Homebirth Access SYDNEY

Mr Elton Humphery
Committee Secretary
Senate Community Affairs Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Via email: community.affairs.sen@aph.gov.au.

Re: Inquiry into National Registration and Accreditation Scheme for Doctors and Other Health Workers

Dear Mr Humphery

I am writing further to your email of 18 June in relation to your request for additional comments in relation to the Community Affairs Legislation Committee's inquiry into the National Registration and Accreditation Scheme.

Homebirth Access Sydney (HAS) continues to have a range of concerns in respect of the exposure draft of the *Health Practitioner Regulation National Law Bill 2009* (known as Bill B) which was released by the Ministerial Council on 12 June. We have also made those concerns known to NRAIP but wish to bring them specifically to the attention of the Committee.

Our key concern about Bill B pertains to the registration of privately practicing midwives offering homebirth.

As you may recall, HAS is principally a consumer organisation with a focus on supporting homebirth families and increasing the access to birthing choices – in particular homebirth - for women in NSW. We were established in the 1970s to provide information and support to people interested in homebirth including parents, midwives, child birth educators and birth support workers. We currently have a membership of around 400 families and birth professionals and are one of the very few maternity consumer organisations in Australia with a large and active membership of families in their pregnancy and early parenting years.

Many of our members came to homebirth after seeking a better experience of antenatal care and birthing than they had previously experienced in the hospital system. These include many women wanting continuity of care through their pregnancy and birth and seeking reduced intervention during birth.

In general terms our organisation has been pleased with the Government's reforms of maternity services, particularly with the introduction of legislation designed to expand the role of midwives in the provision of maternity services, by giving them access to the Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS),

and by providing a Commonwealth-supported professional indemnity insurance (PII) scheme for eligible midwives.

However, we are extremely concerned that one class of midwives will be excluded from the reforms: midwives who attend births at home. Excluding these midwives from proposed legislative reforms at the same time as the Registration and Accreditation Scheme is established, will effectively make attended homebirth illegal in Australia.

Impact of Bill B on maternity consumers

Under the National Registration and Accreditation Scheme, due to be established by Bill B, any midwife who cannot obtain professional indemnity insurance cannot be registered. Section 69 of Bill B provides that:

> ***69 Eligibility for general registration***
> *(1) An individual is eligible for general registration in a health profession if:*
>
> > *(a) the individual is qualified for registration in the health profession, and*
> >
> > *(b) the individual has successfully completed:*
> >
> > > *(i) any period of supervised practice in the health profession required by the National Board established for the health profession, or*
> > >
> > > *(ii) any examination or assessment required by the Board to assess the individual's ability to competently and safely practise the profession, and*
> >
> > *(c) the individual is a suitable person to be registered in the profession, and*
> >
> > *(d) there is, or will be, in force in relation to the individual appropriate professional indemnity insurance arrangements, including a policy held, or arrangements made, by the individual's employer that will cover the individual, and*
> >
> > *(e) the individual is not disqualified under this Law from applying for registration, or being registered, in the health profession, and*
> >
> > *(f) the person meets any other requirements for registration stated in a registration standard for the health profession.*
>
> *(2) Without limiting subsection (1), the National Board established for the health profession may decide the person is eligible for registration in the profession by imposing conditions on the registration under section 101.*

Section 101 of Bill B further provides that:

> ***101 Conditions of registration***
> *(1) If a National Board decides to register a person in the health profession for which the Board is established, the registration is subject to the following conditions:*
>
> > *(a) for a registered health practitioner other than a health practitioner who holds non-practising registration:*
> >
> > > *(i) that the registered health practitioner must complete the continuing professional development program required by the National Board, and*

> *(ii) that the registered health practitioner must not practise the health profession unless professional indemnity insurance arrangements are in force in relation to the practitioner's practice of the profession,*

A National Board, established under section 24 of Bill B, is also empowered to determine whether the professional indemnity insurance arrangement of an individual is appropriate, including whether the type and level of cover are sufficient (section 73).

Bill B further prevents the use of the terms "registered health practitioner", "midwife" and "midwife practitioner" or the use of any title, name, initial, symbol, word or description that might indicate that the person is a health practitioner or authorised or qualified to practise in a health profession (sections 128 and 129). The penalty for breach is $30,000 for an individual or $60,000 for a body corporate.

Therefore, a currently practising, registered, qualified midwife who is unable to obtain insurance, may not practice or identify herself as a midwife after the national registration system is in place.

In addition to being prohibited from practicing under the National Registration and Accreditation Scheme, any person who is not registered will be subject to prosecution under state laws if she provides birth services. For example, section 10AG of the *Public Health Act 1991 (NSW)* prohibits a person from engaging in a restricted birthing practice unless she is a registered midwife or medical practitioner, with a penalty of $5,500 or imprisonment of 12 months or both. Similar legislation exists in most, if not all, state and territory jurisdictions in Australia, along with prohibitions against holding oneself out as a midwife if not registered.

Availability of Professional Indemnity Insurance for private midwives

Professional indemnity insurance is currently not available for private midwife practitioners in Australia. This largely results from the small number of midwives in private practice, which currently cannot support a market-priced premium that is affordable.

On 24 June 2009 the Government introduced the *Midwives Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009* and the *Midwives Professional Indemnity (Runoff Cover Support Payment) Bill 2009* (**'the PII bills'**) into the House of Representatives. The PII Bills implement the Government's new professional indemnity scheme for certain midwives (called "eligible midwives" in the PII Bills). Pursuant to the PII Bills, the Commonwealth will contract with an insurer to provide professional indemnity insurance at an affordable price to eligible midwives. In doing so, it will also require the contracted insurer to develop and maintain a database that the wider insurance market will be able to use in developing longer-term products. The insurance is intended to be available so that eligible midwives can be appropriately covered from 1 July 2010, in line with proposed new requirements of the National Accreditation and Registration Scheme.

However, the explanatory memoranda to the PII Bills states that:

> Professional indemnity insurance is currently not available for private midwife practitioners in Australia. From the perspective of the insurance industry, the two most commonly stated reasons for this are: (1) there is a lack of accurate and up-to-date data (which is necessary for insurers to be able to assess their actuarial liability); and (2) the potential premium pool is very low and would

currently not support a market-priced premium level that is affordable for midwives.

These reasons are relevant to all private midwife practitioners in Australia, whether they practise in hospital or in home environments and do not provide a reason to exclude homebirth midwives from the Government-backed insurance scheme.

Safety and risk for maternity consumers

Excluding privately practicing midwives offering homebirth presents a significant safety risk to those women who will continue to choose to birth at home after the Registration Scheme comes into effect. Currently, midwives offering homebirth are eligible for registration, so a woman has a degree of quality assurance and is able to distinguish a registered midwife from a lay midwife, doula, or other birth attendant. Without registration, and where a fully trained and previously registered midwife cannot call herself a midwife purely because of a market failure in the provision of insurance products, a woman has no means of assessing the adequacy and currency of her caregiver's qualifications.

From our experience working with consumers of maternity services and their families, our organisation is confident that prohibiting homebirth will not stop women birthing at home – or we suspect midwives wanting to offer homebirth to women and their families.

Homebirth is a minority choice in Australia, as it is in most jurisdictions of the world. However, women choose it for a variety of very sensible reasons, including:

- to avoid interventions (such as inductions of labour, episiotomy, epidural, forceps or vacuum extraction of their babies and caesarean section deliveries),
- to have a natural, drug-free birth,
- to birth in an environment where they feel safe,
- to have continuous care from a known midwife during pregnancy, birth and the postnatal period,
- to enable the full participation of the woman's partner and children in the birth,
- because they don't see birth as an illness or hospital as necessary,
- to avoid repetition of previous poor hospital birth experiences, and
- because research supports the safety of birthing at home.

Currently, just over 700 women in Australia plan a homebirth each year. Women who choose homebirth are typically well informed about their options for care, the risks of different models of care, the evidence regarding safety of different birth locations, the possible consequences of their decision and the physical and emotional stages of childbirth. Most homebirth families have back-up plans for transfer to hospital if complications arise during labour.

There is a wealth of international evidence to support the safety of planned, assisted homebirth for women with low risk pregnancies[1].

In a study published in April 2009 in *BJOG: An International Journal Of Obstetrics And Gynaecology* of more than half a million women, researchers found no difference in death or serious illness among either mothers or their babies if they gave birth at

[1] Ackermann-Leibrich et al (1996); Bastian, Keirse, & Lancaster (1998); Campbell R, Macfarlane A (1994); Chamberlain, Wraight, & Crowley (1997); Crotty, Ramsay, Smart, & Chan (1990); Gulbransen, Hilton, & McKay (1997); Johnson & Daviss (2005); Macfarlane A, McCandlish R, Campbell R. (2000); Murphy & Fullerton (1998), Olsen O. (1997); Wiegers, Keirse, & van der Zee (1996); Woodcock, Read, Moore, Springer NP, Van Weel C (1996); Stanley, & Bower (1990)

home rather than in hospital[2]. This study looked at almost 530,000 low-risk births over seven years in the Netherlands where homebirth rates are close to 30% of all births.

Treating low-risk birth within a highly medicalised model has seen intervention rates rise rapidly, to approximately 30% caesarean section rates across Australia. This contrasts with a World Health Organization recommended caesarean section rate of 10-15%. Among the homebirth population, the caesarean section rate is much lower, approximately 5% (though reliable data is unavailable). Indeed, reversing the trend to high intervention and medicalised birth models is a driving force behind the Government's proposed reforms to give a greater role to midwives in maternity care.

Planned homebirth for low-risk women using certified professional midwives is clearly associated in international research with significantly lower rates of medical intervention and no higher intrapartum and neonatal mortality than that of low-risk hospital births.[3]

Registered midwives use the Referral Guidelines[4] of the Australian College of Midwives to support informed decision making by their clients when it may be necessary for the woman or baby to be seen by, or transferred to the care of, other health professionals or facilities such as obstetricians and hospitals.

Preventing the registration of midwives attending homebirth will put consumers at grave risk of either choosing to birth without the assistance of any health care professional or receiving sub-standard care. This clearly obstructs the Registration and Accreditation Scheme's aim of providing greater safeguards for the public.

Consumers rely on registration to ensure that they are choosing a skilled and professional carer. To remove this indicator of quality from consumers, not on the basis of professionalism but on the availability of a suitable insurance scheme, puts women and their babies at serious risk.

Our organisation has no doubt that more women will birth unattended, a situation which we do not support and about which the Government's recent Maternity Services Review professes to be concerned.

A legislative framework which encouraged unattended birth also disregards the World Health Organization's Millennium Development Goal 5 of promoting a skilled attendant at every birth.

Birthing at home *without* the attendance of a qualified midwife, known as 'freebirthing', can be extremely dangerous and is not supported by our organisation. The very reason attended homebirth is so safe is the same reason that freebirth is not: a midwife is trained and skilled at detecting complications during labour and either addressing them or transferring her client. At an attended homebirth, the midwife observes the birthing woman in a one-to-one situation (unlike in a hospital, where a midwife cares simultaneously for several labouring women) and can act quickly to address any complications. If it becomes illegal for midwives to attend homebirths, more women will freebirth and there will be no person present who is trained and skilled at recognising and managing the onset of complications.

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[2] A de Jonge, BY van der Goes, ACJ Ravelli, MP Amelink-Verburg, BW Mol, JG Nijhuis, J Bennebroek Gravenhorst, and SE Buitendijk *Perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births* BJOG An International Journal of Obstetrics and Gynaecology RCOG 2009 (15 April)

[3] See footnote 1.

[4] These can be found at http://www.acmi.org.au/text/ corporate_documents/ref_guidelines.htm

This was recognised by NSW coroner Nick Reimer in June 2009, when he handed down findings into the death of a baby born at home. Mr Reimer noted that homebirth was a woman's inherent right and a practice that "will not go away" and urged the Federal and State Health Ministers to exercise "great care" in drafting legislation that would make homebirthing illegal, saying homebirths will be driven underground with "disastrous ramifications"[5].

In April 2009, the death of the baby of a prominent freebirth advocate also gained significant public attention. There has not yet been a coronial report into the death of that baby, though perhaps the presence of a qualified midwife would have prevented that death.

Sections of the press fail to distinguish between freebirth and professionally attended homebirth, so that the dangers of the former taint the safety of the latter. This distinction, so often blurred, is at the heart of the current legislation, which will not stop homebirth, but will prevent or punish those who undertake homebirth safely. Under the PII Bills and Bill B, the safe option of attended homebirth will become criminal and the dangerous option of freebirth will be unintentionally promoted.

Other than through small-scale trials and in limited geographic areas, homebirth has never been publicly funded and widely available in Australia. Despite this, a small minority of women have continued to choose to birth at home. We expect that, if homebirth is to be criminalised, the number of women birthing without the presence of a qualified midwife would rise, and their births would become immeasurably riskier.

We are deeply concerned that this situation will only be exacerbated if professionally attended homebirth becomes unlawful.

International best practice in maternity care

A second consequence of criminalising homebirth is to isolate Australia internationally in terms of best practice maternity care. In many countries, homebirth is both legal and publicly funded (for example, New Zealand, the United Kingdom, the Netherlands). Indeed, some countries actively encourage the choice to birth at home as explicit policy and as a key element of increasing the rate of normal birth (for example, the United Kingdom[6]). We are not aware of any countries where homebirth is illegal.

The World Health Organization has stated that:

> The midwife is the most appropriate and cost effective type of health care provider to be assigned the care of normal pregnancy and normal birth, including risk assessment and the recognition of complications.[7]

Furthermore:

> **a woman should give birth in a place she feels is safe, and at the most peripheral level at which appropriate care is feasible and safe** (FIGO 1992). For a low-risk pregnant woman this can be at home, at a small maternity clinic or birth centre in town or perhaps at the maternity unit of a larger hospital. However, it must be a place where all the attention and care are focused on

[5] Sydney Morning Herald 30 June 2009

[6] See Royal College of Obstetricians and Gynaecologists, Royal College of Midwives and National Childbirth Trust, 2007, *Making normal birth a reality: Consensus statement from the Maternity Care Working Party our shared views about the need to recognise, facilitate and audit normal birth* and UK Department of Health, 2004, *National Service Framework for Children, Young People and Maternity Services.* London.

[7] World Health Organization: Care in Normal Birth, 1996, p 6.

her needs and safety, as close to home and her own culture as possible. If birth does take place at home or in a small peripheral birth centre, contingency plans for access to a properly-staffed referral centre should form part of the antenatal preparations.[8]

Conclusion

The concerns of our organisation in relation to these matters are urgent. Although the registration scheme is due to commence on 1 July 2010, this proposal affects every woman becoming pregnant from October 2009, as she must plan her maternity care and will have no certainty that her choice of birth location and attendant will be legal for any baby conceived after that time.

As we have indicated, our primary concern is the safety of mothers and babies and the likelihood that the de-registration of privately practicing midwives will lead to a dangerous increase in women birthing at home with no professional care provider.

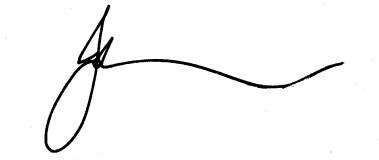
Though the number of women birthing at home in Australia is small as a proportion of the total births, it is the role of the Government to ensure that *all* consumers in the health system are provided with appropriate protection, not just the majority.

Our preference would be for privately practicing midwives offering homebirth to be included in the PII Bills and we have conveyed this view to the Government. However, given there has been no indication from the Government that this will happen, Homebirth Access Sydney strongly urges that Bill B be amended to require: *that the registered health practitioner must not practise the health profession unless professional indemnity insurance arrangements,* ***where available,*** *are in force- in relation to the practitioner's practice of the profession.*

The alternative is simply dangerous and places birthing mothers and their babies at grave risk of harm.

Maternity consumers must not be made to bear the impact of inadequacies in the private insurance market.

Yours sincerely



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[8] World Health Organization: *Care in Normal Birth*, 1996, p 12 (emphasis added). The reference within the quote to 'FIGO 1992' is a reference to the publication: Recommendations accepted by the General Assembly at the XIII World Congress of Gynecology and Obstetrics. *Int J Gynecol Obstet* 1992; 38(Suppl):S79-S80.