



The Nursing and Midwifery Board of Australia

By Email: nmba-consultations@ahpra.gov.au.

5 May 2011

Dear Madam/Sir,

I make the following submission on behalf of Homebirth Access Sydney (HAS) in response to your call for public comments in relation to the Draft of professional indemnity insurance for midwives guideline, the Revision of professional indemnity insurance arrangements registration standard and the 'Quantum of cover' for professional indemnity insurance for midwives guideline.

HAS is principally a consumer organisation with a focus on supporting homebirth families and increasing access to birthing choices – in particular homebirth - for women in NSW. HAS was established in the 1970s to provide information and support to people interested in homebirth, including parents, midwives, child birth educators and birth support workers.

HAS currently has a membership of around 250 families and birth professionals. We 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.

HAS values the opportunity to put forward the perspective of maternity consumers in relation to the draft proposals on professional indemnity insurance for midwives under the new national laws. We would be pleased to expand on any of the issues raised in this submission if required.

General Comments on PII

HAS was initially pleased with the directions the Government took with regards to reforming the provision of maternity services in Australia, and specifically expanding 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.

We have long been concerned that the clients of privately practicing midwives (PPMs) who are planning a birth at home have not had access to insurance cover.

While we understand that the Draft of professional indemnity insurance for midwives guideline (the Guideline) sets out the mechanism whereby PPMs are exempted from the PII requirements for births at home (until July 2012), we remain unconvinced that a better solution cannot be found – both for the short and long term - which would allow PPMs to access an insurance product for intrapartum care in the home.

When the new PII legislation was introduced into Parliament, the explanatory memoranda to the PII Bill stated 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.

The Maternity Services Review Report which formed the basis of the Government policy and legislation noted that “a situation where a health professional operates without appropriate professional indemnity cover is not considered acceptable.”¹ We agree entirely.

Following a number of multi million dollar compensation payouts against obstetricians in the early 2000s, an insurance crisis affected all providers of birthing services. However the Commonwealth stepped in to subsidise insurance to obstetricians and general practitioners through the Premium Support Scheme and High Cost of Claims Scheme, both of which continue to operate. Despite considerable lobbying efforts by consumer organisations and professional bodies, similar options were not made available to midwives, even though, to our knowledge, there had been no successful insurance claim against a midwife and there had been several against obstetricians. The enormous cost of PII discouraged many midwives from private practice and as the pool of homebirth midwives shrank to an uncommercial size, the existing insurers ceased offering professional indemnity coverage to PPMs in 2002. As a consequence, in 2001 as the Guideline notes, women birthing with PPMs have had no protection through their midwives’ PII since.

However, it also means that until 2001, there was insurance coverage for privately practicing homebirth midwives, and claims data should be available through the insurers who covered them until that time. This undermines the argument that insufficient data exists. We have not seen such data, but since our organisation is unaware of a single successful claim against a midwife, we believe that it would not reveal midwives to be uninsurable because of their risk profile.

The second reason noted in the Explanatory Memorandum for the unavailability of PII— that the pool of midwives is too small to enable a commercially viable insurance product—is further reason to include homebirth midwives in the scheme (thus increasing the size of the pool). The Government in the new PII legislation has addressed a market failure in the availability of insurance products, just as it did in 2002 with the Premium Support Scheme and High Cost of Claims Scheme. However, the market failure applies equally to homebirth midwives and to not fully include them in the PII Scheme is both illogical and unfair.

The reason homebirth midwives have been excluded from the PII Scheme is evident from the Maternity Services Review Report, which notes that since:

¹ Australian Government, 2009, *Improving Maternity Services in Australia: The Report of the Maternity Services Review*, p 54.

homebirthing is a sensitive and controversial issue, the Review Team has formed the view that the relationship between maternity health care professionals is not such as to support homebirth as a mainstream Commonwealth-funded option (at least in the short term). The Review also considers that moving prematurely to a mainstream private model of care incorporating homebirthing risks polarising the professions...²

The opposition of some health professionals, whose position in the maternity services system is already subsidised, to the inclusion of homebirth, is unsupportable.

The costs to PPMs providing homebirth services are likely to increase with the introduction of the PII scheme (as set out in the Guideline) and other associated requirements under the Quality and Safety Framework. Even through PPMs offering homebirth will not be able to purchase PPI for intrapartum care at home, they will still be required to purchase insurance for antenatal and postnatal care. HAS would like to emphasise that given the likelihood of adverse events occurring during antenatal or postnatal care, that this does not represent a good outcome for consumers. These costs are likely to be passed onto homebirth consumers, who will still have no access to Medicare rebates for labour and birth at home or insurance cover for their intrapartum care.

The costs of homebirthing are already substantial with families generally paying between \$4000 and \$5000 for their package of care for the antenatal, intrapartum and postnatal period. We remain concerned that any further increases in the cost of professionally attended homebirth will put consumers at grave risk of either being forced to choose to birth without the assistance of any health care professional or receiving sub-standard care.

Currently, most PPMs have small practices, which consist almost exclusively of homebirthing women and usually book less than 30 women a year. Increasing costs and seemingly onerous administrative requirements are already resulting in PPMs leaving their practices. Currently in NSW, there are less than a dozen PPMs offering homebirth services – often in restricted geographic areas - and the midwives currently providing homebirth services tend to be fully booked.

The consequence we are most concerned about are those where women are simply unable to find a care practitioner with whom they can birth at home, and that as a result will feel forced to birth at home without a midwife or with an unqualified birth attendant, when this is not something they wanted.

There is a wealth of international evidence to support the safety of planned, assisted homebirth for women with low risk pregnancies³.

Attended homebirth is safe because midwives are trained and skilled at detecting complications during labour and either addressing them or transferring their clients when required. 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. HAS is concerned that any increase in unattended birthing as a result of women being unable to access a homebirth midwife, could place both mothers and their babies at significant risk.

² Australian Government, 2009, *Improving Maternity Services in Australia: The Report of the Maternity Services Review*, p 21.

³ 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)

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 impacting on homebirth, saying homebirths could be driven underground with "disastrous ramifications"⁴.

HAS is particularly concerned that the draft Guideline gives no indication about what is planned with respect to the homebirth exemption after July 2012 – now just over 12 months away. The limited time frame for the exemption is repeatedly emphasized, but in the absence of any suggestion about the way forward after this time, there is enormous concern among homebirthing families.

Quantum of Cover

With regard to the question of the possible inclusion of a minimum dollar value of quantum of cover for midwives in the draft Guideline, it is difficult for our organisation to support this for PPMs offering homebirth. Neither of the current insurance products available to midwives cover intrapartum care in the home. As a consequence, PPMs who almost exclusively provide homebirth services, are being forced to pay premiums which only cover their clients' antenatal and postnatal, not intrapartum care - arguably the time when claims are most likely to arise. This cannot be seen to offer value to homebirth consumers.

Including a minimum dollar value for all midwives in the Guideline is likely to result in PPMs providing homebirth paying inflated premiums which cover birth in a hospital setting but not in the home when they are not providing hospital birth. At this stage, credentialing arrangements are yet to be established in NSW which would allow PPMs to provide intrapartum care in NSW Health facilities. We remain concerned that these costs are likely to be passed onto consumers, making attended homebirth increasingly inaccessible.

We also have some concerns about the way in which a minimum dollar value might be determined. Given the Government has previously indicated that no data is apparently available to allow a comprehensive PII product for homebirth midwives to be developed, we can only assume that the minimum dollar value of quantum of cover for midwives would be developed by looking to similar obstetric cover. We believe such an approach would inflate the risks facing homebirth midwives who have far fewer clients, whose clients are generally at low risk of complications, and with whom they have built up a relationship of trust and cooperation during their pregnancies. Such inflated risk would again be likely to inflate the cost of PII to midwives and ultimately the cost to consumers.

Requirements for midwives to exercise the exemption under s284

Informed Consent

HAS is happy to support the requirement that informed consent is given by the woman who is the client of the midwife in private practice. However, as the Guideline notes, for midwives, there has been no other option since 2001. In the experience of our organisation, PPMs already ensure that potential clients are aware of this situation when they book for care.

This might be best facilitated if a standardised consent form is developed by the NMBA.

That the midwife complies with any requirements set out in a code or guideline approved by the NMBA under s39

HAS is happy to support the Board's requirements that midwives practise according to the Code of Professional Conduct for Midwives in Australia, the Code of Ethics for Midwives in Australia and the National Competency Standards for the Midwife. We believe that these Codes and

⁴ Sydney Morning Herald 30 June 2009

Standards provide important quality assurance standards for consumers about the service they should expect from their midwife.

Reports to be provided by midwives in private practice

Likewise, HAS is happy to support the Board requirement that PPMs contribute the required data to the National Perinatal Statistics Unit (NPSU) for national perinatal data collection.

We believe this is important to help provide an evidence base for future policy and practice developments, and to address the situation that has already been identified where insurance providers claim that sufficient data is not available to allow them to provide a product for intrapartum care in the home.

Requirements relating to safety and quality in the private practice of midwifery

In general terms we support the Board's requirement that midwives claiming the PII exemption for homebirths are able to demonstrate they practise according to the requirements set out in the *National Midwifery Guidelines for Consultation and Referral* and the *National Guidance on Collaborative Maternity Care*.

However, there are a number of specific areas that remain of concern to homebirth consumers. Specifically, we would again recommend that a standardized consent form be developed which could be used as part of a woman's antenatal record, which could then contain all her relevant information and assist if she is required to move between care settings or is having tests or investigations from a range of practitioners. Such a form could also provide evidence in situations where a woman declines recommended care advice and help ensure that her right to informed choice is protected.

This is particularly important - both for women and midwives - in the situation in which a disagreement arises about care and whether a birth at home is safe.

Our organisation has been contacted a number of times in recent months by distressed women, late in their pregnancy, when a midwife has refused to provide care for her to birth at home, citing safety concerns or complications. These situations can be difficult to manage both from the perspective of the mother concerned and the midwife, and can lead to women choosing birth at home with a support person such as a doula, rather than birth in hospital.

We believe there needs to be standard forms in circulation to document issues around informed consent to protect both birthing women and midwives. One such form which might provide a useful starting point has been developed by the Australian College of Midwives' (ACM) and is produced as part of the document *When a woman chooses care outside the recommended ACM National Midwifery Guidelines for Consultation and Referral* in their *National Midwifery Guidelines for Consultation and Referral (2008)*. This document aims to assist midwives to support a woman's decisions after a discussion regarding informed choice has taken place. (The document has been reproduced in the Appendix to this submission.)

We would urge the NMBA or other appropriate body to develop a national, standard issue form which details both a woman's case notes and contains relevant referral information if required.

In relation to the requirement to demonstrate collaborative arrangements, while we support this in principle, we continue to have concerns about the willingness of some medical practitioners to actually collaborate in practice. Many of our members have experienced hostility from doctors and hospital based clinicians about their choice to birth at home and we are aware that PPMs are frequently on the receiving end of a similar lack of professional cooperation.

The Australian Medical Association and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists have specific policy of not supporting homebirth. It is

unrealistic to expect that members of these organisations will readily enter into collaborative arrangements with midwives who provide homebirth services to women.

For example the Government's Maternity Services Review notes:

General practitioners (GPs), medical specialists and their representative organisations identified their highest priority as that of maintaining Australia's excellent record of safety in maternity care and emphasised the need for specialist expertise within the maternity care team. An issue of concern was the loss of skilled professionals and its impact on the provision of maternity care, most noticeably in rural and remote areas. These professional groups also expressed concern about moves towards homebirthing.⁵

HAS has been made aware of a number of recent incidents in NSW where PPMs have faced particular difficulties when transferring clients to hospital during a birth. We are extremely concerned that in an environment in which there appears to be an increasing willingness by hospital staff to complain about homebirth transfers and in which midwives are apparently not afforded a right of response to complaints, that women and their midwives will be reluctant to transfer to hospital. This is a situation which could place the lives of women and babies at serious risk and we would stress must be avoided at all cost.

We would urge the Board to work with hospitals and other relevant professional organisations to ensure that genuine, effective collaborative arrangements are in place for the benefit of pregnant and birthing women and their babies.

Please feel free to contact me should you require any further information about this submission.

Yours sincerely



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⁵ Australian Government, 2009, *Improving Maternity Services in Australia: The Report of the Maternity Services Review*, p 4.

Appendix

WHEN A WOMAN CHOOSES CARE OUTSIDE THE RECOMMENDED ACM NATIONAL MIDWIFERY GUIDELINES FOR CONSULTATION AND REFERRAL

The following document was developed from a similar document published by the College of Midwives of Ontario 'When A Client Chooses Care Outside Midwifery Standards of Practice' January 1994, Revised September 22, 2004.

The document aims to assist midwives to support a woman's decisions after a discussion regarding informed choice has taken place.

A woman in the care of midwives may occasionally choose not to accept a care pathway as recommended in the Australian College of Midwives' (ACM's) *National Midwifery Guidelines for Consultation and Referral* (the *Guidelines*). It is also possible that a woman in midwifery care may choose care that the midwife judges is beyond her ability to safely manage, or decline care that the midwife considers essential for the provision of safe care.

Ethical principles underlying health care and health law emphasize the importance of respecting the autonomy of those receiving health care and the rights of individuals to choose among alternative approaches, weighing risks and benefits according to their needs and values. Midwives, like all health professionals, are responsible for being clear about their scope of practice and limitations, giving recommendations for care if appropriate and for informing women about risks, benefits and alternative approaches.

Midwives are also responsible for providing care consistent with the national professional standards for midwives. These include national midwifery competency standards⁶, codes of ethics⁷ and professional conduct⁸, and relevant state or territory based regulatory requirements for midwifery practice.

Should a situation arise in which the woman chooses care outside the recommendations in the *Guidelines* the midwife must engage with the woman and her family and with hospital staff through identified channels where applicable, in a thorough discussion of the request, looking for options and resolutions within midwifery professional standards to address the woman's needs.

In exceptional circumstances, the issue may not be able to be resolved to both the woman's and the midwife's satisfaction. This appendix is meant to assist midwives in addressing those occasions when a solution within the recommended care pathways of the *Guidelines* cannot be found.

When a midwife advises a woman that a certain course of action must be followed in order to comply with midwifery standards of practice, and the woman refuses to follow that advice, the midwife should:

1. **Advise** the woman not only of the recommended guideline but also of the rationale and the evidence behind the guideline in this case;
2. **Consult** with at least one of the following:
 - a. another midwife,
 - b. a physician,
 - c. a peer review group or
 - d. an ethicist.

⁶ Australian Nursing and Midwifery Council, 2006, National Competency Standards for the Midwife

⁷ Australian College of Midwives, Australian Nursing and Midwifery Council, Australian Nursing Federation, 2008, Code of Ethics for Midwives in Australia

⁸ Australian College of Midwives, Australian Nursing and Midwifery Council, Australian Nursing Federation 2008, Code of Professional Conduct for Midwives in Australia

Consultation should include discussion of appropriate next steps if the woman continues to choose care outside the recommended guideline, and consideration of the safest and most ethical course under these circumstances, i.e. continuation of primary midwifery care or referral of care;

3. **Share the advice** of the consultation with the woman; and
4. **Document** in the accompanying **care plan** and the woman's notes the informed choice process, when and with whom the consultation took place, the recommendations arising from the consultation, the date on which the woman was advised of the recommendations and the woman's response.

After completing steps 1 to 4 above, if a satisfactory resolution has not been achieved for the woman or the midwife, the midwife has two choices. Using her ethical judgment, the midwife must decide to either:

a) Continue care and respect the woman's choice for her care and:

1. continue making recommendations for safe care;
2. continue to engage other caregivers as appropriate who might become involved in provision of care (eg. Hospital staff, other midwives in practice);
3. continue to document all discussions and decisions.

OR

b) Discontinue care:

1. clearly communicate to the woman that the midwife is unable to continue to provide care;
2. send a written referral that confirms the termination of care by a date that provides the woman with a specific amount of time to find another caregiver. This time should be reasonable and will vary according to location and circumstance. If, during this time, the woman cannot arrange alternate care, the midwife should make a reasonable attempt to find a caregiver who is willing to see the woman and provide alternate care;
3. maintain a copy of this letter including the proof of receipt, in the woman's health record.

In the course of labour or urgent situations, the midwife may not refuse to attend the woman. When the steps for discontinuing care of the woman have not been undertaken or completed prior to the onset of labour, the midwife must attend the woman.

In circumstance where a woman refuses emergency transport or transfer of care in the course of active labour, the midwife must remain in attendance as the primary care provider, and may be called upon to deal with an urgent situation, or one that is not within the midwife's standards, scope or abilities to perform.

In these situations the midwife should:

1. Attempt to provide care within professional standards
2. Attempt to provide care to the best of her ability
3. Attempt to access appropriate resources and/or personnel to provide any needed care

