Caesarean Awareness Network Australia
PO Box 7193
Mt Crosby QLD 4306

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

Dear Senators,

I am writing this submission to bring to your attention the effect of the proposed legislation on women planning a high risk hospital birth, or having an emergency or elective caesarean birth.

Private midwifery care complements public obstetric care

Women who have a caesarean birth often need to see multiple care providers during the pregnancy, birth, and post-natal period. These include the obstetrician, shift midwives at the hospital, paeditrician, and anaesthetist at a minimum. Often the birth is also attended by additional theatre nurses and a student obstetrician. Women going through the public health system may have continuity of care provider (the hospital they attend) but may not know the obstetrician doing the surgery. They will almost certainly not know the shift midwife attending, nor the other doctors, unless they have a private obstetrician who has booked a private paeditrician and anaesthetist at additional expense to the woman (and consequently Medicare).

The woman may be experiencing stress related to the reasons the caesarean surgery has become necessary, or at the very least will have a more painful and longer recovery than would happen after a normal birth. Caesareans correlate to higher rates of post-natal depression, post-natal infection and other complications, breathing difficulties in babies, and more.

Some women planning an elective caesarean would like to engage a private midwife in addition to their obstetrician. By having their own midwife attend, these women will have continuity of carer – not just care provider. The midwife can assist in explaining their medical history to the many other health professionals involved, and can . The midwife will know the woman's preferences, and can stay with her to support breastfeeding in recovery (many hospitals cannot enable this as there are not enough midwives on staff to have one stay in theatre recovery). Having a known and trusted midwife for ante-natal care, at the birth, and post-natal care means that post-natal depression, infections, and breastfeeding difficulties can be picked up and treated sooner.

While there would still be considerable costs to the woman if she chose to have a private midwife in addition to her obstetrician, there are women who are happy to pay for these services. Particularly for the highest risk cases, where a public obstetrician in a specialist fetal medicine area at a tertiary hospital is the best choice, a private midwife provides a “safety net” of continuity and support.

Proposed legislation reduces options rather than enabling choice
Unfortunately, the proposed legislation makes this impossible. Public hospital obstetricians cannot make collaborative arrangements under this legislation, and very few private obstetricians will be willing to make collaborative arrangements with midwives whose core business is homebirth. Rather than improving choices for women, this legislation reduces the choices available. Women must choose between the best obstetrician for their circumstances, knowing they will not be able to collaborate with a private midwife; or, if they are lucky enough to find one, an obstetrician who can collaborate with their midwife but perhaps is not as experienced in their particular pregnancy issue.

For women in rural and regional Australia, there simply will not be a choice. These women are most in need of the support of private midwives. Living hours away from the nearest maternity hospital, some of these women are lucky enough to have midwives living in their local community. If they commence labour earlier than expected, or have concerns about their pregnancy, they have someone nearby who can advise them on whether they should go straight to hospital or can labour at home for some time first. But it is unrealistic to expect a maternity hospital to collaborate with a private midwife who the hospital's head obstetrician may never have met. It is unrealistic to expect these midwives to develop and maintain collaborative relationships with hospitals hours away from their community. Rural and regional Australian women will have no choice but to accept the induction or planned caesarean they are offered, if they are experiencing a pregnancy where labouring without a midwife in attendance is unsafe.

Every woman, every choice
Fundamentally, the proposed legislation removes a woman's right to make her own choices when it comes to maternity care. Rather than taking the choice away from women, we would like to see legislation that enables women to make their own choice. Research shows that the vast majority of women make maternity care choices, including elective caesareans, based on what they believe is best for the health of their baby. In an attempt to force all women receiving midwifery care to also see a private obstetrician, this legislation will also force all women receiving public obstetric care to forgo their right to access private midwifery support that complements their obstetric care.

We would like to see legislation that enables women to ask questions and make their own care provider choice – including their choice of midwife.

Your Sincerely,

Emma Davidson
ACT Representative
Caesarean Awareness Network Australia