Australian Private Midwives Association

Submission to 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

Who we are

The Australian Private Midwives Association (APMA) represents midwives in private practice working almost exclusively in self employment. Most of our current members provide care for women choosing to birth at home. APMA was formed in 2009 from several representative groups, to ensure midwives in private practice were represented in the current reform process.

Executive Summary

Support for reforms

APMA welcomes Health Minister Nicola Roxon's maternity reform agenda, and her stated vision of improving choice and access to midwifery care[1] for Australian women. Successful implementation of these reforms will increase options for women.

Although we support the Minister's plans, APMA welcomes the reference of the above Bills to the Senate Community Affairs Legislation Committee to detail our concerns about the implementation of the maternity reforms and in particular the impact of these reforms on the current private practice midwifery workforce.

We support the passing of the three bills, once it is clear that midwives will provide care under these reforms on their own responsibility, consulting and referring when clinically required. We do not support the requirement of a formal, legislated, one sided "collaborative arrangement", and are completely opposed to this arrangement being in the form of a signed agreement between a midwife and medical practitioner/hospital.

Private practice midwifery 2010 – at a crossroads

APMA are fundamentally concerned as to whether the current private practice workforce will be able to make a successful transition to practicing under these reforms. This will be tested in July 2010, when Commonwealth-subsidised professional indemnity insurance for midwives commences, and again subsequently in November when Medicare and Pharmaceutical Benefits Scheme (PBS) arrangements come into force. We believe that the ability of existing private midwives to remain in practice, and provide care to women under the new arrangements, is an important test of the real-life viability of the reform processes.

The effective implementation of these Bills is significantly complicated by the concurrent introduction of the National Regulation and Accreditation Scheme (NRAS) for health practitioners. The Senate Committee's previous inquiry into these Bills was due to their interaction with the NRAS law, and this second reference to the Committee is in part because of a similar interaction.

Following the previous Senate enquiry into these three midwifery bills, an exemption was granted for midwives from the requirement for professional indemnity insurance covering the intrapartum (labour and birth) component of homebirth[2] care. This exemption is conditional on a number of requirements including compliance with a quality and safety framework which is yet to be developed within the NRAS process. This framework potentially brings further complicating interactions with these Bills.

Midwives' ability to provide care to women birthing at home remains a key test of implementation. This will depend on midwives' eligibility, collaborative arrangements and details of the government's indemnity insurance package which have yet to be formally agreed or announced. Midwives in private practice remain unsure of who will be able to practice from 1 July 2010.

Collaborative arrangements

The amendments put forward on 5th November to the Health Legislation Amendment (Midwife and Nurse Practitioner) Bill 2009 and the Midwifery Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 require that the midwife works in a "collaborative arrangement" with "one or more medical practitioners"[3] in order to access professional indemnity insurance or Medicare funding. This provides a mechanism for medical control over midwives' eligibility, access to professional indemnity insurance and therefore ability to register and practice in self-employment. It also establishes medical control over midwives' access to funding.

In the last week APMA has received written advice from the Health Minister that she does not intend to proceed with the amendments to the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009, announced on 5 November. This decision removes the requirement for midwives to have collaborative arrangements in place before being able to access Commonwealth-subsidised professional indemnity insurance.

Further advice is that the Health Minister **does** intend to proceed with amendments to the Health Legislation Amendment (Midwife and Nurse Practitioner) bill which states that "participating" midwives will require "collaborative arrangements" for access to Medicare.

APMA welcomes the removal of the 5th November amendment from the Midwives Professional Indemnity bill. However, the impact of this on midwives' ability to practice is not entirely clear, as interpretation of the legislation around these reforms and the intersection of these reforms with the national regulation scheme and associated processes is complex. If professional indemnity policies under the scheme require midwives to have collaborative arrangements as a condition of their insurance, then it is possible that midwives' access to insurance will remain under medical control. Thus midwives' registration status is also under medical control.

Current regulation of midwifery

Currently, midwifery practice is highly regulated. Midwives sign yearly declarations as to their competence and there are extensive mechanisms to investigate and deal with unsatisfactory practice. Midwives working outside the hospital system, the current midwives in private practice or "independent" midwives, are constantly scrutinised for compliance to regulatory mechanisms. Many are referred for every birth to the relevant state boards for scrutiny to ensure regulatory compliance.

Current collaborative practice

Consultation and referral (collaborative practice) appropriate to midwives' scope of practice is an area which is regulated. Midwives currently have competency standards which directly refer to consultation and referral and collaborative practice, and clear practice guidelines on when to consult or refer. Midwives, of course, practice collaboratively now. The general mechanisms for collaboration include (with the woman's consent):

- Booking women in to a public hospital regardless of place of birth
- Utilising consultation and referral guidelines to plan when additional care may be required

- Consulting and referring to the most appropriate secondary or tertiary provider when clinically necessary

- Communicating with the booking hospital and/or with the woman's GP to organise necessary aspects of emergency care which a midwife cannot obtain on her own (i.e. scripts for drugs such as Syntocinon for use if a woman had a post partum haemorrhage, pathology forms for routine blood tests)

- Upon labour transfer from home to hospital, the midwife transfers still providing care within the hospital context. In most hospitals this does not include provision of "clinical" care. From the woman's perspective she has the primary relationship with her private practice midwife and would prefer as much care from this midwife as possible.

There are many other examples of ways of working collaboratively including shared documentation and potential case conferencing.

Unfortunately, confidence in the regulatory system for midwives is not apparent in these reforms. A requirement for "collaborative arrangements" which are compulsory for midwives and voluntary for their collaborative partners (i.e. medical practitioners or hospital systems) provides a secondary "defacto" regulatory mechanism. APMA expect to see doctors making "collaborative arrangements" subject to conditions which are inconsistent with midwifery guidance.

Midwives and medical practitioners all recognise the necessity of collaboration. However, when there is the ability for one practitioner to control the practice of another, this is not collaboration. The proposed mechanism grants the ability for medical practitioners, as a voluntary participant in the "collaborative arrangement", to unilaterally set parameters for a midwife's practice. This is not acceptable to midwives as professionals.

Need for clear vision

Despite the concentration of expertise and time in this maternity reform project, at no stage has it been clarified what "vision" is proposed for maternity care at the completion of these reforms. There has been no consultation with midwifery stakeholders in regard to what might enable midwives to deliver the required result in collaboration with their medical colleagues. While the benefits of continuity of midwifery care have been acknowledged by the Minister, and in the Maternity Services Review, there has been no evident attempt to identify potential mechanisms and barriers to delivering continuity.

The position that the reform models will not be prescriptive has been articulated repeatedly by Government representatives. Thus the project has proceeded without any shared understanding of what is intended, and no way to model how it will be delivered.

Recommendations

APMA makes the following recommendations:

- We propose the introduction of legislated requirement for "collaborative practice", rather than "collaborative arrangements". Midwives would be required to demonstrate "collaborative practice" by using standardised clinical documentation for planning and provision of care. This would record specific indications of collaborative practice, in

particular consultation and referral as required, with the consent of the women for whom care is provided.

- We request that proper account is taken of the needs of women who will be under the care of private midwives at the end of June 2010. These women need assurance that they will be able to continue in their midwives' care under the new arrangements starting 1 July 2010. This depends on current private midwives being able to make a continuous transition in operation, and requires clarification regarding:
    - the homebirth exemption framework,
    - definitions for professional indemnity insurance regarding antenatal, intrapartum, and postnatal care, and
    - defining eligibility for insurance.
- We propose that a role be created, within the Department of Health and Ageing for a person with expertise in contemporary midwifery, to co-ordinate midwifery issues in the maternity reforms and be the point of contact for midwifery stakeholder groups.

Introduction

This submission focuses on the difficulties with "collaborative arrangements" as proposed in the amendments however these are finally defined in secondary regulation. Other potential difficulties with this maternity reform agenda, to which these three bills relate, will also be discussed including which midwives will be eligible for MBS, PBS and professional indemnity insurance and how the model will be set up to enable women to access the same midwife (continuity of care) for pregnancy, birth and the postnatal period.

Support for reforms

APMA congratulates the Minister on her vision of increasing women's access to midwives and primary midwifery care. We recognise her historic initiative to grant private practice midwives access to subsidised professional indemnity insurance, Medicare and subsidised medicines under PBS. In addition we recognise her action to negotiate a two year exemption from professional indemnity insurance for homebirth.

We recognise that this is a significant shift in Australia's health care system, in reaction to ongoing calls from consumers for access to midwifery care. The Minister has also initiated inter-jurisdictional cooperation to support these reforms, including the development of a national maternity plan, and legislative reforms at state and territory level to enable midwives to prescribe.

Women who use private midwifery

Women seeking the care of a private practice midwife are generally highly motivated to seek out this option. It is not something women are typically offered and therefore these women are

doing so in a highly informed fashion. Most women must currently fund private midwifery care entirely out-of-pocket. They often are very clear in their decisions around care and also are aware of their rights in relation to self determination in all elements of care. Often, seeing a private practice midwife is the only way they feel that they can access these rights.

Transition for private midwives – the many levels of reform

The concerns of our members relate largely to their ability to provide care as autonomous practitioners under these reforms. These professionals face a wave of major changes in 2010, most of which are currently undefined. These include:

- transition to national registration and associated new requirements, including professional indemnity insurance,
- eligibility criteria for Commonwealth-subsidised insurance, Medicare and PBS regarding qualifications, experience and credentialing,
- access to the Pharmaceutical Benefits Scheme (PBS),
- prescribing rights under state and territory law, and associated prerequisites,
- access to Medicare, subject to various conditions,
- possible "grandfathering" clauses in transitional arrangements,
- the "homebirth framework" under the 2 year exemption,
- requirements regarding "collaborative arrangements".

This leaves private practice midwives in doubt about their ability to practice at all after 1 July 2010, and unclear what private practice midwifery will "look" like as the changes evolve over the year. Of most urgent concern, there is no indication as to which private practice midwives will be "eligible" to access indemnity and therefore to practice after July 2010.

From 1 July 2010 midwives providing homebirth care (nearly all of our members) will be required to practice within the "homebirth framework", currently being developed in Victoria within the NRAS project. The framework will set the requirements for private practice midwives to access the exemption from a requirement for PII (under section 284 of the NRAS legislation). This work is occurring separately from the DoHA national maternity reform work. These additional requirements have not been completed and there is no draft of the exemption framework available yet.

Many women whose babies are due after 1 July 2010, when these requirements come into force, have already commenced care with a private practice midwife. It will remain unclear for some time under what conditions they can receive birth care from their midwives, if at all. If these amendments proceed, these women's birth care will also be determined by their midwives' ability to establish the required "collaborative arrangement" between midwives and medical practitioners. Currently practicing midwives can expect the insurance they must

purchase by 1 July 2010 to be conditional on their having the arrangements, as yet undefined under secondary legislation, in place.

Requirement for collaborative arrangements

APMA regard the most concerning, and potentially most limiting, aspect of the transitions is the requirement of "collaborative arrangements". A one sided legislated requirement that private practice midwives work with a medical practitioner, possibly in a defined way under a signed agreement, is completely unacceptable to midwives who are already educated and regulated to provide care as autonomous practitioners, consulting and referring when it is required.

APMA recognises safe care for women is paramount and recognises the government intention to ensure midwives provide safe, collaborative care.

APMA is also aware that safe care relies upon communication and seamless interface between carers when consultation and referral is required. "Collaboration" is a respectful, two way process of communication between autonomous practitioners having equal standing. A "collaborative arrangement" particularly where this equates to a prospective, signed agreement, mandated for midwives to comply does not ensure safety and does not offer an opportunity to demonstrate how and when collaborative care was provided.

The one sided nature of these legislated requirements clearly places medical practitioners/hospitals in a position of control. They can elect to participate, or not. This leaves the midwife constantly under threat of a withdrawal from the arrangement. Potentially the impact of this withdrawal is that the midwife will have no insurance and therefore will be practicing outside the conditions of registration. This could lead to a decrease, rather than an increase, in access to private practice midwifery care and potentially may increase unsafe situations for women.

For women experiencing a normal pregnancy, a midwife is the appropriate primary carer. Other practitioners may provide primary care, but this is the specific remit of the midwife. Collaboration occurs to plan for situations that may arise unexpectedly and if or when a woman requires secondary or tertiary care.

Current regulation of midwifery

All midwives are currently regulated to work collaboratively. Midwives sign a declaration yearly to state that they are working to midwifery competency standards as defined by the Australian Nursing and Midwifery Council including that they consult and refer when clinically indicated[4].

Midwives have a number of professional standards[5], work within a Code of Ethics[6] and a Code of Professional Conduct[7]. Consultation and referral is all part of these various standards and codes.

Midwives are regulated to the International Confederation of Midwives' definition of a midwife (ICM 2005)[8]. Midwives are required to sign yearly declarations of competency to the ANMC competency standards for the midwife under which consultation and referral is required when conditions arise outside the midwives' scope of practice.

Midwives also utilise tools to assist their own decision making around consultation and referral to secondary care providers such as The National Midwifery Consultation and Referral

Guidelines[9]. Documentation of use of these guidelines would be auditable in the woman's notes.

Midwives' documentation either in hand-held records, in women's notes or in purpose developed notes (i.e. Queensland Health has developed midwifery notes specifically for midwives in private practice) would be of auditable standard demonstrating consultation and referral as determined necessary and as agreed to by the woman.

The Midwifery Practice Review process developed by the Australian College of Midwives with Commonwealth funding provides a credentialing mechanism for midwives[10]. During this process midwives provide evidence of collaborative practice.

Discussions have occurred within the Midwifery Technical Advisory Group around multidisciplinary case review and/or audit.

All midwifery documentation would be to auditable standards with clearly identified processes for consultation and referral.

Current collaborative practice

APMA has no doubt that there are difficulties in relationships between midwives in private practice and obstetricians in private practice. Appendix two provides examples of episodes where midwives have attempted to work collaboratively and have been rejected, or where women have approached medical practitioners for collaborative support and have been rejected.

There are many reasons for these difficulties. A difference of professional views or philosophies is a significant barrier. These difficulties are unlikely to resolve quickly. Signed documentation which may reflect these differences is likely to magnify problems.

The way in which collaboration currently works, and often works well, for private practice midwives and the women they work with involves consultation and referral to public hospitals and centres on collaboration with employed medical practitioners in hospitals. Midwives often book women in to public hospitals as a back up should the need arise. These hospitals accept bookings because women are public patients. Midwives consult and refer to employed doctors within the hospital when required. They also provide letters and summaries at the completion of care to GPs to whom the woman returns for care.

APMA does recognise it is vitally important that under these reforms midwives work appropriately with medical practitioners and that systems are built to support two-sided collaborative practice. The mechanisms proposed by the government do not support a two-sided respectful process because they provide a mechanism for further medical control.

Responses to Terms of Reference

(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;

- The complexity and the intersection of the various components of legislation mean that we remain unclear as to the full ramifications of having "collaborative arrangements" present in one bill, and not in another.

- We are also unsure of other mechanisms for requiring "collaborative arrangements" such as a requirement in secondary regulations or within an insurance policy.

- If insurance is contingent on practicing in a "collaborative arrangement" it is likely that a medical practitioner will be able to block a midwife's ability to practice by vetoing "collaborative arrangements". Midwifery practice under conditions of registration will be contingent on insurance (with the exception of birth care during a homebirth).

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

- The legislated requirement that midwives enter collaborative arrangements that require compliance from a medical practitioner (i.e. are two-sided, such as in the form of a signed agreement) mean doctors are afforded an ability to prevent competition.

- This is clearly the intention of the AMA, as stated by the vice president of the AMA in their recent media release[11]. The president of the AMA has also stated personally that he does not see that midwives could be in competition with obstetricians, as if they were, he would proceed very differently.

- Midwives provide pregnancy, labour and birth care and post birth care as routine practice. In the current health system secondary and tertiary specialists (obstetricians) provide primary care to well women. Medical practitioners have the virtual complete control of the market in the private sector.

- The balance of provision of primary, secondary and tertiary care under these reforms rests on the ability for midwives to enter the market in a more significant way, providing primary care for women in pregnancy.

- A requirement that medical practitioners provide some kind of agreement in order for the midwife, with whom they will be in competition, to be funded, is anti-competitive.

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

- APMA have evidence from many sources that private practice midwives will find obtaining a "collaborative arrangement" with individual medical practitioners (or individual on behalf of institutions) very difficult.

- The barriers to collaborative arrangements include philosophical barriers, increased responsibility and workload for obstetricians backing up private midwives, increased market competition without financial incentive to participate and medico legal concerns.

- Private practice midwives' inability to access "collaborative arrangements" means that they will be unable to participate in these reforms. This will create difficulties in delivering increased access and choice.

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

- The Health Minister's office has advised APMA that there is a requirement for a named person to "sign off" collaborative arrangements, but that this does not preclude arrangements with hospitals.

- APMA have concerns that a "collaborative arrangement" signed by an individual, on behalf of a hospital, will create further difficulties. Clinical application will be difficult.

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

- The Minister has made clear her intentions to increase access and choice. We see her clear leadership in negotiating a two year exemption from a PII requirement for private practice midwives providing homebirth care as an example of her commitment.

- However the amendments of 5th November will most definitely have a negative impact on safety and continuity of care for Australian mothers. We are particularly concerned about the impact on the provision of homebirth care.

- It is unlikely that private practice midwives who are unindemnified for birth in the home are likely to be able to source a collaborative arrangement easily which covers homebirth care. Even if doctors are willing to participate, there are likely to be medico legal barriers when a significant component of the care will be provided outside of indemnity insurance (i.e. the birth at home).

- If midwives are unable to obtain collaborative arrangements for homebirth care they may be less likely to register. APMA is unsure of the impact of these decisions on safety and quality.

- The other negative impact on safety is the ability of medical practitioners to elect to participate. If they are fundamentally concerned about the situation from the perspective of the midwife or the woman at the outset, they may elect not to participate to begin with. If they do not agree with the choices that a midwife, or a woman, makes then they can elect to discontinue the arrangement. By withdrawing, again, the midwife will potentially be practicing without insurance, therefore outside the conditions of registration. This may limit choices for women, and may encourage freebirth – birth without an attendant.

(f) any other related matter

Continuity of Care and Carer

- Midwives in private practice, and in some public hospital models, provide continuity of care to women. Continuity of care is defined in different ways but for midwives in private practice it means that the same midwife cares for the woman from early pregnancy to six weeks after birth, often in partnership with one or two other midwives.

- It is unclear how midwives will provide continuity of care under these reforms. Medicare funding for intrapartum (labour and birth) care is limited to women birthing in hospital and under the Health Insurance act is limited to women admitted as "private patients".

- Midwives currently in private practice predominantly provide birth care for women in the home. They do not provide hospital based care for women in birth as only employed midwives are able to do this. No midwives in private practice currently have visiting access to hospitals, due to lack of insurance. Mechanisms to establish pathways for intrapartum care (i.e. visiting access for midwives in private practice) have not been discussed within the technical working groups or MSAG.

- The ability of these reforms to widely increase access and choice is going to be stifled by the requirement for women to be admitted to hospital as private patients in order to receive Medicare-funded intrapartum care. As an example, options for Aboriginal and Torres Strait Islander women wanting access to midwifery care will be limited as most Aboriginal women are unlikely to be admitted to hospital as a private patient i.e. have private health insurance.

- No modelling of "hybrid" schemes with midwives working partly in private practice and partly employed by the state has been discussed. Hospitals do not generally employ midwives to provide "one on one" care as it is not viewed as cost effective. A significant cultural shift will be required for a midwife to come in to the hospital to provide care as a hospital employee to her private client.

- A further issue is access to medical back-up for the clients of private practice midwives. We have been advised by DOHA that medical back up could only be provided by private doctors. However it is possible that private patient fee structures could be adapted to provide medical care by publicly employed doctors. If back-up is required to be provided by private obstetricians, implementation will be difficult. This is due to the small number of private obstetricians working in public hospitals, particularly outside of urban areas, and would also be limited by doctors' willingness to work on call for midwives' clients.

Homebirth

The safety of homebirth in Australia is repeatedly questioned, usually by medical opinions. The Minister has stated that the two year exemption from the requirement for professional indemnity insurance for homebirths will provide sufficient time to collect data around homebirth. Since the mid 1990s national data has been collected from registered midwives providing homebirth care. The "hole" in the data is where births are not attended by a registered midwife. This data is not collected now, and it will not be collected in the future. There have recently been some high profile stories about homebirth deaths, which have not

been attended by registered midwives. The figures for these deaths are not reported statistically now as they are not attended by registered midwives.

With the direction these reforms are taking, statutory requirements over private practice midwifery will increase dramatically. As we have stated above, midwives feel that their ability to continue in practice is at risk. If conditions become unsustainable, midwives will not be able to continue to function as registered caregivers.

Most private practice midwives are concerned about their ability to practice to the ICM definition of a midwife under these reforms. If the current private practice midwifery workforce is unable to take up these reforms, it will be a significant waste of resources, both financial and human.

The loss of the private midwifery workforce would also result in a number of women, who would generally seek midwife care, potentially not being able to access that option. This will increase the rate of women birthing at home alone. The "free birth" movement has been critical of the author of this submission. Women who choose to free birth now do so for many reasons and they are their own. It is the intention of this author to inform the Senate enquiry so that women who would not normally choose to free birth are not forced to do so by a lack of registered midwives providing homebirth care. The other possibility is that women will be attended in significant numbers by unregistered practitioners. This cannot be seen to be a move which would increase quality, safety or reporting of outcomes.

Uptake and viability

APMA, participating in all technical working groups and the Maternity Service Advisory Group, are unaware of significant modelling around these reforms. When we have asked how many midwives the department expects to initially be involved, the answer has been "around 200". Conveniently, this is the best estimate of the current number of private practice midwives.

However, most of the current private practice midwives remain extremely unsure of their ability to register, and practice, under these reforms. Most of the current private practice midwifery workforce state their unwillingness to enter "collaborative arrangements", as a signed agreement with a medical practitioner or hospital. They clearly already collaborate, as they are regulated to do, with hospitals and individual doctors, as and when required. They are providers of primary care, autonomous practitioners who are regulated to provide care to women throughout pregnancy, birth and postnatally.

Midwives in private practice remain unsure of the financial viability of private practice, with a series of new compliance requirements. Medicare funding may or may not improve financial viability. Some modelling of private practice midwifery income has been performed by Maternity Coalition, which suggests a take home income for midwives charging scheduled fees (allowing for $25,000 of business costs such as indemnity, car and phone expenses) of around $50,000. This is significantly lower than the salaries of hospital-based continuity of care models. The potential (provided for the in the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009) of capping midwives' ability to charge above the scheduled fee also must be considered in this light. If midwives must charge over the scheduled fee in order to achieve financial viability, access will be limited to those who can afford gap payments.

The low level of discussion around models of private practice and requirements to enter private practice means that APMA is unsure as to how many of the current private practice midwives will actually become MBS eligible midwives. APMA recognises that midwives working in private obstetricians' rooms may also be eligible, and whilst this is a valid option, it is not likely to greatly increase access to continuity of care and therefore the benefits of midwifery care.

Need for clear vision

The requirement for stakeholder management has never been more necessary. These reforms hold significant promise to increase maternity care options for women in Australia.

Midwives are heavily regulated professionals who are already providing primary care to women. Funding reforms and the brokering of an insurance package are significant developments, but they do not change the way midwives currently work.

Government support to mediate the significant power imbalance between medical practitioners and midwives is necessary. Legislation requiring midwives to sign agreements and work in an "arrangement" with one or more medical practitioners further imbeds the imbalance in power.

Leadership to reform maternity care will not be easy, but the Health Minister has demonstrated that she has a clear commitment to midwives and to private practice midwifery care being accessible to Australian women. We support this position and ask that attention be given to the mechanisms which will be required to ensure successful implementation.

Recommendations

- APMA recommend that the Senators suggest the introduction of legislated requirement for "collaborative practice", rather than "collaborative arrangements".

"Collaborative practice" rather than "collaborative arrangements" provides an opportunity for midwives to demonstrate working with medical practitioners and hospitals, consulting and referring as required. It does not provide a mechanism for medical practitioners and hospitals to veto working with midwives, thus preventing midwives from participating in these reforms.

Midwives, when applying for Medicare eligibility, could provide a document stating they will work in collaboration with medical practitioners and hospitals. Midwives would demonstrate "collaborative practice" by using standardised clinical documentation for planning and provision of care. An example of the style of documentation is the Queensland Health Midwifery Notes developed within the Office of the Chief Nurse in 2008 for use by private practice midwives. Midwives would document specific indications of collaborative practice, in particular consultation and referral as required, with the consent of the women for whom care is provided. Documentation would be to the standard required for auditing by Medicare. This possibility has been presented to the DoHA and will be presented to the Minister office.

- APMA request that proper account is taken of the needs of women who will be under the care of private midwives at the end of June 2010.

These women need assurance that they will be able to continue in their midwives' care under the new arrangements starting 1 July 2010. There is an urgent need for communication around

this issue as many of these women have already booked care with private practice midwives. This depends on current private midwives being able to make a continuous transition in operation.

- We propose that a role be created, within the Department of Health and Ageing for a person with expertise in contemporary midwifery, to co-ordinate midwifery issues in the maternity reforms and be the point of contact for midwifery stakeholder groups.

The development of the role of the Commonwealth Chief Nurse and Midwifery Officer has been a significant one for the profession. However this portfolio is extremely large. The current appointee, whilst having presided over the National Maternity Service Review, is not a midwife. There would be a benefit to the Department of Health and Aging within this large reform process to have contemporary midwifery expertise available.

Conclusion

APMA welcomes the reforms proposed by Nicola Roxon and applauds the Minister's commitment to make changes to Australia's health care system that will enable more women to access the benefits of continuity of midwifery care. However, as outlined in this submission, APMA does hold grave concerns about difficulties in the implementation of these reforms that may result in limitations to this access. One such difficulty is found in Nicola Roxon's amendments of 5 November around the requirement of "collaborative arrangements". APMA welcomes the current inquiry into these amendments.

APMA also has concerns about the transition for currently privately practicing midwives. As the details of the many aspects of these reforms have not yet been defined, midwives currently practicing privately remain uncertain of their future. Likewise, women who are pregnant and due to give birth after 1 July 2010 also find themselves in a state of limbo, uncertain of what their choices will be. Current privately practicing midwives provide care almost exclusively around birth at home. There are still many unknowns in regards to the effects of these reforms on homebirth care. While there is an exemption from PII for intrapartum care at home, there are requirements around accessing this exemption and these requirements have not yet been defined.

While APMA acknowledges that collaboration and referral are important aspects of midwifery practice, as acknowledged by the required midwifery competencies, we believe that the amendments of 5 November will not result in care that is truly collaborative. Rather, there will be a situation whereby one profession will have the ability to control another, in this case medicine controlling midwifery. As these two professions are in competition in providing care around pregnancy and birth, this is not appropriate nor is it equitable. Midwifery is already a regulated profession and under the ICM definition of a Midwife, midwives are professionals who practice under their own authority. To place midwifery under the control of the medical profession is inequitable and changes the essence of midwifery.

APMA believes there is a strong need for a role within DOHA for a person with recent midwifery expertise to assist in giving advice and sharing knowledge around midwifery practice.

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[1] Roxon, Nicola (Federal Minister for Health) 2009, *House of Representatives Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 Midwife Professional indemnity (Run-off Cover) Bill 2009 Second Reading Speech,* 20 August, House of Representatives Hansard, Canberra, <http://parlinfo.aph.gov.au/parlInfo/genpdf/chamber/hansardr/2009-08-20/0063/hansard_frag.pdf;fileType=application%2Fpdf>

[2] Australian Health Ministers' Conference, *Joint Communique,* 4 Septmber 2009

[3] The Parliament of the Commonwealth of Australia, *Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009,* <http://www.aph.gov.au/SENATE/committee/clac_ctte/health_leg_midwives_nurse_practitioners_09_nov09/tor.pdf>

[4] Australian Nursing and Midwifery Council 2006, *National Competency Standards for the Midwife, <http://www.anmc.org.au/userfiles/file/competency_standards/Competency%20standards%20for%20the%20Midwife.pdf>*

[5] Australian Nursing and Midwifery Council 2009, *Professional Standards, <http://www.anmc.org.au/professional_standards>*

[6] Australian Nursing and Midwifery Council 2008, *Code of Ethics for Midwives in Australia,* <http://www.anmc.org.au/userfiles/file/research_and_policy/codes_project/New%20Code%20of%20Ethics%20fo%20rMidwives%20August%202008.pdf>

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