Elton Humphery
Committee Secretary
Senate Standing Committee on Community Affairs
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Joint Submission from:
Professor Sally K Tracy, University of Sydney (midwife)
Professor Alec Welsh, University of New South Wales (obstetrician)
A/Professor Andrew Bisits, University of Newcastle (obstetrician)
Dr Mark B Tracy, University of Sydney (neonatologist)

Dear Mr Humphery,

Re: **Amendments (5th Nov, 2009)** to the: **Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 (MNP Bill); Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 (MPI Bill)**

Please find a joint submission from four senior clinicians from New South Wales. A/Professor Bisits would be pleased to make an oral submission on our behalf. We welcome the Community Affairs Legislation Committee Inquiry into the *Amendments* to the above Bills currently before the Parliament.

We applaud the government's plan to make greater use of the midwifery workforce as part of sweeping reforms to the maternity system. We continue to support a collaborative model of care, but believe that it should not be designed to make one profession dependent on another. We understand collaborative arrangements should ensure that clinicians provide woman centred care; facilitate women's access to both midwifery and medical care as appropriate and provide a mechanism to enhance inter-professional cooperation and communication.

We propose that the evidence of, and ultimate auditing of collaboration would be through the pregnancy record (either the woman's 'hand held' notes or the hospital record as determined on a local level). The pregnancy record would be used on an individual basis to document the consultation and referral process and would provide proof of collaboration with medical

practitioners of the woman's choosing. It would be maintained and stored suitably for the statutory time period and be available for auditing. The pregnancy record should incorporate or reference the National Midwifery Consultation and Referral Guidelines, or other future guidelines to be devised and endorsed by the ACM and RANZCOG professional bodies. Whilst an alternative might be for a general overarching 'contract' between the clinicians to apply to any women under the care of midwives, the use of individualised documentation of collaborative plans would allow a more specific form of collaborative care.

We offer the following responses to the questions being considered by the Community Affairs Legislation Committee:

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 license to practice;

The press release from the United General Practice Australia (UGPA) (18th November 2009) stated

> "UGPA congratulates the Government on its recent amendment to the *Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009*, which specifies a legal requirement that midwives and nurse practitioners must work in formal collaborative arrangements with medical practitioners".[1]

If such a legal contract is required before being eligible for Commonwealth-subsidised professional indemnity insurance (PII), midwives will indeed be subject to the approval and control of a collaborating doctor to gain professional indemnity and registration as an 'eligible' midwife. There is a definite risk of medical veto.

There has never been a precedent for written agreements or contracts binding midwives to medical practitioners. In the public system (the default model on which to base the new arrangements) collaboration is enhanced by trust and mutual respect for each others professional scope of practice, with no need for endorsement of one profession by the other.

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

Although restrictions imposed by legislation may fall outside of the reach of the Trade Practices Act we feel the amendment encourages restrictive practices which contravene the accepted anticompetitive nature of working relationships in Australia.

[1] http://www.ama.com.au/node/5133

The following statement suggests competition will be curtailed through the amendments:

> "*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*"[2]

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

If midwives are required to form collaborative agreements with individual doctors rather than area health services in rural and remote Australia the reforms will be unworkable. Sometimes there is no doctor available within hundreds of kilometres, and those available are often locums who are often short-term in appointment, making collaboration with a single doctor impossible. Improving access for these women was a key platform of the maternity reforms and may now not be realized. It is unclear whether a hospital, health service district or authority may be included within the definition of "one or more medical practitioners", but it appears unlikely.

There are many outer regional and rural areas in Australia, serviced by GPs in the absence of obstetricians, where the provision of midwifery led services (eg midwives' antenatal clinics) in the public sector have been vigorously resisted. There is a risk that midwives living in these regions will not be able to find a suitable medical practitioner with whom to form a legal collaborative agreement before being able to register as an 'eligible' midwife. This will seriously limit women's access to midwifery care from an MBS 'eligible' midwife outside the metropolitan area.

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

The purpose of the amendment around collaborative arrangements is not clearly understood. The medico-legal implications for both parties in such an arrangement are also not known at present.

In the public health system there is no precedent for further documentation of a collaborative contract between doctors and midwives. A well supported and efficient regulatory framework currently ensures collaborative practice between all members of the maternity system. Doctors and midwives are currently legally bound to practice within their professional regulatory

[2] Bracey A and McKenzie S "Govt. will mandate nurse practitioner teamwork" *Medical Observer* Friday 6 November 2009

framework of standards, competencies and scope of practice; as well as the policies, guidelines and current evidence shaping practice in the institutions within which they provide the service.

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

In line with international evidence, all available research data supports midwives working in collaborative relationships with health systems, with medical practitioners and with women themselves. Midwifery care has received the highest scientific endorsement in the past year, with a Cochrane systematic review[3] of eleven randomised controlled trials involving over 12,000 women from around the world demonstrating that outcomes for women receiving continuity of care from known midwives were better than for women who received fragmented care from multiple midwives and doctors.

Women enjoy better birth outcomes when they are treated in a model of care that provides coordinated, continuous, and comprehensive woman-centred care that is delivered by appropriately trained health professionals. In the maternity system, such continuity is achieved when women experience care through every episode of the pregnancy, birth and postnatal continuum with one known lead care provider such as an appropriately educated midwife.

If these new measures are implemented, and it is not possible for a midwife in rural and remote areas to access a contract with a medical practitioner, Indigenous communities and other vulnerable community groups will be particularly affected. The original legislation could have opened up greater access to maternity services for people in the community, as well as providing more choice for women. The changes will ensure that lack of access to timely and affordable care remains an ongoing issue for many women around Australia.

f) any other related matter.

The amendments introduce another level of legally binding regulation around the profession of midwifery which is unprecedented nationally or internationally. This move contravenes the international definition of the midwife approved by the International Confederation of Midwives, the International Confederation of Gynaecologists and Obstetricians and supported by the World Health Organisation.[4]

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[3] 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.

[4] *International Confederation of Midwives Definition of the Midwife, adopted by the International Confederation of Midwives, Council Meeting, 19th July, 2005, Brisbane, Australia*

Recommendations:

That the **amendments** applied to the MNP Bill and the MPI Bill stating additional threshold criteria for the purposes of defining an eligible midwife be removed for the purposes of defining an eligible midwife.

Yours sincerely,

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