Submission to the Australian Senate

Community Affairs Legislation Committee

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

By

Maternity Coalition

11 December 2009

Brief presented to Minister Roxon on collaborative arrangements, 8 December 2009:

Australia's National Maternity Consumer Advocacy Organisation

December 2009

Ensuring appropriate collaboration by Medicare midwives

Key deliverables:

- ensure that midwives consult and refer according to their professional guidelines,
- facilitate women's access to medical care when necessary,
- provide mechanisms which build inter-professional cooperation and trust.

"Collaborative arrangements": unrealistic and unworkable

The proposed mechanism of prospectively requiring midwives to hold written "collaborative arrangements" with doctors, is unrealistic and flawed. If implemented, the reforms will not provide access and choice. Start-up on 1 July 2010 is not possible for existing private midwives and leaves women without the option of private midwifery care.

Disincentives for doctors to enter collaborative arrangements:

- Responsibilities: **liability**, commitment, availability, oversight of midwives' practice.
- Competition: medical resistance to entry of another provider to marketplace.
- Professional guidance: e.g. RANZCOG College statements.
- Cultural: inter-professional antagonism and lack of experience with midwifery models.

Our proposal: "collaborative practice"

Audit and support of midwives' actual collaborative practice, using professionally appropriate processes, while maintaining access and choice for women.

Existing mechanisms for ensuring collaborative practice:

- Regulation and existing professional guidance, inc. guidelines for consultation and referral.
- Midwifery Practice Review – regular credentialing and assessment.

New auditable mechanisms to ensure collaborative practice:

- "Supervision of midwives": existing British model to support and guide individual midwives.
- Shared clinical documentation: standard clinical notes in triplicate, shared with woman and referral hospital. Document also collates required evidence for Medicare audit.
- Participation in multidisciplinary case review: best practice engagement with referral hospital.

Benefits of auditing collaborative practice:

- stronger quality assurance than collaborative arrangements.
- assesses midwives' actual practice.
- stronger than for other comparable caregivers, e.g. GP antenatal care.
- avoids provoking interprofessional conflict.

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Australia's national maternity consumer advocacy organisation

National Office

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To: The Secretary
Senate Community Affairs Legislation Committee
community.affairs.sen@aph.gov.au

11 December 2009

Dear 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

Please see below our submission to your inquiry.

Summary

- Maternity Coalition supports the Minister's maternity reform agenda and welcomes her commitment to improving access and choice for Australian women.
- Informed choice and continuity of care must underpin any reforms to maternity services.
- In order to offer true choice to women the reform package must enable midwives to continue work in self-employed private practice providing continuity of care to women.
- The Minister is concerned to ensure that midwives who provide care to women consult and refer appropriately and build cooperative relationships with medical practitioners.
- The 5 November amendments require a midwife to enter into a prospective "collaborative arrangement" with one or more medical practitioners in order to access insurance, MBS and PBS.
- This requirement is fundamentally flawed and will obstruct access to midwifery care.
- Under the amendments midwives will be compelled to enter into arrangements with doctors but there is no corresponding compulsion for doctors to enter into such arrangements with midwives.
- There are significant disincentives and extremely limited incentives for doctors to enter into collaborative arrangements with midwives.
- There are alternative mechanisms (some already in place and others that would need to be developed) that would be more effective in ensuring genuine collaboration between the professions.
- These mechanisms would audit and support midwives' actual collaborative practice using professionally appropriate processes.
- These alternative mechanisms would facilitate (rather than obstruct) the increased availability of midwifery care for Australian women.
- The 5 November amendments should not proceed.
- Subsidised professional indemnity insurance should be provided to midwives who meet eligibility criteria regarding qualifications, experience and credentialling.
- Access to Medicare and PBS should be dependent on a midwife meeting eligibility requirements and collaborative practice standards.

Introduction

Maternity Coalition welcomes the opportunity to provide a submission to the Senate Committee for Community Affairs on this very important legislation. We believe that the Committee's work facilitated a good outcome to the problems brought before it in the previous inquiry. We are hopeful that the current inquiry will also help these important reforms to deliver a positive outcome for Australian mothers and families.

Maternity Coalition is Australia's umbrella organisation representing consumers of maternity services. We are uniquely placed to provide an informed analysis of the proposed reforms and to offer an insight into the cultural and structural obstacles to maternity services reform. Maternity Coalition's position is informed by our:

- engagement at the local level with the maternity care system throughout Australia supporting consumer representatives who work with services to ensure that they meet women's needs and give women better access to continuity of midwifery care;
- work since 1989 representing our members who have experienced the diverse range of maternity services available in Australia, in both public and private healthcare settings and through both obstetric and midwifery-led care;
- strategic, policy-focussed role lobbying efforts at a state and Commonwealth level for systemic reforms which will deliver choice, continuity and control to all birthing women;
- partnership with the midwifery profession, aimed at building the profession's ability to deliver the care women are seeking;
- close engagement with the Government's maternity reform agenda. This Government has taken the historic step of recognising consumers as stakeholders in the maternity care system. Maternity Coalition has provided two consumer representatives to each of the stakeholder meetings hosted by the DOHA, since the first MSAG meeting on 12 August 2009.

Maternity Coalition is a strong supporter of Minister Roxon's maternity reform agenda, with its goals of improving access and choice for Australian mothers by improving their access to midwifery care. The benefits for women of access to continuity of midwifery care have been well established by science and recognised by Australian governments. The Minister's stated intentions, as outlined in her second reading speech, indicate a desire to deliver on a long history of reviews and recommendations for improving Australia's maternity care system.

The Minister has also committed to ensuring that midwives, working under the new arrangements, do so with "collaborative arrangements" in place including appropriate referral pathways with hospitals and doctors. The presumed intention of this commitment is to ensure that midwives consult and refer appropriately, that women receive the care they need when they need it, and that all caregivers work cooperatively in the interests of the woman and her baby. While Maternity Coalition strongly supports all of these goals, we believe that the mechanism chosen to deliver them will undermine the reforms.

Maternity Coalition has held concerns about the requirement for "collaborative arrangements" since the beginning of the Maternity Services Advisory Group (MSAG) process. Prior to 5 November 2009 it was expected that this requirement would be set out in the regulations to the three Medicare for midwives Bills.

We have always considered the mechanism unrealistic, and at risk of giving medical practitioners a veto or control over midwifery practice. The announcement on 5 November that the requirement would be included in the legislation precludes the option of adjusting the regulations until they work, and puts the whole reform process at risk.

Maternity Coaltion submits that the amendments will have unintended consequences which are contrary to the intentions of the broader reforms. We submit that the amendments

should be withdrawn and that a different mechanism to ensure safety and encourage collaboration amongst caregivers should be established.

Our submission is divided into three main sections. The first section attempts to explain, as briefly as possible, why the proposed “collaborative arrangements” mechanism is ineffective for protecting the safety of mothers and babies, or to encourage genuine collaboration. This includes addressing the terms of reference of this inquiry.

We then outline our proposed solution to this problem in the section, titled *“A way forward: collaborative practice”*, starting on page 11.

Following the main body of our submission, Appendix 1 offers our analysis of what models of care might be possible under the reforms and what obstacles they might face.

This submission has been prepared consistent with the TOR of the Senate Committee inquiry. During the preparation of this document we have been advised that the Minister has undertaken not to proceed with the collaboration amendments to the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009.

While we appreciate the goodwill in the Minister’s action, it is unclear what exact effect it will have on the “medical veto” problem.

Department of Health and Ageing (DOHA) staff have stated they expect a requirement for midwives to have "collaborative arrangements" will be included in the conditions of the insurance.

Under the new registration law, practitioners “must not practise the health profession unless professional indemnity insurance arrangements are in force”.

It appears the midwife must have a "collaborative arrangement" for her insurance to be "in force", to meet the conditions of her registration (this would be easily audited by the regulator if they chose). Thus, the midwife cannot legally practice without a doctor's permission, which they would attain via a "collaborative arrangement".

In this case, only the “circularity” issue has been addressed, in that the midwife will not be required to have a “collaborative arrangement” in place before insurance and then registration.

“Collaborative arrangements” remain a prerequisite for Medicare, which will be be a key to delivering the intended reforms. Because of this, midwives and new services using Medicare for midwives funding remain entirely dependent on doctors willing to enter agreements.

Based on the likelihood that “collaborative arrangements” may be a condition of insurance, we have chosen to retain reference to our concerns about “collaborative arrangements” as a prerequisite for self-employed practice, but have noted with a ** the text in sections which may be affected in some way by this recent development.

What is being delivered to women?

In order for these reforms to deliver choice, continuity and control to women, they must offer women the option of engaging a self-employed, community-based midwife who can provide continuity of care.

The value of Minster Roxon’s reforms lies in the care which they will deliver to Australian women and families. With professional indemnity insurance and Medicare rebates, women will be able to access models of care in which midwives are primary caregivers. Central to midwifery models of care, is the principle of continuity of carer, in which a known caregiver

provides care throughout the maternity episode. This is what women have been asking for, and what the Maternity Services Review proposed.

Medicare is a social insurance mechanism which operates by paying consumers a rebate for the cost of purchasing care from private providers. Thus these reforms apply to care which is being privately purchased by a woman from a midwife. Eligibility to provide Medicare-rebatable services is granted to individual providers, traditionally working in self-employment.

According to our analysis, the following broad models will be supported under the new legislation:

- midwives working in self-employed midwifery practice, either individually or in partnerships with other midwives, in a similar model to Australian General Practitioners (GPs);
- midwives employed or contracted to work in the private practices of doctors; and
- midwives contracted to work in models run by public hospitals.

A more detailed analysis of the possible models of care under Medicare for midwives is provided in Appendix 1. The analysis in this appendix was developed before the 5 November amendments, and has had a financial analysis of midwives' Medicare payments and income removed. Appendix 1 shows how challenging it will be to deliver continuity of care through the Medicare for midwives reforms, largely due to Australia's fundamentally problematic health funding system.

Maternity Coalition submits that the effectiveness of these reforms is dependent on the first model being available. The other two models offer the possibility of improving choice and access for women but are not sufficient in themselves as an outcome of the reforms. Neither model offers women the accountability of directly employing a midwife to provide care. The fundamental consumer principles of "choice, continuity and control", are best served when the midwife is directly accountable to the woman for the care she provides, in line with her professional guidance. Additionally, the second two models are likely to take a substantial amount of time to set up and it is unlikely that they will be an option readily available to all women throughout Australia for a very long time (if ever).

It is therefore essential that self-employed, private midwifery practice is supported as an option under these reforms.

Collaborative arrangements – the key issue

The proposed mechanism of prospectively requiring midwives to hold written "collaborative arrangements" with doctors is unrealistic and flawed. If implemented, the reforms will compromise women's access and choice to self-employed private midwifery care.

Purpose of collaborative arrangements

All stakeholders recognise the need for midwives to work collaboratively with other caregivers – primarily with doctors providing obstetric care. This is fundamental to a primary care profession like midwifery, and is recognised in the professional guidance which defines midwives' practice.

These reforms promise to support an increasing number of midwives moving into roles of greater professional autonomy, consistent with their scope of practice. Given this, it is reasonable to expect that mechanisms will be put in place to:

- ensure that midwives consult and refer according to their professional guidelines,
- facilitate women's access to medical care when necessary, and
- provide mechanisms which build inter-professional cooperation and trust.

We presume that the purpose of requiring "collaborative arrangements" is to ensure that these objectives are delivered.

Nature of collaborative arrangements

The precise nature of collaborative arrangements has not yet been defined. However our understanding, based on participation in the MSAG consultations, is that the arrangements will:

- be written documents, meeting a minimum standard of evidence for Medicare audit;
- have the agreement of the collaborating medical practitioner(s) to be valid;
- be in place before the service is rendered by the midwife, or insurance is purchased**;
- be entered into by individual doctors – our advice from the Minister's office and DOHA is that institutions (such as hospitals) may enter into collaborative arrangements, but that that an individual doctor must be nominated as being in the arrangement; and
- be entirely voluntary for doctors.

Additionally DOHA have stated their intention not to be prescriptive regarding the content of "collaborative arrangements". No wording or limitations on nature or extent are likely to be specified.

Most importantly, there is no requirement for "collaborative arrangements" to be based on accepted principles of collaboration.

Despite the work yet to be done, mostly in setting a minimum standard of evidence, the essential characteristics of "collaborative arrangements" are clear.

Flaws of the "collaborative arrangements" mechanism

All stakeholders agree with the need for collaboration between caregivers, and in particular for midwives to work collaboratively. However the Government's proposed mechanism is not a result of consultation with the appropriate stakeholders. Midwifery, nursing and consumer groups were not consulted regarding how collaboration should best be ensured, and it is unclear what medical groups were consulted other than the Australian Medical Association (AMA).

Some stakeholders consider the amendments to have purposes well beyond assurance of midwives' collaborative practice. In its media statements, the AMA claims the 5 November amendments as its own *"win for the profession"*. "Collaborative arrangements" are their preferred mechanism to "*ensure that nurse practitioners were not supported to work in competition with doctors",* and to ensure that *"the role of medical practitioners, particularly the patient's usual General Practitioner, is not undermined"*.

Our interpretation of the effect of the 5 November amendments is consistent with that of the AMA, in that the amendments provide medical control over women's access to midwifery care. Midwives will only be able to enter private practice**, or provide Medicare-rebatable services, if they meet doctors' criteria, which may be dictated by insurers, hospitals, professional colleges or perceived liability, in addition to the doctor's personal preferences.

We recognise that the Minister has made it clear all along that she intends insurance and Medicare to be provided on condition of midwives' working collaboratively with doctors. Until 5 November these requirements were to be articulated in the regulations under the Bills, and thus had the prospect of relatively easy amendment if found to be obstructing implementation of the scheme. By spelling out this specific mechanism in the primary legislation, any future amendments would be very difficult to implement.

In the context of Australia's poorly developed culture of collaboration in maternity care, the proposed mechanism puts the reforms at risk. The requirement for collaborative arrangements as a prerequisite for indemnity, grants medical control over midwives ability to function in self employed practice**. As a prerequisite for Medicare, the requirement grants medical control over how midwives practice. Both of these mechanisms put womens' access, control and choices for continuity in birth care at risk.

Disincentives for collaborative arrangements

Participation by medical practitioners in collaborative arrangements with midwives is voluntary. There are extremely limited incentives, and significant disincentives for doctors to enter collaborative arrangements with midwives.

Disincentives include the following:

- **Responsibility.** This is one of the strongest disincentives for doctors to enter collaborative arrangements, as identified by doctors. By entering the arrangement, doctors carry additional, real or perceived, responsibilities, including:
    - **Commitment.** Doctors who are currently happy to work collaboratively with midwives in private practice might be reluctant to enter documented collaborative arrangements which they perceive will require new and significant commitments from them.
    - **Availability.** This may include providing 24/7 cover, which is necessary for intrapartum care.
    - **Oversight and control** of midwives' practice. We do not expect this to be an intended part of collaborative agreements, but this is a deeply entrenched element of current medical culture. Many doctors will expect that it is their responsibility to ensure that midwives are practising "safely". Midwives, however, are responsible for practising to midwifery standards and guidelines.
    - **Liability.** Doctors are very sensitive to issues of liability, and are very wary of anything which may make them liable for another practitioner's practice or outcomes. Doctors frequently report that they often have to "carry the can" for the mistakes of others, although this is not necessarily supported by evidence or analysis. In some cases GPs already frequently refuse to provide care or collaborate with midwives for women planning homebirths, citing insurance problems.
- **Workload.** Individual doctors, and institutions they may represent in collaborative arrangements, are frequently working at or above a sustainable level in the Australian maternity care system. Entering into collaborative arrangements with midwives may risk a real or perceived increase in the load they carry. The most real risks are likely to be in rural areas, where GP-obstetricians are often stretched, or urban areas where Medicare midwives may seek arrangements with overloaded public hospitals. While we are of the view that these reforms promise to make a substantial contribution to addressing our current maternity workforce problems, the perceptions of individual providers are rarely informed by this understanding.
- **Competition.** There are strong cultural and financial disincentives against doctors allowing midwives into the private maternity care marketplace which they currently have almost entirely to themselves. We explore this further below under the terms of reference.
- **Financial**. Establishing and engaging in collaborative arrangements will involve time and potentially significant cost. Doctors are likely to seek legal and insurance advice on the implications of entering arrangements with midwives, potentially at cost.
- **Professional**. A range of professional guidance is interpretable as advising against collaborating with midwives in some circumstances. For example, the *Royal Australian and New Zealand College of Obstetricians and Gynaecologists* (RANZCOG) publishes an organisational position statement opposing homebirth. Some obstetricians, even in public hospitals, cite this as a reason not to collaborate with midwives in the care of women planning homebirths. RANZCOG's recently released guideline on "*Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care"* does not support private midwives working in collaboration with public hospitals.
- **Cultural.** Although there are examples of excellent collaboration between obstetricians and midwives, Australia has a well documented and publicly visible

culture of division between the professions. There are ongoing arguments about whether doctors should be in control of midwives' practice, whether midwifery care is "safe", and what choices women should make. Midwives may provide care for women who make choices some doctors feel uncomfortable with, such as homebirth, or labour and/or birth in water. Private hospitals, or doctors in private practice using these hospitals, will be sensitive to the dominant medical culture in which they operate, which will rarely support true collaborative practice.

Incentives for collaborative relationships

Balanced against the very substantial disincentives listed above, there are some incentives:

- **Financial.** There are very specific and limited circumstances in which doctors would have a financial incentive to enter collaborative arrangements with midwives. Doctors with private obstetric practices of adequate size could employ midwives to work within their practices to provide services to women. The relationship would be based on employment and direction of the midwife by the doctor. This does not constitute a collaborative arrangement between a doctor and a midwife in self-employed private practice.
- **Strong collaborative values.** Most practitioners express strong support for collaborative values. Some will hold these values highly enough to enter collaborative arrangements in order to support their midwifery colleagues.
- **Community service values.** Some doctors will support midwives in order to assist access to maternity care in their community.
- **Organisational policy.** State governments may use policy to drive public hospitals into supportive relationships with midwives in private practice.

Unfortunately even the most enthusiastic doctors will confront the disincentives above.

Power relationships

At the heart of consumer concerns with "collaborative arrangements" are power relationships. This is fundamental to the Minister's promise to deliver "choice" to mothers. Thus, these reforms must be about empowering women in their own experience of motherhood.

Consumers are increasingly determined to be empowered in the health care system. They expect to be able to make "informed choices" in an environment where they are provided with enough evidence-based information to make those choices.

The law recognises a woman's right to make decisions about her maternity care, including refusal of any care, as long as she is competent to make decisions. While pregnant, the woman's baby is legally part of her body. As a parent, mothers and fathers are generally able to decide on their baby's care, however there are some limitations on a parent's ability to make decisions about the care of a baby once born.

Australia is relatively poorly progressed in developing a culture of "informed choice" in maternity care. Consumers repeatedly tell stories of being denied their rights to choose or refuse care. Clinical cultures are often oriented to gaining compliance, and punishing women for choosing against hospital policy. For example, many hospital-based birth centres will deny access to continuity of midwifery care for women who decline ultrasounds or other screening tests. These policies are not evidence-based, nor do they improve women's safety.

The desire to receive care in a culture of informed choice is a significant factor in women's persistent and increasing requests for continuity of midwifery care. Informed choice is difficult to deliver in fragmented models, as the many caregivers (women can expect to receive care from 20 to 30 different individuals) do not have time to become familiar with the woman, or her needs or wishes. Women routinely report that their written care plans and agreements are ignored by new caregivers.

In a continuity of midwifery care model, with one, two or three primary caregivers, a woman does not need to repeatedly explain her story to strangers. She can gain confidence that once in labour, she will be cared for by someone who understands what she wants, and who she can communicate with as her needs change.

Continuity of care, by itself, increases the power of the woman in the care environment. This may even be part of the way continuity of care improves measurable outcomes. This also challenges many caregivers' perspectives of patients as passives recipients of care.

Delivering informed choice and continuity of care requires each caregiver to be responsible for the care they are providing. We fully expect collaborative agreements, negotiated between midwives and doctors, to greatly complicate real and perceived responsibility for women's care, and to make informed choice very difficult to deliver. Doctors can be expected to set parameters for midwives' practice that are separate to midwives' professional scope of practice. They may say they are willing to collaborate, but refuse to be involved in the care of women planning homebirths. They may believe that women with previous caesareans, or who are aged over 32, or who decline some screening tests, should not receive midwifery care (these are real examples).

The current proposal gives open scope for collaborative arrangements on the medical practitioner's terms, and risks defining midwifery care based on doctor's comfort zones, rather than evidence and midwives' scope of practice. Women will have 2 people to negotiate their choices with: the midwife, who is responsible to her; and a doctor, who is not. This disempowers women by establishing inappropriate power relationships between her caregivers.

These reforms should empower women in their birth care, and use women's power to grow a culture of collaboration in maternity services.

Responses to TOR

Below we respond in detail to the points in the terms of reference for this inquiry.

(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;

Insurance conditional on "collaborative arrangements"

The 5 November amendment to the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009* requires midwives to have a *collaborative arrangement* with *one or more medical practitioners*, before having access to Commonwealth-subsidised professional indemnity insurance.

As there is currently no commercial insurance product for midwives working in private practice, they are likely to be dependent on Commonwealth support for access to insurance until private products are available. Midwives working in hospital employment are covered by their employer's insurance.

Under the new National Registration and Accreditation Scheme, professional indemnity insurance is now a requirement for registration as a health practitioner. It is anticipated that evidence of insurance will be required on renewal of registration. Practitioners may be subject to disciplinary action if found to practice without insurance. The only exception to this is midwives providing intrapartum (labour and birth) care to women at home, for which the Health Ministers have granted a two-year exemption.

In summary, to register and work in self-employed practice, a midwife will need Commonwealth-subsidised indemnity insurance, which is conditional on having a collaborative arrangement with *one or more medical practitioners*. This conditionality may be

expressed in the legislation, as proposed in the 5 November amendments; in conditions for eligibility, as was previously planned; or in the conditions attached to insurance policies, as has been stated by DOHA.

This puts the ability of midwives to register and practise as regulated professionals in the hands of another profession.

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

Minister Roxon has made it clear that she intends her maternity reform agenda to deliver improved "choice" in birth care to all Australian women. Although "competition" has not been explicitly described as a goal, it is clear that giving women real choice will empower them to decide which model they prefer in the maternity care marketplace.

Medicare for midwives is likely to do just that, if only to a limited extent at first (see Appendix 1). Midwives, GPs, GP-obstetricians and specialist obstetricians will become alternative providers of antenatal, intrapartum and postnatal care in the maternity care marketplace, within the restrictions of Australia's funding structures.

To some extent the different providers are, and will remain, complementary, providing to different demographic, geographic or clinical needs. However in some services, such as antenatal care for healthy women, direct competition may develop as midwives move into private practice.

Medicare-funded midwifery care must not be positioned as a service to plug holes in the medical system of maternity care. It must be an option women may choose. Some consumers explicitly seek midwifery care, in contrast to medical models, and want their midwife to be working for them, not a doctor.

By their own account, a motive for the AMA's lobbying to introduce these amendments has been to prevent competition. AMA Vice-President Steve Hambleton stated in the *Medical Observer* that *"the crucial amendment would ensure that nurse practitioners were not supported to work in competition with doctors"*. The provisions relating to midwifes mirror the nurse practitioner provisions. The AMA also stated that the amendments would ensure that *"the role of medical practitioners, particularly the patient's usual General Practitioner, is not undermined."* These statements reinforce the doubt that the amendments' primary effect will be to ensure safety for women and babies.

The amendments as announced on 5 November give two mechanisms for doctors to control midwives' access to the market. "Collaborative arrangements" are a prerequisite for insurance**, controlling access to the marketplace. They are also a prerequisite for Medicare, controlling access to taxpayer money. Furthermore, in some circumstances the arrangements must be made with local providers of the same services e.g. GP obstetricians in rural towns.

Demand from women as consumers of maternity care services should shape the maternity care market, and professional bodies should set and maintain standards. There should be no provision for members of one profession to control consumer access to the services of another.

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

Implementation of these reforms faces significant obstacles as a result of Australia's health care and funding systems. Appendix 1 outlines our analysis of the potential models which might function under the reforms, and the difficulties most of them face. These reforms face major challenges, regardless of the effect of the 5 November amendments.

We have already outlined the significant disincentives for doctors to enter into these arrangements. Maternity Coaltion's awareness of these very real problems comes from our

long experience in supporting the implementation of new models of maternity care, and conversations with doctors across the cultural spectrum.

Maternity Coalition members have considerable experience as consumer representatives working with public maternity facilities, in states where Governments are committed to providing women with more choice and access to continuity of care. In some sites we see significant resistance from doctors to participation in clinically conservative, hospital based, midwifery models of care, even in circumstances where without their collaboration local maternity services will close.

Many women planning a homebirth in the care of a privately practising midwife struggle to find GPs and obstetricians who are supportive or even tolerant of their choice, and have difficulty gaining referrals for routine blood tests and scans.

In places where this attitude prevails, midwives will not be able to find collaborative arrangements and work in self-employed practice. This will of course preclude women being able to access their care.

As we have outlined above, even where doctors are philosophically supportive of privately practising midwives, there are significant disincentives to their participation in collaborative agreements. They may be advised against participation by their insurers or practice partners, or they may not have the support of their employer. They may be willing and able to collaborate with midwives, but not to enter a written arrangement.

We consider that the requirement for collaborative arrangements, as currently proposed, will create significant difficulties for delivering the intended access and choice for Australian women.

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

The wording of the amendments implies that collaboration can only happen when the midwife has agreements with each individual doctor who will be providing consultation and referral services. This is the position taken by more extreme medical voices, and appears to have shaped these amendments.

The reality of consultation and referral in day-to-day clinical care is very different. Most maternity care is provided in a system which does not depend on individual caregivers choosing who they are willing (or not) to collaborate with. Primary carers in the community, e.g. GPs and midwives, usually consult and refer to hospitals with pools of staff filling defined roles, not to individual doctors.

A relevant example already operates in Australia's maternity care system. A significant proportion of Australian women receive antenatal care from GPs working in the community, usually without obstetric training. These women will usually progress to birthing in a public hospital. GPs are not required to have collaborative arrangements with the hospital, or with individual doctors within the hospital. Hospitals may develop shared care protocols to facilitate collaboration with GPs, but these carry no compulsion, and hospitals report poor compliance by GPs. It is the expectation of the woman, the GP, the hospital, and the hospital's maternity care staff that the public hospital will provide the care needed by the woman. Collaboration is the assumed arrangement, not something that needs to be specially negotiated.

This assumption lies behind current successful collaboration between private midwives and public hospitals. There certainly are public hospitals which obstruct cooperation with private midwives, but even these provide care to women when they need it. Collaboration works best when the woman's caregivers all understand that collaboration is a part of their professional responsibilities.

At the heart of the amendment's wording is the proposition that Medicare-funded midwives should be treated differently from GPs who provide antenatal care. The clear implication is that collaboration with GPs is part of an obstetrician's job, but collaboration with midwives is

optional, and should be the choice of individual doctors. In this sense, a mechanism which is intended to drive collaboration risks undermining it.

Our proposal, outlined from page 11 is that a different mechanism should be used to ensure collaborative practice by midwives. Our proposal establishes far stronger processes to ensure collaboration between midwives and hospitals, than are in place for GPs.

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

We consider the amendments to be ineffective in ensuring safety or continuity of care for Australian mothers, and to carry some additional risks.

The requirement for collaborative arrangements risks the establishment, in some cases, of de-facto "parallel regulation" of midwifery practice. In other words, there is a risk that midwives may find themselves with conflicting expectations about their practice, from their professional guidance and regulation, and from the explicit or implied terms of their collaborative agreements.

The potential for this already exists in the existence of two sets of guidelines for consultation and referral for maternity care. One has been developed by the Australian College of Midwives (ACM), and is referred to by regulators when assessing the practice of midwives. The other has been developed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), and is recommended by them for the use of midwives. Some doctors have already indicated their expectation that midwives would collaborate with them in line with the RANZOG guidelines, and we would expect that many doctors would be strongly inclined to follow the recommendations of their professional body.

Two conflicting guidelines for the same decision-making process is not an acceptable situation for a professional to be in. The same problem of conflict may arise between midwives professional responsibilities regarding the woman's informed choices.

Doctors are not experts in midwifery, or in assessing and guiding midwifery practice. It is risky to put them in a role where they may believe that this is their responsibility.

The amendments also risk denying some women care. Women choosing to birth at home are especially vulnerable, if local midwives are unable to gain collaborative arrangements, or their arrangements are conditional on not providing homebirth care. The two-year exemption for homebirth, under the National Registration and Accreditation Scheme, may not help this, as the viability of midwives' practice may be dependent on access to Medicare, and their access to insurance for antenatal and postnatal care is likely to be dependent on collaborative arrangements either prospectively** or retrospectively (in the insurer's conditions).

A way forward: collaborative practice

This may be considered a response under the Terms of Reference, item **(f) any other related matter**.

As stated above, Maternity Coalition supports what we believe to be the Minister's intentions behind the requirements for collaborative arrangements. This is to:

- ensure that midwives consult and refer according to their professional guidelines,
- facilitate women's access to medical care when necessary, and
- provide mechanisms which build inter-professional cooperation and trust.

In short, the desire is that midwives' practice is collaborative. We believe this goal to be supported by all stakeholders.

An effective mechanism for delivering this goal must recognise the professional autonomy of the midwife, and be oriented toward midwives' adherence to their professional standards and guidelines which have been carefully developed to provide for the safety of midwifery care. Additionally, it must encourage inter-professional cooperation without reinforcing power imbalances.

Realistically, several concurrent mechanisms will be necessary. This is the case already with the currently proposed "collaborative arrangements" mechanism. For midwives' professional integrity, they must be consistent with current regulatory frameworks and professional guidance, although there are risks to this as we have outlined above.

We propose that "collaborative practice" become the required standard, rather than "collaborative arrangements". Auditing midwives' collaborative practice would assess whether midwives have truly practised to the required standards of collaboration, rather than simply having an agreement with a doctor in place.

Between existing and additional mechanisms outlined below, we believe a stronger system of quality assurance can be established than that currently proposed, without antagonising inter-professional sensitivities, and with a far higher likelihood of successfully delivering choice and access to women.

Exisiting mechanisms for ensuring collaborative practice

Regulation. Midwifery is a regulated health care profession. Regulation, currently by state-based boards and councils, and from 1 July 2010 to be under the Australian Nursing and Midwifery Board (ANMB), is for the protection of the public. Standards, codes and guidelines are developed by nursing and midwifery experts to define and guide midwifery practice. This guidance may be developed by the regulator, a quasi-regulator (e.g. the Australian Nursing and Midwifery Council) or a professional body, which for midwives is the ACM.

Midwives are required to work collaboratively by their professional guidance. For example, Midwives' consultation and referral to medical practitioners is guided by the ACM's *Midwifery Guidelines for Consultation and Referral*. A major proportion of the intentions outlined above are to ensure that midwives' practice is consistent with these guidelines. Interestingly, a collaborative arrangement with a medical practitioner is a weak mechanism for this task, given doctors' lack of expertise in midwifery, and that the role of doctors should not be to review midwives' practice in detail.

The ANMB will be responsible for ensuring midwives practice to the standards of their profession from July 2010. Strengthened processes have already been developed for the new regulator to maintain professional standards from this time, including continuing professional development and currency of practice requirements.

Midwives' practice, even in self-employed practice, is under scrutiny. Midwives need to interact frequently with hospitals, where private midwives find they are scrutinised very closely, and sometimes harshly. Any clinical concerns, including failure to consult or refer appropriately, may result in a complaint to the regulator. From July 2010, new mandatory reporting requirements will strengthen this. Consumers may also make complaints, and processes for improving support to consumer complainants are being strengthened at state and federal levels.

Midwifery Practice Review. This is a credentialling process developed by the Australian College of Midwives to assess and advise on individual midwives' practice and professional development. Midwives participating in this voluntary process must submit documentary evidence of their professional development and outcomes, assessed against Australian midwifery competencies. The competencies include collaborative practice.

In summary, regulatory and professional processes already in place require midwives to work collaboratively and offer significant quality control. Regulatory systems are being strengthened under the National Registration and Accreditation Scheme.

New mechanisms to ensure collaborative practice

Maternity Coalition proposes that the following new mechanisms be used to ensure midwives' collaborative practice. Each mechanism includes audit and support elements.

Professional support from midwifery consultants for midwives in private practice, separate from line management. This has previously been proposed in Australia using the descriptions "guardians" or "mentors".

All British midwives have 24/7 access to expert support, under the title "supervision". According to the British regulator of midwifery, the Nursing and Midwifery Council, *"Supervision is a means of promoting excellence in midwifery care, by supporting midwives to practise with confidence, therefore preventing poor practice".* Under this mechanism each midwife has access to an expert midwifery consultant who *"Provides support and advice to midwives to ensure their practice is consistent with the regulatory framework"*.

In the British system, "informed choice" is a key focus: *"Supervisors also have a role in advising and supporting women who use midwifery services; advocating for the right of all women to make informed choices and providing additional advice to women who are experiencing difficulty in achieving care choices."*

Establishment of such a system in Australia would need the confidence of midwives working within its scope, and would need to be "owned" by the midwifery profession. In our opinion, at this stage the culture of midwifery regulation in Australia is not yet adequately developed to take this responsibility. In the transition to national regulation, there is currently no clear mechanism for progressing midwifery professional issues or addressing consumer expectations of midwifery care.

We propose that a system of midwifery consultant support be established for Australian midwives in private practice. It should receive government funding, and be managed by the profession. Participation by midwives could be a requirement of credentialling for eligibility for Medicare. This system would ensure that midwives have support from an expert in their own profession to collaborate to their professional standards.

Shared standard clinical documentation is considered to be a best-practice strategy for ensuring that all caregivers of the woman have access to the same full clinical history. "Patient hand-held records" are becoming normal for maternity care, and are supported by evidence of their effectiveness. Women carry their own records, often with multiple copies allowing for maintenance of records at each place of care. Hand-held records often form an evidence-based or good practice clinical pathway, with the right questions asked at the right time along the maternity episode.

Queensland Health has developed standard "Midwifery Notes" for the use of homebirth midwives in Queensland, designed to facilitate collaboration between privately practising midwives and public hospitals. These notes are in triplicate, providing copies for the midwife, mother and hospital. Spaces are provided for hospital booking details and GP referral.

We propose that shared clinical documentation, similar to the QH Midwifery Notes, should be used as a mechanism for supporting and auditing the quality of midwives' collaborative practice. The clinical pathway within these notes would guide midwives in their collaboration with doctors and hospitals, in addition to their existing guidance for consultation and referral. Booking with hospitals, consultation and referral with hospitals or doctors, and submitting of copies of notes to hospitals or doctors would all be recorded within the notes.

The notes would document the informed choice process by women, and could be signed by the woman when she has made choices against the midwife's advice or guidance.

As much as possible, these notes should be standard across models of care and should follow the woman. If for any reason a woman moves between models of care, the documentation is continuous and consistent, and facilitates seamless maternity care.

Audit by Medicare could check that key collaborative responsibilities were attended to in individual women's documentation, and signed off by the midwife or collaborating hospital or

doctor. Evidence of the midwife's participation in Supervision could be provided in the documentation, also available for audit.

Participation in multidisciplinary case review is considered a best-practice process for reviewing clinician's clinical practice and building a collaborative culture of care. Practitioners involved in individual women's care, from all professions, meet to discuss and analyse cases, and provide feedback on clinical decision making and practice. Health care facilities with a focus on continuous quality improvement, professional development, and collaborative culture, already run multidisciplinary case review sessions on a regular schedule.

It is not practical for every woman's case to be reviewed, but midwives could be required to submit the appropriate copy of their clinical documentation for each case at the conclusion of the woman's care (usually 6 weeks) to the collaborating facility. In cases where women did not give consent to named documentation being passed on, a de-identified case history could be prepared and submitted.

A specific place on standard midwifery notes could be provided, where submission of clinical documentation for multidisciplinary case review could be documented, and be accessible for audit by Medicare.

Benefits of auditing collaborative practice

In our view, audit of midwives' collaborative practice using the new and existing mechanisms outlined above would deliver stronger quality assurance than the proposed collaborative arrangements mechanism. The mechanisms practically support midwives' appropriate collaboration, and assess midwives' actual practice. They are far stronger than for other comparable caregivers, for example for GPs providing antenatal care. [Our understanding is that GPs are not required to meet any specific requirements to provide antenatal care, in regard to education or professional development, collaborative arrangements with hospitals or specialists, or sharing of clinical documentation].

Our proposed mechanism avoids provoking inter-professional conflict. Midwives are not overseen by doctors, but are regulated by their own professional regulator. Doctors are not confronted with the need to make difficult judgements about signing up to collaborative arrangements. Midwives and doctors are able to negotiate collaboration without the complications of one having power over the other.

If doctors or hospitals decline to provide care on referral from a midwife, this must be assessed in the light of their professional or organisational responsibilities. Doctors or hospitals may decline to participate in multidisciplinary case review, without preventing midwives from practising. Midwives and their collaborative partners would have the benefit of Supervisors to clarify midwifery scope of practice and professional responsibilities.

A Commonwealth Midwifery Advisor

The progress of these reforms has been very difficult for the Minister, DOHA, and stakeholders. We believe that a significant cause for this has been a lack of in-depth expertise in midwifery, especially private practice midwifery, within DOHA.

As the Commonwealth has now committed to working with privately practising midwives, it would be very helpful to all parties if a person with strong expertise in this area was employed in a suitable role in the Department.

Conclusion

Maternity Coalition submits that the following steps be taken regarding legislation:

- the 5 November amendments to both the Medicare and the indemnity Bills should be withdrawn.

- subsidised professional indemnity insurance should be provided to midwives meeting eligibility criteria regarding qualifications, experience and credentialling.
- Access to Medicare should be made conditional on eligibility and meeting standards of collaborative practice.

We propose the following text be inserted in place of the 5 November amendments in the *Health Legislation Amendment (midwives and nurse practitioners) Bill 2009:*

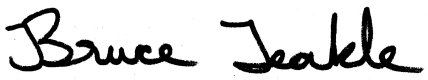
"so far as the eligible midwife renders a service to a standard of collaborative practice as specified in the regulations..."

This would drive collaborative practice by midwives through making it a condition of access to Medicare rebates. Collaborative practice would be defined in the regulations, where amendments can be relatively easily made by the Minister if required.

We prefer not to make collaborative practice requirements a prerequisite for "eligibility". This avoids making it a requirement for insurance, and consequently the ability to register for private practice. Any risk of "circularity" is thus avoided, where midwives have difficulty achieving prerequisites in the required order. Additionally, any difficulties or delays in establishing the various new processes for these reforms would not impact negatively on midwives' ability to register.

Maternity Coalition thanks the Committee for its attention to these issues. We would be pleased to contribute to the Senate Committee's Review in any way requested, including by appearing before the Committee.

Yours sincerely,



Bruce Teakle

on behalf of the Maternity Coalition National Committee

Appendix 1

This document is an edited version of a more complete analysis of possible models under Medicare. Proposed Medicare fees and income analyses have been removed to satisfy our confidentiality commitments.

Continuity of midwifery care under Medicare

There are many ways in which eligible midwives might provide care under Medicare funding. However there are limited pathways in which Medicare funding might support women's access to continuity of midwifery care.

Below are all the models we envisage would be possible, and able to provide continuity of care, under the Medicare for midwives reforms. The financial, cultural and structural obstacles to these models are outlined.

Medical practice midwife model

This model appears to be viable (perhaps the most viable of all proposed models).

The simplest version of this model is the eligible midwife working in a contractual arrangement and in clinical collaboration with a private specialist obstetrician (or possibly a GP obstetrician). Women could receive care from practice midwives along the maternity episode, possibly with continuity of carer, with obstetric visit frequency as determined by the practice. Practice midwives provide antenatal, intrapartum and postnatal care under Medicare, with medical care from practice doctors (or under backup arrangements), and additional nursing and midwifery care from hospital staff.

Access to medical referral under Medicare (including intrapartum) is inbuilt to the model, and women would be billed over the scheduled fee as determined by the business plan.

This model would fit with current urban private specialist obstetric practices, providing intrapartum care in private hospitals. However women in rural areas have poor access to private specialist obstetricians, or private hospitals. This model would be unlikely to function in rural areas, where intrapartum care is provided in public hospitals. In these areas, obstetric services are primarily provided by GP obstetricians, who tend not to provide intrapartum care under Medicare.

Key points:

- Women must have private health insurance (or ability to self fund) for intrapartum care as private patients.
- Women must be able to pay the gaps over the Medicare rebate for visits, and claim what they can from the Medicare Safetynet.
- Midwives practise within a medical business, and are paid at a contracted rate by the business.

Summary: this model looks viable as a variant of existing private specialist obstetric practices, for women with private health insurance, in urban areas.

Hybrid public/Medicare model

In this model women receive antenatal and postnatal care in a community setting from an eligible midwife working privately and covered by Medicare, and with collaborative arrangements with a public hospital. Intrapartum care is in a public hospital, from the same midwife working as a hospital employee. Two versions of this model can be imagined: midwife-initiated and hospital-initiated.

“Midwife-intitiated” hybrid model

This model faces structural challenges, and is financially and culturally problematic.

In this model, a midwife in private midwifery practice seeks a cooperative employment and collaborative arrangement with a local hospital. The hospital agrees to engage the midwife as a casual employee for intrapartum care, and provide consultation and referral for antenatal and postnatal care. When the midwife brings a labouring woman in for intrapartum care, the woman is admitted as a public patient and the midwife clocks on as a casual employee on an hourly rate. Hospital medical, midwifery and nursing staff provide care as needed.

This model faces significant challenges:

- Cultural: Private practice midwives would be entirely dependent on a public hospital entering into collaborative arrangements and agreeing to necessary employment arrangements. Public hospitals frequently have entrenched nursing and medical cultures antagonistic to reform, and have no evident incentive to form this sort of relationship with midwives in private practice.
- Structural: midwives must straddle two modes of employment, frequently switching from private practice to public employment. Issues would include employment awards, practice protocols and guidelines, and clinical governance.
- Financial: under proposed MBS scheduled fees this model would not attract midwives. A midwife working in this model and charging scheduled fees to 40 women per year can expect to earn an annual taxable income of approximately XXXXXX (see Appendix B) after practice costs (see Appendix D). This is approximately XX% of the income this midwife could expect in employment (Appendix C). The midwife would also not receive additional benefits of superannuation contributions, sick leave, long service leave, professional development allowance etc.
- Payment by women of approximately $XXXX per birth above the scheduled MBS fee would raise the midwife’s income into a viable range.

Summary: if viable at all, this model would depend on:

- exceptionally supportive hospitals willing to form collaborative and employment arrangements, despite absence of incentives, and
- a clientelle willing to pay well above the scheduled MBS fees, or
- a funded third party employer/contractor for the midwife.

“Hospital-initiated” hybrid model

This model appears to be viable, but is structurally and culturally challenging.

This model is similar to the “midwife-initiated” model above, but is “owned” by a public hospital. Medicare is billed for antenatal and postnatal services, under eligible midwives’ provider numbers. Intrapartum midwifery care is provided under employment, to women admitted as public patients. Contractual arrangements would ensure the midwives receive an income at a similar level to employment in comparable public models, after insurance and other eligibility expenses.

Midwives participating in such a model might face eligibility expenses of approximately $10,000 per year (insurance plus other business expenses). MBS rebates for one FTE midwife would contribute approx $XXXXX per year (see Appendix B), resulting in a net benefit to the service of approx $XXXXX per year.

It is unclear what scope there is for public hospitals to define uninsured women as private patients for intrapartum care in order to claim MBS rebates.

Challenges:

- Cultural: this model is a significant departure from traditional nursing arrangements, and would require professional and management support and expertise to develop

and maintain. Nursing and medical resistance could easily veto these arrangements. The casual “walk in” employment arrangement is not an existing model, and would be culturally challenging for hospital management to support.

- Structural: arrangements for claiming MBS rebates for antenatal and postnatal services provided by a midwife contracted/employed by a public hospital are unclear and legally problematic.
- Financial: although the model attracts a significant income from MBS, the model also provides services which have frequently not been previously provided by public hospitals, e.g. antenatal care, postnatal care.

Summary: this model appears viable if Medicare rules are clear and supportive, and where expertise in midwifery models can support its development. However, broad uptake of this model will require overcoming major cultural barriers.

Private midwifery practice model

In this model, common in other countries, a midwife works in private midwifery practice, alone or in a group practice with other midwives. Midwives provide continuity of primary care to women who engage them directly.

Although place of birth should not define a model of midwifery care, current cultural and structural influences make place of birth disproportionately important. For this reason this model is divided into homebirth and hospital birth versions.

Hospital birth under private midwifery practice

This model is financially and culturally problematic, and does not appear viable.

Women planning a hospital birth engage a midwife for antenatal, intrapartum and postnatal care. Care may be from a partnership or group practice, or from a single midwife who may have backup arrangements with other private practice midwives. Midwives maintain collaborative arrangements with hospitals and/or private doctors.

Birth care is in hospital, to the woman admitted as a private patient, and is Medicare funded. Intrapartum medical backup must be from doctors willing to provide private care under Medicare.

A midwife working full-time, caring for 40 women per year, and charging scheduled fees for all visits could expect to earn a taxable income of approx $XXXXX per year (see Appendix E) after practice costs.

This model faces significant obstacles:

- Structural: from our preliminary research, the required medical backup for intrapartum care appears unlikely to be available except in rare circumstances. Private hospitals appear unlikely to support this model. In areas where data is available, very few births currently occur to private patients in public hospitals (3.6% of public hospital births in Qld, 2006). Practical and cultural obstacles, and absence of incentives, make it unlikely that doctors would change their current practices in order to support this new model.
- Cultural: arrangement of visiting rights to hospitals, and 24/7 medical cover arrangements with doctors are culturally very challenging. Visiting rights for midwives are a novel concept, and subject to veto by antagonistic stakeholders.
- Financial: a midwife working in this model and charging scheduled fees can expect to earn an annual taxable income of approx XX% of the income she could expect for similar work employed in the public system. The midwife would also not receive additional benefits of superannuation contributions, sick leave, long service leave, professional development allowance etc..
- Affordability: payment by women of approx $XXXX per birth above the scheduled MBS fee would raise the midwife’s income into a viable range.

- Affordability: women using this model would need to carry appropriate private health insurance, to cover hospital costs for birth.

Summary: this model does not appear to be viable, mainly due to collaboration obstacles. Financial obstacles would make it accessible only to women with private health insurance and the ability to pay significantly more than scheduled fees.

Homebirth under private midwifery practice

The viability of this model is entirely dependent on overcoming highly problematic cultural obstacles regarding collaborative arrangements.

Women planning to birth at home would engage a midwife (perhaps in a partnership or group practice) to provide all their primary care, including birth at home, as women currently do for homebirth.

Midwives might continue to charge a single episode of care fee as most currently do, or might break fees into stages or visits. Women should be able to claim MBS rebates for antenatal and postnatal care, which would total $XXXXX per year per FTE midwife, or $XXXX per birth (see Appendix F). Midwives would pay their current practice costs, plus $7,500 per year professional indemnity insurance, and any new compliance costs (we estimate a total of approximately $10,000 per year).

Intrapartum care is not covered by professional indemnity insurance or MBS rebates.

Midwives intending to provide this care would require collaborative arrangements with hospitals in order to register (meeting eligibility requirements), and to claim MBS rebates. Preliminary conversations with hospital staff indicate that hospitals are extremely unlikely to enter collaborative arrangements with midwives providing homebirth care.

Summary: this model is financially viable and meets demand from an established market, and has established suppliers. However requirements for eligible midwives to have collaborative arrangements make this model very challenging to establish under the planned rules for eligibility and MBS access.

Conclusions

All models except the “hospital-initiated hybrid” only offer improved choice, continuity or access to higher income women.

Requirements to gain medical agreement to collaborative arrangements pose major obstacles to private midwifery practice, especially when offering homebirth care.

The proposed level of MBS payments restricts access to private midwifery practice to women with greater financial resources.

Intrapartum care under Medicare is likely to be mostly restricted to medical practice midwives.

Appendix B

Employment income

Nurses and Midwives (Queensland Health) Certified Agreement (EB7) 2009, hourly rate for Clinical Midwife, Nurse Grade 6, pay point 4: $45.56/hour.

Maximum average loading for penalties: 30%

Average hourly rate including penalties $59.23/hour

Assume average intrapartum care of 10 hours per birth, for 40 births = 400hrs/year.

Annual income for employed intrapartum care = $23,692.00

Appendix C

Annual income, caseload midwife, Queensland Health

(Nurses and Midwives (Queensland Health) Certified Agreement (EB7) 2009)

Clinical midwife Grade 6, 4years experience: $73,439 per year

Schedule 9: 30% loading for caseload model of care annualised salary.

Total annual income for caseload midwife = $95,470, plus superannuation, sick leave, long service leave, professional development allowance, etc..

Appendix D

Private midwifery practice costs

Insurance	$7,500 (set by Commonwealth Government)
Car	$8,700 (RACQ annual cost for a Toyotal Corolla, 15,000km/year)
Phone	$1,800 ($150/month estimate)
Office costs	$4,000 (estimate, including business costs)
Registration and professional development expenses	$3000
Total	$25,000

References:

Professional Guidance for midwives, requiring collaboration:

ACM Midwifery Guidelines for Consultation and Referral

ANMC National Competency Standards for the Midwife

QNC Code of Practice for Midwives

Modern Supervision In Action:

http://www.nmc-uk.org/aDisplayDocument.aspx?DocumentID=6770