11 December 2009

Senator Moore - Chair
Senate Standing Committee
on Community Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

By Email: community.affairs.sen@aph.gov.au

Attention: Mr Elton Humphrey

Dear Senator Moore

Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills – Proposed Collaborative Arrangements Amendment

Please find Homebirth Australia's submission following. We would be happy to provide oral evidence to the committee.

Yours sincerely

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Secretary
On behalf of Homebirth Australia

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HOMEBIRTH AUSTRALIA IS AN INCOME TAX EXEMPT CHARITABLE ENTITY

Who Are We?

Homebirth Australia (HBA) is the peak body for Homebirth awareness and promotion. HBA was established in 1980. HBA has midwife and consumer members with an executive of equal representation.

Our Aims

- To support the rights of homebirth parents to choose how, where and with whom they give birth
- To increase public awareness and acceptance of homebirth.
- To provide communication and support to members of Homebirth Australia.
- To provide information to parents planning homebirth.
- To provide information, support and networking to service providers.
- To convene an annual national conference.

Recommendations

- **Removing the current 'collaboration arrangement' amendment that requires individual midwives to enter into a collaborative arrangement with an individual doctor.**

- **Establishing a requirement for midwives to demonstrate they have the ability to communicate with a local hospital and secure the services of the appropriate practitioner in a timely fashion**

- **Inclusion of homebirth in the funding and indemnity arrangements to support women who have had previous trauma and reduce the number of unattended homebirths and establish greater competition and a full complement of choice.**

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

Terms of reference and the Government's proposed collaborative arrangements amendments

(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;

Homebirth Australia acknowledges the recent removal of the amendment from the Midwife Professional Indemnity (Contribution) Bill. It does now not seem likely that individual midwives will be prevented from registration. Midwives should be able to register, however it is likely that by including the amendment in the Midwife and Nurse Practitioner Bill that Procedural GP's and Specialist Obstetricians will have the ability to veto the daily practice of midwives and remove the rights of women to exercise control over their bodies.

This distinct ability removes any need to have a midwifery registration board and places Australia outside the international definition of a midwife.[1] The definition explicitly states that the midwife can *"conduct births on the midwife's own responsibility"*. Whilst this may be true for some cases, it would seem highly likely that a midwife will only be "allowed" to practice on the say so of a medical practitioner.

With the controversy surrounding homebirth, namely, the philosophical divide between obstetrics (which focuses on pathology and complication) and midwifery (focusing on wellness) we believe the vast majority of medical practitioners will not support homebirth midwives. Homebirth Australia is also concerned that the small number of progressive practitioners willing to support homebirth midwifery would be bullied from within the profession or given medico legal advice from their insurer not to collaborate with homebirth midwives and perhaps even any midwife who is not employed by the medical practitioner.

How will it be possible for homebirth midwives to find Drs who are prepared to enter into collaborative arrangements when their own recently released guidelines from The Royal Australian and New Zealand College of Obstetricians and Gynecologists (RANZCOG) state?

> "The College does not support *Home Birth* or *'Free-standing' Birth Centres (without adjacent obstetric and neonatal facilities)* as appropriate Health Care Settings. The College acknowledges that a very small minority of women will choose to birth in these centres, even if appropriately informed of the consequences (RANZCOG, 2009)"[2]

Point of reflection: Will women be able to access a registered midwife for care that is not sanctioned by a "collaborating Dr" eg hospital based vaginal birth after caesarean, homebirth, birth post dates, multiple births etc. Or will a midwife be forced to 'abandon care'.

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[1] International Confederation of Midwives (Adopted at ICM Congress 19 July 2005, Brisbane, Australia)

[2] Royal Australian New Zealand College of Obstetricians and Gynaecologists (2009). Guideline: Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care. *RANZCOG*

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

The general unwillingness from medical practitioners to 'share the market' with midwives is well established. Currently maternity care is anti-competitive. This has been supported by Governments who have over time refused to include midwives in Medicare funding. Anti-competitive behaviour, coupled with this amendment, not only spells the death of homebirth care with a registered midwife it also suggests that the major reform announced by Minister Roxon will be unworkable.

Currently maternity services, particularly in the private sector, where Medicare funded midwifery would compete is totally anti-competitive. Despite the Australian taxpayer funding billions of dollars in the combined packages of medical indemnity premium support, private health insurance rebate and Medicare funding itself, maternity care is a closed shop controlled by obstetric practice.

Virtually no private health funds provide a rebate for private midwifery care or homebirth. Since 2002 some funds have cited the lack of indemnity insurance as a reason. The fact is few funds ever provided a midwifery rebate equal to obstetrics. The cost of private obstetric care has been reported to be as high as $20,000 in parts of Sydney and Melbourne. The most expensive homebirth midwife charges $5500. Homebirth Australia has made numerous representations to the Private Health Insurance Ombudsman. The office seems unwilling to promote competition within maternity care.

Although it has been clearly stated by Minister Roxon that homebirth will not be funded or indemnified (the act of birth at least) by Government at this time this decision is not based on research evidence, consumer demand, or fiscal prudency, it is based on a political imperative to placate the Australian Medical Association.

This is a serious issue with already tragic consequences. Dr Andrew Pesche led a media campaign against homebirth earlier this year. He cited 4 deaths and 4 brain-damaged babies as a result of homebirth[3]. These cases were not substantiated and it is Homebirth Australia's belief that most if not all of the cases were unattended homebirths. Whilst Dr Pesche may not be interested in increasing the safety of women choosing homebirth I am sure Minister Roxon and this Committee is.

Without access to funding women will continue to give birth at home without a registered midwife. What is more unpalatable for politicians, the wrath of the Australian Medical Association or preventing possible unnecessary injury and death?

In NSW the number of unassisted homebirths doubles that of those attended by a registered midwife. It is unacceptable that women who are unable to afford or find a registered midwife feel the only way they can be safe is to birth at home unattended. Many women who 'choose' unattended homebirth are refugees from the hospital system, still suffering trauma often from abusive care.

To date there has been no work at all to maximize the safety of women choosing homebirth. Concurrently women without medical indication are able to choose a

[3] Lawrence, K and Dunlevy, S "Four Dead in Homebirthing" The Daily Telegraph, April 6 2009 pp1

caesarean section and access a raft of human resources and technological equipment. Do we say to women choosing caesarean that they can make the choice but we won't provide a pediatrician to check your baby, or a special care nursery? Of course we don't. The reason this practice continues is that it is supported by medical interest.
At the moment this is exactly what we are saying to women choosing homebirth. You can make the choice but we won't provide funding or insurance, perhaps soon not even a registered midwife.

Point of Reflection: How can private maternity care be considered 'competitive' when private midwifery will only operate if a Dr agrees?

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

The amendments will make broad reform virtually impossible and will continue the chasm between medical practitioners and midwives. Sadly they will also continue to keep women out of the 'reform agenda'. Homebirth Australia believes that these steps are actually retrograde and worse than the work of previous Governments.

The proposed amendments are unworkable for many rural and virtually all remote communities. If a midwife is required to have a formal collaborative agreement with an individual practitioner, must this be a procedural GP trained in Obstetrics? If so many GP's that remain in rural communities either do not have a Diploma of obstetrics or they do not practice and are not 'up to date' with their skills.

In the event of any GP being able to 'collaborate' this makes a mockery of any attempt to establish safe practice. Compared to a GP without a Diploma in Obstetrics a midwife has superior training and experience as a specialist in healthy pregnancy and birth.

In remote areas medical positions are often filled by locum staff. How could this amendment practically operate? A new arrangement would need to be struck with each locum.

The amendment is likely to prevent the planned mainstream reform to enable broad access to private midwifery and simply enhance private obstetrics through the employment of midwives in GP's/obstetricians rooms.

Point of Reflection: With fewer medical practitioners in rural areas, is it acceptable to prevent midwifery practice establishing when this may be the only local care possible?

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

One can reasonably conclude this is a requirement of a deal struck between the Minister and the Australian Medical Association. If midwives were only required to demonstrate they could access and interact with a local hospital this would strip the power of many individual Drs to control midwifery practice. It is well known that the AMA will accept nothing less than midwives and nurse practitioners working 'for and on behalf of' private doctors. This amendment will achieve this goal by stealth.

We consider the following comment from Australian Medical Association Vice President, Steve Hambleton unwise but nonetheless honest of the intent of the AMA

"...the crucial amendment would ensure nurse practitioners were not supported to work in competition with doctors"[4]
(Although only referring to Nurse Practitioners, Midwives are naturally also included)

The 'requirement to collaborate with an individual doctor will not increase safety and it flies in the face of the collegial arrangements doctors have with each other and have had for decades. In rural and regional communities GP's will cover each others 'on call periods'. A GP that attends the birth of a particular woman may never have met her before. The example was discussed at a NSW Health forum where it was argued that a GP may have never met a 'home birthing woman' until transfer to hospital and this could not be supported. Begrudgingly it was acknowledged that GP's care for the clients of colleagues that they have never met on a regular basis.

Homebirth Australia does not support a system where women receive care from a health professional they have never met. Whilst it sometimes may not be possible, it is certainly optimal to have interaction with other maternity health professionals. If midwives were to refer and consult with a number of professionals at a local hospital, it would be more likely that midwifery practice and homebirth care would be greater understood and even respected. If midwives shared their case notes (with the permission of the woman) with the local hospital then a number of practitioners are 'exposed' to homebirth care.

This could minimize the abusive behaviour experienced by women and midwives when transferring to hospital. It also reduces reliance on one individual, which is proposed by the current amendment. Considering this practitioner would also have their own caseload (a specialist obstetrician sees 250-300 women per year in fulltime practice) it seems practically impossible that one individual could provide superior care than a hospital maternity unit.

Point of Reflection: How will the control from an individual doctor promote continuity of midwifery across the health system? How can women access a registered midwife for homebirth if doctors refuse to collaborate?

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

As previously mentioned, Homebirth Australia believes this amendment has the capacity to seriously impact on the safety of mother's and babies. The committed reform to enable women access to continuity of midwifery could also be seriously impacted. It is our belief that what could have been major reform will end up (unless there is major intervention) to be nothing more than midwives working in obstetricians rooms providing a degree of midwifery care controlled by obstetric practice. With this scenario it is unlikely that there will be reductions in interventions or costs.

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[4] Bracey and McKenzie "Govt will mandate Nurse Practitioner teamwork" *Australian Medical Observer*, November 6 2009

Women choose homebirth for a variety of reasons, some to avoid intervention, many for the continuity of midwifery care. A growing number of women are refugees from the hospital system, women who have been damaged and who in most cases will go to extreme lengths to prevent anything similar happening again. It is cruel for a government to ignore the fact that women maimed by a maternity system that is a broken mess.

Over the years Homebirth Australia has been alerted to hundreds of cases where women choosing homebirth were put in serious danger because of another practitioner was opposed to the woman's choice. They include

- A woman approx 28 weeks pregnant being refused antibiotics from her GP, when she presented with a urinary tract infection (UTI). This was on the basis of her decision to homebirth and being under the care of a private midwife. The risk of premature labour at this stage in pregnancy is high and a UTI should be treated seriously and promptly.

- On transfer from homebirth a woman was deliberately given a 'non-therapeutic' dose of syntocinon (despite evidence to demonstrate that this could have assisted a vaginal birth) in order to 'prove' the earlier prediction of the registrar that this woman 'would pay' for choosing homebirth. She endured nearly 4 hours of very painful contractions that were not effective. Her private midwife had no clinical standing and her repeated requests were not listened to.

- A woman who transferred from home to hospital was told if she refused a syntocinon infusion her care would cease and she could give birth in the gutter outside.

- A woman's sole carer during pregnancy was her private midwife. When she transferred for a caesarean section, despite the woman begging, her midwife was denied entry to theatre on the basis that only 1 person could be present (partner). A short time before the same midwife was allowed entry with another woman's partner when a woman had a caesarean section for placenta praevia.

- A woman in a rural community wanted a physiological third stage. She was informed and demonstrated it. She was told by 1 GP that she would not care for her with this request. Another GP told her he would transfer to another hospital around 75 mins drive. This was despite the local hospital having call in anaesthetics cover. The woman could not find a homebirth midwife who would travel to her and felt the only 'safe' option for her was to give birth at home without a skilled attendant.

How can we expect that the majority of maternity health professionals will collaborate under a legislative requirement when a significant proportion of the medical profession cannot grasp the rights of women to make decisions about their bodies and the resultant requirement for them to support.

This amendment has legitimised a 'supervising' and 'controlling' role of medical practitioners not only over midwifery practice, but also women's choice to self-determination. Much of obstetric practice is based on pathology and crippled with scenarios of risk. This is why approximately 80% of Australian women leave the hospital system having had an intervention of one form or another. The inverse should be the case with only 20% of women needing an obstetric intervention. Australia's caesarean section

rate alone is over 50% more at 32%.[5]

The reform process has failed to put women in the centre, acknowledging them as the most important player. With a greater consumer emphasis some of the professional 'warring' could be avoided.

Point of Reflection: How ethical is it to prevent a woman who has experienced a traumatic hospital birth a registered midwife when she subsequently chooses homebirth?

(f) any other related matter.

The definition of collaboration is "the act of working together"[6] with one or more people in order to achieve something". Homebirth Australia sees collaboration as a dynamic process of communication, something that is fluid and open in its approach and method.

While the principles of collaboration should be based on the rights and responsibilities of both women and health professionals, the actual act of collaboration is nothing more than a commitment to communicate and work together. The amendment does nothing to assist midwives and doctors to work together in order to achieve something. It simply places even more power and control in the hands of medical practitioners; it dismisses midwifery care as nothing but doctors' assistants and is basically a 'permission to practice'.

The Convention of the elimination of all forms of discrimination against women (CEDAW) declares [7]

Article 2

States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:

(d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;

(e) To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise;

(f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;

Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

[5] Australia's Mother's and Babies 2007, Australian Institute of Health and Welfare, Canberra.

[6] Encarta Dictionary

[7] United Nations (1979) The Convention of the elimination of all forms of discrimination against women. http://www.un.org/womenwatch/daw/cedaw/cedaw.htm

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Homebirth Australia does not know of a health service where men are unable to make decisions about the healthcare they receive or are refused. Childbirth is such a significant event and yet women who choose homebirth or private midwifery are discriminated against through a lack of equitable funding and indemnity insurance protection. If this amendment is effected it is entirely possible that individual choices a woman makes will only be honoured if a doctor agrees.

If a woman persists it is also possible that she will be denied the care of a registered midwife. If a registered midwife agrees to support that woman's choose despite the doctor disagreeing, that midwife is under threat of deregistration. If the woman chooses to birth at home unassisted, she is under threat of a DOCs notification and possible removal of her baby.

Point of Reflection: Do women choosing obstetric care and elective caesarean section have more rights than women choosing a midwife and homebirth. Why is private obstetric care funded and supported while private homebirth is not (with homebirth being 4-5 times cheaper and proved by research to be just as safe)?