Royal College *of* Nursing, *Australia* (RCNA)
National Office | 1 Napier Close | PO Box 219 | Deakin West | ACT 2600
p +61 (02) 6283 3400 | f +61 (02) 6282 3565
e: canberra@rcna.org.au | www.rcna.org.au

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Mr Elton Humphery
Committee Secretary
Senate Standing Committee on Community Affairs
PO Box 6100
PARLIAMENT HOUSE
CANBERRA ACT 2600

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

Dear Mr Humphery

Senate Inquiry into *Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related bills*

Royal College *of* Nursing, *Australia* (RCNA) is pleased to provide the attached submission to the Senate Standing Committee on Community Affairs on the *Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related bills.*

RCNA is the peak national professional organisation for Australian nurses. RCNA represents nursing across all areas of practice throughout Australia. RCNA has members in all states and territories of Australia, and internationally. A not-for-profit organisation, RCNA provides a voice for nursing by speaking out on health issues that affect nurses and the community. With representation on government committees and health advisory bodies, RCNA is recognised as a key centre of influence in the health policy arena in Australia. When health policy decisions are made, RCNA presents a professional nursing perspective, independent of political allegiance.

Please do not hesitate to contact me for further information or clarification of issues raised.

Sincerely

Debra Y Cerasa FRCNA
Chief Executive Officer

Royal College *of* Nursing, *Australia* (RCNA) Submission to the Senate Standing Committee on Community Affairs on *Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related bills*

1. Introduction

RCNA offers continuing support for the Australian Government's maternity services reform directions, specifically new arrangements to improve choice and access to maternity services through providing access to Medical Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) rebates to women receiving midwifery services and affordable indemnity insurance for midwives. RCNA, however, has considerable concern relating to the Government's decision to introduce additional amendments as proposed on 5 November 2009 to the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 making it a requirement in primary legislation for midwives to have collaborative arrangements specifically with medical practitioners in order to be eligible for MBS provider status. Additionally, RCNA is fundamentally opposed to any MBS eligibility condition supporting a requirement for signed collaborative agreements between a midwife and one or more medical practitioners. Safe, appropriate and collaborative care can be demonstrated by measuring, reporting and evaluating outcomes and by auditing evidence, not through the undertaking of a signed agreement.

2. Regulatory duplication

RCNA views the proposed amendments as an unnecessary and potentially restrictive move that will duplicate existing regulatory mechanisms. The Australian Nursing and Midwifery Council (ANMC) Competency Standards for the Midwife, the Code of Ethics for the Midwife, and the Code of Professional Conduct for the Midwife form part of the strong regulatory framework supporting collaborative practice within which midwives currently work. Regulatory authorities have established measures in place to protect the public and deliver disciplinary action where midwives have breached practice requirements by not practising collaboratively when required.

3. Signed collaborative arrangements

RCNA is of the firm view that midwives' eligibility for Medicare provider status must not be dependent on meeting requirements for collaborative arrangements. Rather, the practical option is that collaborative arrangements be an auditable requirement of care once MBS eligibility has been granted. RCNA is fundamentally opposed to any MBS eligibility condition supporting a requirement for signed collaborative agreements between a midwife and one or more medical practitioners.

Signed written agreements will impose a significant administrative burden on an already stretched workforce and are an impractical option for which there is no supportive evidence to suggest that they would lead to safer health care delivery. There are, however, significant risks that any requirement for signed agreements could restrict equity in access to Medicare funded midwives and present a barrier to participating in the new arrangements for both the medical profession and midwives. This would effectively undermine the purpose of the intended reforms seeking to respond to growing pressures on maternity services as workforce shortages persist and births continue to rise.

The requirement for midwives to have collaborative arrangements with individual medical practitioners is impractical and unworkable for the following additional reasons: a lack of incentive for medical practitioners to participate; medical practitioners have concerns about medico-legal implications of the collaborative arrangements with a midwife; and shortages within and transitory nature of the medical workforce will make the management of collaborative arrangements complex for example, the need to engage with locums and medical practitioners on short-term contracts.

It is also noted that to ensure an effective implementation of the new arrangements, RCNA supports the position that midwives should have the opportunity to apply for and be granted visiting access to hospitals without the additional requirement for a collaborative arrangement with an individual medical practitioner. Additionally, it should be a professional expectation that hospital staff would collaborate with the midwife and afford them the same access to information as any other visiting health professional.

4. Professional integrity

There is scope to define and confirm collaborative practice within regulations supporting the legislation. RCNA has concerns that unnecessarily embedding the requirements in the Act may result in unanticipated restrictions to practise that could stymie progress and be counterintuitive to the intention of the reforms. Also at risk is that proposed amendments could lead to the undermining of the professional integrity of midwives particularly in the provision of evidence of collaborative practice. There is potential that this requirement could give medical practitioners a pseudo-regulatory role enabling them to determine the suitability of midwives for ongoing eligibility for MBS provider status or even midwives' ability to retain a license to practise.

The proposed amendments present a one way arrangement placing an onus on participating midwives to form collaborative arrangements with medical practitioners which could effectively bring them under the clinical supervision of a medical practitioner. This presents an unprecedented professional shift where participating midwives may be compelled to comply with the perspectives of medical practitioners to whom they are tied under their collaborative arrangement. This presents a radical shift in professional relationships and current practice norms which promote collaborative professional partnerships between two distinct professional groups. This outcome would not promote flexibility and responsiveness in practice and could potentially stifle innovation within the midwifery profession.

Midwives in Australia today provide safe, quality care for Australian women and there is no justifiable reason to duplicate regulatory arrangements by legislating collaborative arrangements that could diminish the clinical decision making capacity of midwives as they are inappropriately corralled under the watch of medical practitioners. Preference should be placed on developing and building collaborative care systemically through organisational pathways rather than a focus on individual professionals.

5. Safety and quality

There is a significant body of evidence that midwives in Australia provide safe care for which they are autonomously accountable. It must be clearly noted that the reform arrangements do not propose an extension to the scope of practice of a midwife, rather, this is a reform to funding mechanisms only. Therefore, safety and quality of maternity services are not at risk. The option of a signed agreement with a medical practitioner does not present a case for improved safety and quality, particularly if this is a one way requirement. For example, a midwife might be compelled to compromise in decision-making and comply with the views of a medical practitioner in order to maintain a relationship they require to maintain a license to practise rather than depend on their own professional judgement. RCNA argues that safe, appropriate and collaborative care can be demonstrated by measuring, reporting and evaluating outcomes and by auditing evidence, not through the undertaking of a signed agreement.

6. Access to PII and maintaining license to practise

RCNA is aware that there are concerns within the midwifery profession that the Government's proposed amendments to the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 to link midwife Medicare eligibility to collaborative arrangements with a medical practitioner(s) will create scope for the decisions of medical practitioners to affect whether a midwife can access the Commonwealth Professional Indemnity scheme that they require to gain and maintain license to practise. The requirement for eligible midwives to have collaborative arrangements with one or more medical practitioners could expose midwives to losing their license to practise as a result of a medical practitioner's decision. Should a medical practitioner decline or withdraw from a collaborative arrangement with a midwife, the midwife could be left in breach of their mandatory registration conditions as they will not be able to access or maintain professional indemnity insurance without their collaborative arrangement with a medical practitioner in place.

It is suggested that the Inquiry respond to the call from the midwifery profession and confirm that the Midwife Professional Indemnity (Commonwealth Contribution Scheme) legislation will adequately ensure that decisions relating to their collaborative arrangements with midwives made by medical practitioners will not impact on a midwife's access to the indemnity insurance required to maintain license to practise.

7. Clarification required that amendments are not anti-competitive

The midwifery profession has also expressed concern that if proposals for signed agreements form part of the required collaborative arrangements for midwives to gain Medicare eligibility, an anti-competitive environment would be created. While the proposed reforms may provide opportunity for midwives working in private practice, signed collaborative arrangements could mean medical practitioners may wish to block the activity of private midwives by not agreeing to participate in a collaborative arrangement to protect their own business interests. This is particularly relevant in rural settings where there is often a very small and transitory medical workforce.

8. Amendments present a barrier to intended reforms

The promoted intention of the new arrangements for midwives is increased access and choice of midwifery services for women in the community. The proposed amendments around collaborative arrangements suggest that the Government is favouring a service delivery model centred on medical practitioners where midwives will work as employees of privately practising obstetricians (GP or specialist). As discussed, there are significant risks that midwives who are engaged by a private medical practice will face challenges in establishing a collaborative arrangement in order to become Medicare eligible. This represents a barrier to realising the full potential of the intended reforms which is ultimately a loss for the community. It is vital that the broader community can benefit from the unique reach of midwives and that the proposed amendments do not threaten the access potential the new arrangements will bring to a range of under serviced communities such as rural, remote, urban, socio-economically disadvantaged, and Aboriginal and Torres Strait Islander communities. Linking Medicare eligibility for midwives to the approval by individual medical practitioners will threaten the key intention of the proposed reforms.

9. Challenges to private practice

Enhancing maternity services through the growth of private midwifery practices in an environment where a midwife is tied to a medical practitioner will be very challenging. There will be little incentive for midwives to leave employed practice to work in private Medicare funded practice where the scope and nature of their work could be highly dependent on the nature of the relationship and collaborative arrangement they have with the medical practitioner to whom they are tied. Additionally, RCNA is advised that it is currently unclear that the proposed rebate levels will sufficiently attract midwives into private practice.

10. Suggested ways forward

To ensure the Government is able to deliver on its reform commitments, RCNA supports the Australian College of Midwives' (ACM) position that the potential mechanisms for resolving the issues raised above are:

1. That references to "collaborative arrangements" are not added to the definition of an eligible midwife in the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009;
2. That if the amendments proceeds, the regulations must make clear that signed collaborative agreements between midwives and medical practitioners are not compulsory for demonstrating eligibility; and
3. That midwives be able to demonstrate safe, consultative practice through the use of formalised maternity care notes for each woman for whom they provide care which can be audited by Medicare Australia or the Nursing and Midwifery Board of Australia as appropriate.

Contact details

Debra Y Cerasa FRCNA
Chief Executive Officer
Royal College *of* Nursing, *Australia*
P 02 6283 3400
debra.cerasa@rcna.org.au

Kathleen McLaughlin
Director, Professional Services
Royal College *of* Nursing, *Australia*
P 02 6283 3427
kathleen.mclaughlin@rcna.org.au