditable by an appropriate body (the Nursing and Midwifery Board and/or Medicare Australia).

Midwives already routinely document their care. All state and national perinatal data is recorded by midwives who are responsible for documentation for every woman giving birth. So use of such a record by Medicare provider midwives would not be new or unfamiliar to midwives.

Other barriers to implementation of these reforms

The terms of reference refer to 'any other related matters'. ACM wishes to briefly note 3 aspects of implementing these reforms that will need to be addressed for the reforms to be successful. The Department is aware of each of these issues.

Attracting midwives to provide Medicare funded care

The implementation of the collaborative arrangements mechanisms will be critical to the success or otherwise of these reforms as it will determine the level and nature of participation by each of the midwifery and obstetrics professions. Unless workable provisions for ensuring collaboration are designed, there will be a low level of incentive for midwives to leave employed practice to work in private Medicare funded practice unless they can see mechanisms for providing continuity of care on their own responsibility.

It is unclear that the proposed rebate levels will successfully attract midwives into private practice. Our preliminary analysis based on levels of rebate proposed at the Technical Advisory Group meetings suggest that a midwife charging the scheduled fees working in private practice could make around half that of a midwife working in a similar model in the public hospital sector if s/he bulk billed. Therefore a midwife in self employed private practice would find it difficult to run a business and make a similar living without charging women a substantial gap payment. This may limit the capacity of midwives to offer care to women in socio-economically disadvantaged communities.

Facilitating continuity of care for women through Medicare midwives having visiting access to hospitals

The ACM has always understood that these reforms were specifically developed to address the increasing desire of women to access continuity of midwifery care. Whilst understanding that other models (i.e. midwives providing antenatal care in obstetrician's rooms) would also be available, midwifery continuity of care is the area where research evidence demonstrates benefits to women[7]. Midwifery continuity of care is a model where a known midwife provides pregnancy, labour and birth and postnatal care to a woman until six weeks post birth.

The ability for midwives in private practice to provide MBS funded labour and birth care in hospitals, and therefore provide continuity of care under these reforms, will depend on the ability of the midwife to gain visiting access to hospital(s).

There are barriers to be overcome for private practice Medicare midwives to gain visiting access to public hospitals. Hospitals are unaccustomed to granting visiting access to midwives. Decisions about access tend to be made at the individual institution level. Committees that make decisions about such matters are usually made up of medical practitioners who may have little familiarity with midwifery practice and regulation.

Furthermore, where midwives do gain visiting access there remains the challenge of obtaining medical input to the care of any of their clients during labour. Women choosing private midwifery care will need to be admitted as private patients. Private patients of visiting obstetricians currently access the midwifery and medical staff of hospitals, with a fee being payable for this service. Such arrangements are yet to be negotiated for private MBS provider midwives. If the woman becomes a public patient so as to access hospital medical care, the midwife will lose the capacity to continue to provide care, as she will no longer be either funded or insured for the care. Women are likely to be very concerned and anxious if their known MBS midwife is unable to continue to attend them during a caesarean section or other medical procedure.

Input from state and territory governments will be needed to assist with overcoming these barriers. It is our understanding that the Minister has initiated dialogue with her state and territory counterparts on such issues as part of developing the National Maternity Services Plan.

Women's access to planned birth at home with a registered midwife

ACM acknowledges that health ministers (federal and state) responded to the community concerns (as documented in the earlier inquiry by this committee and in the media) by agreeing on a two year exemption from the requirement to hold professional indemnity insurance for midwives providing labour and birth care to women at home. This decision was welcome, as it has temporarily alleviated the risk that women may choose to give birth at home without a registered midwife in attendance, which would be dangerous.

It is our understanding that midwives will need to meet certain criteria to be eligible for this exemption. These criteria are being developed by the Victorian government on behalf of all other governments and consultations with stakeholders are planned for early 2010.

This issue is raised in this submission simply to underline that the implementation of a requirement for "collaborative arrangements with a medical practitioner" may also impact on midwives seeking the indemnity exemption. It is likely that obstetricians, whose professional college is opposed to homebirth, would be reluctant to enter a collaborative arrangement with a midwife providing homebirth care. Insurers may be unlikely to sanction doctors entering a formal relationship with a midwife who is not indemnified for part of their care (i.e. is exempted from PII requirement for birth at home).

The ongoing difficulties around homebirth continue to present difficult choices for current private practice midwives, including decisions about continuing registration and accepting clients who are

currently pregnant and whose babies are due after 1 July 2010. Timely passage of the Midwives Professional Indemnity (Commonwealth Contribution) Bill 2009 would be helpful in enabling the Department of Health to make insurance available to eligible midwives before national registration commences on 1 July 2010.

References

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[5] Liedtka et al 1998 Enhancing care delivery through cross-disciplinary collaboration: A case study. *Journal of Healthcare Management* 43:185-205.

[6] Cohen et al 1997 What makes teams work: Group effectiveness research from the shop floor to the executive suite. *Journal of Management* 23: 239-290.

[7] Hatem M, Sandall J, Devane D, Soltani H, Gates S. Midwife-led versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD004667. DOI:10.1002/14651858.CD004667.pub2.