Submission by the Australian Nursing and Midwifery Federation

Australian Government Department of Health and Aged Care consultation on expanding eligibility under the Midwife Professional Indemnity Scheme for low-risk homebirths

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Introduction

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 326,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The ANMF welcomes the opportunity to provide feedback to the Australian Government Department of Health and Aged Care on the *Expanding eligibility under the Midwife Professional Indemnity Scheme (MPIS) for low-risk homebirths discussion paper* (the Paper). The ANMF is concerned the aims of the funding committed by the Government to expand the MPIS for protecting women's access to birthing choices and removing barriers to culturally safe care for First Nations communities will not be met by the proposed eligibility criteria.

Questions

Question 1 – Do you think this is an appropriate definition for low-risk homebirth?

No, the ANMF does not support this as an appropriate definition for low-risk homebirth.

The ANMF has significant concerns regarding the lack of autonomy afforded to midwives to perform their role in accordance with their regulatory obligations as proposed by the Paper and definition for low-risk birth. There is also the potential for reduced access and choice for women that is likely to result from a narrow eligibility profile and oversight of risk assessment by the "*other health service provider or professional"* as included in the criteria.

Existing regulatory tools such as the Nursing and Midwifery Board of Australia (NMBA) registration standards, *Midwife Standards for Practice*, *Code of Conduct for Midwives*, *Registration standard for endorsement for scheduled medicines for midwives*, and the *Safety and quality guidelines for privately practicing midwives (PPMs)*, clearly and extensively describe the expected standard of care, collaboration and scope of practice for midwives across all contexts of practice, including privately practicing midwives (PPMs). As per the aims of the National Registration and Accreditation Scheme, these regulatory tools are designed to protect the public through a "*culturally safe and responsive, risk-based approach*"[1]. If the MPIS is to be expanded to protect women's access to birthing choices and remove barriers to culturally safe care for First Nations communities, the parameters of midwifery practice, as described by the existing regulatory tools, should be the accepted framework under which midwives can access professional indemnity insurance, including for their practice in the context of homebirth.

[1] Ahpra & National Boards. (2024). Regulatory principles for the National Scheme. Accessed 31 July 2024 at https://www.ahpra.gov.au/About-Ahpra/What-We-Do/Regulatory-principles.aspx

Question 2 – would you suggest any changes to the criteria listed, and if so, why? (provide evidence where possible)

The ANMF has several concerns regarding the inclusion of criteria outlining the management of women with Category B and C conditions.

Firstly, the requirement to have another "*qualified health service provider or professional who can determine if homebirth is safe and appropriate".* Midwives have the skills, knowledge and education to identify if there is a risk to a woman from birthing at home. They also have a regulatory responsibility to discuss and collaborate where risks arise. This criteria disregards midwives' clinical judgement, autonomy and professionalism, diminishes the woman's voice, and potentially re-establishes the barriers to access that midwives and women have experienced under Collaborative Arrangements.

Furthermore, the purpose of the Australian College of Midwives (ACM) *Guidelines for Consultation and Referral* (the ACM Guidelines)[2] is to "*guide clinical midwifery care," "detail the clinical indications for engagement of other health care professionals" (p4)* and help inform the clinical decision making of midwives working in all models of care. The evidence or consensus position underpinning categorisation of a condition identifies where consultation and referral to other health care professionals within a multidisciplinary team is required. Whilst management of that condition may be outside of the scope of practice for a midwife, the evidence isn't speaking to the risk that condition poses in a homebirth environment. There are numerous examples of conditions in Category B and C that have no influence on the safety or appropriateness of the place of birth. For example, "*Edinburgh Postnatal Depression Scale (EPDS) >12*" (p29) is a Category B condition, that does not complicate the birthing process, should not exclude a woman from a homebirth and does not require the input of another health practitioner "to determine if homebirth is safe and appropriate" but requires multidisciplinary input outside of the scope of practice of a midwife. The intent of the ACM Guidelines is not to determine the safety and/or appropriateness of the place of birth but to guide clinical decision making for all midwives regardless of the woman's chosen place of birth. It is therefore not fit for purpose as a tool to define low-risk homebirth.

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[2] Australian College of Midwives. (2021). National Midwifery Guidelines for Consultation and Referral 4th Ed. ACM, Canberra.

Whilst there is current widespread utilisation of the ACM guidelines in public home birth models of care, the value of applying a tool, that potentially diminishes access to care when it is not fit for the purpose it is being applied, purely due to the lack of existence of any other framework, must be considered and re-evaluated.

The criteria also list compliance with the NMBA *Safety and Quality Guidelines for PPMs* (Safety and Quality Guidelines). Within these guidelines, PPMs "*must hold, maintain and comply with a documented referral pathway/s to support timely and appropriate consultation and/or referral in line with the most recent/current edition of the ACM National Midwifery Guidelines for Consultation and Referral"* (p.5)[3]. This articulates the intended use of the ACM Guidelines [4]. They are an evidence- based and/or consensus-led tool to support midwives in clinical decision making regarding a woman's care.

The ANMF therefore recommends that the ACM guidelines are not utilised as a tool to determine homebirth risk, and that the two criteria referring to management of women with Category B and C conditions be removed. It is sufficient that a low-risk home birth definition includes compliance with the NMBA *Safety and Quality Guidelines for PPMs* which supports the decision making, consultation and referral pathways for PPMs without incorrectly interpreting the utility of the ACM guidelines.

If the criteria detailing the management of women with Category B and C conditions is to remain, the wording must be revised.

The authorisation element of requiring another health professional to "*determine if homebirth is safe and appropriate"* must be removed. The health system, women, babies, midwives and other health practitioners involved in maternity care will benefit when collaboration is based upon mutual trust and respect[5].

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[3] Nursing and Midwifery Board of Australia. (2023). Safety and quality guidelines for privately practising midwives. Accessed 31 July 2024 at https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/Safety-and-quality-guidelines-for-privately-practising-midwives.aspx#

[4] Australian College of Midwives. (2021). National Midwifery Guidelines for Consultation and Referral 4th Ed. ACM, Canberra.

[5] International Confederation of Midwives (2023). Collaboration and partnerships for health women. Accessed 5 August 2024 at https://internationalmidwives.org/resources/collaboration-and-partnerships-for-healthy-women/

Midwives are responsible for the care they provide and for the timely consultation and/or referral of women to other members of the health care team and/or services when needed (as per the existing NMBA regulatory tools). Multidisciplinary conversations around consultation and referral must occur in an environment based upon mutual trust and respect in which the risk/s can be assessed, and clinical decisions made in partnership.

The wording of these criteria must also ensure women are not being "risked out" of continuing care with the primary maternity care provider of their choice. Risk is not static and can fluctuate over the course of pregnancy, birth and the postnatal period. Not all risk is equal, nor does it impact on the place of birth. The expertise and clinical judgement of midwives to provide individualised care, assess individual risk and make evidence-based clinical decisions must be recognised and respected across maternity services. The evidence supports continuity of care leading to better outcomes for women and babies.[6] It is imperative consultation and referral under low-risk models does not interfere with opportunities for women to continue to receive care from their known midwife in a collaborative approach within a multidisciplinary team when complications arise.

Therefore, the ANMF proposes the following wording:

Where the woman has Category B and/or C conditions as listed in the ACM National Midwifery Guidelines for Consultation and Referral the midwife will provide a documented risk assessment and management plan for homebirth, that includes evidence of consultation with and/or referral to another health practitioner with the knowledge and skills to contribute to the woman's care.

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[6] Sandall, J., Turienzo, C.F., Devane, D., Soltani, H., Gillespie, P., Gates, S., et al. (2024). Midwife continuity of care models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews, accessed 8 August 2024 at https://doi.org/10.1002/14651858.CD004667.pub6

Question 3 – Do you have any other comments regarding the inclusion of a low-risk homebirth PII product within the MPIS?

Women's rights and declining recommended care

The Australian Commission on Safety and Quality in Health Care's Australian Charter of Healthcare Rights (the Healthcare Rights)[7] states that people living in Australia have "*Access to healthcare services and treatment that meets my needs,*" "*Be cared for in an environment that is safe and makes me feel safe,*" "*Include the people that I want in planning and decision-making,*" and "*Have my culture, identity, beliefs and choices recognised and respected*"*.* Mandates and restrictions, such as an eligibility profile that controls choice of place to give birth or dictates those who must be involved in care, potentially contravenes the health care rights of women in Australia.

The ANMF stands for the protection of the rights of women and has significant concerns that the continued over-medicalisation of birth and implementation of narrow risk frameworks threatens the rights of women birthing in Australia, thereby creating further risk for women (and their babies), particularly those who do not wish to enter the acute health care system or have experienced traumatic birth.

In a national survey launched in 2021, aiming to explore the experiences of women who had a baby in the previous five years in Australia, 13 per cent of women responded "yes" or "maybe" to the question reporting on the experience of obstetric violence.[8] In Australia, there are also rising rates of birth intervention[9]. Obstetric violence and birth interventions can lead to birth being considered traumatic by women, as well as a loss of autonomy and empowerment. Women often seek to birth outside of a hospital following birth intervention and/or a traumatic birth to feel more in control of their experience and safe from the harms they have endured with previous

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[7] Australian Commission on Safety and Quality in Health Care (2020). Australian Charter of Healthcare Rights. Accessed 25 July 2024 at https://www.safetyandquality.gov.au/sites/default/files/2019-06/Charter%20of%20Healthcare%20Rights%20A4%20poster%20ACCESSIBLE%20pdf.pdf

[8] Keedle, H., Keedle, W. & Dahlen, H. (2024). Dehumanised, violated, and powerless: An Australian survey of women's experiences of obstetric violence in the past 5 years. *Violence against women, 30*(9). Accessed 5 August 2024 at https://doi.org/10.1177/10778012221140138

[9] Australian Institute of Health and Welfare. (2023). Australia's mothers and babies. Accessed 31 July 2024 at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/about

experiences. As these women will now carry an element of risk from their birth history, restrictive frameworks on birth choices, perpetuates the harm created by over-medicalisation of birth and risk.

Irrespective of risk, all women need care and support from a known and trusted maternity care provider to feel empowered and well throughout their pregnancy and following the birth of their baby/babies. It is imperative women feel safe when entering the maternity care system in Australia.

To achieve this, national policy must uphold others' personal bodily autonomy. The rights of women and reproductive justice must not be compromised in efforts to define birth within medico-legal frameworks for gains to be made in the physical and psychosocial outcomes for women and babies in Australia. With the introduction of the proposed criteria, what options will be available to women who decline recommended care? How will the woman's rights be upheld under this framework? How will this promote safety for women who remain steadfast to birth at home regardless of the parameters defined by professional indemnity insurance (PII) for the midwife providing care?

An eligibility framework not only creates potential harm to women and babies, but it also results in a moral and regulatory burden being placed on midwives who are left with the dilemma of whether to provide care. The Paper states that "*future exemptions for professional indemnity insurance for homebirth as outlined in the National Law may not be required with the launch of this insurance product*". The eligibility criteria provide no leeway for midwives to continue to provide care to women who sit outside of the low-risk framework and/or decline recommended care. How will midwives be supported to act ethically and within the constraints of professional regulation?

To this end, the ANMF calls on the Government to provide viable solutions for midwives and women, where women do not meet the criteria for low-risk homebirth as described in the Paper. There must be further accommodations made within the proposed framework and articulation of a clear pathway for midwives to act within regulatory constraints whilst respecting women's choice and autonomy as well as upholding their health care rights.

PII for midwives acting as the second health practitioner at a birth

As per the NMBA *Safety and quality guidelines for PPMs,* a second health practitioner is required to be present for the birth of the baby. "*Second health practitioners must comply with all the requirements of the guidelines to be eligible for the PII exemption for delivering intrapartum services in the home*". In current practice, midwives acting as the second health practitioner do not need to be endorsed and the exemption allows them to be present at the birth without PII for the care they provide in these circumstances. Where the midwife acting as a second health practitioner is not endorsed, they may provide this care in regional and remote areas where PPM/health practitioner numbers are limited, or to gain experience prior to moving into private practice whilst being employed by a public or private health service. It is not clear how the expansion of the MPIS to include low-risk home birth will impact on the PII requirements of midwives who attend homebirths as the second health practitioner. The ANMF has concerns regarding the viability of home birth services in regional and remote areas and the pipeline for PPMs with the proposed removal of the PII exemption for homebirth and seeks further consultation with the Australian Government Department of Health and Aged Care to resolve this issue.

Admitting rights for midwives

Midwives have faced and continue to face significant challenges in gaining admitting rights to their local acute maternity health services with many being denied this opportunity despite having undergone the processes to gain and demonstrate their competence to practice as an endorsed midwife. This issue demonstrates a lack of willingness on the part of the broader multidisciplinary maternity care system to participate in collaboration with PPMs. When midwives and women continue to experience rejection and aggression from other health practitioners and health services in consulting, referring and transferring care to acute settings the safety and quality of care of women is jeopardised regardless of the risk frameworks that are in place. Cross-professional respect and willingness to collaborate is essential and starts with broad acceptance of PPMs as capable, competent and valued members of the maternity care system. The ANMF recommends the Government step in to develop a national framework for midwives to access

admitting rights as a matter of process rather than luck. Admitting rights are an essential element to achieve the consultation and referral that underpins safe and quality care between primary and acute maternity care models as well as a step towards safety and empowerment for women who access the acute maternity care system due to the development of complications, not as their first choice.

Instead of mandating additional “safety measures” on midwifery practice that reduce choice and remove access for women, the ANMF also calls on the Government to investigate other barriers to collaborative care, that exist within the maternity system which prevent women from feeling respected and safe and diminish the utility of midwifery to primary care.

Data Collection

The *Privately Practicing Midwives Access to Professional Indemnity and Midwife Professional Indemnity Run-off Cover Schemes Impact Analysis*[10] states there is inadequate data to assess the risk posed by midwives providing homebirth in Australia. The ANMF recommends the extensive international data on homebirth collected by comparable countries such as New Zealand and the UK be applied to the Australian context and inform future directions for PPM PII. The ANMF also recommends the Government urgently create a national data set to capture the practice of PPMs and endorsed midwives to ensure a lack of data is no longer a barrier to women’s access to midwifery-led models of care in Australia.

[10] Department of Health and Aged Care. (2024). Privately Practising Midwives Access to Professional Indemnity and Midwife Professional Indemnity Run-off Cover Schemes Impact Analysis. Australian Government. Accessed 29 July 2024 at https://oia.pmc.gov.au/published-impact-analyses-and-reports/privately-practising-midwives-access-professional-indemnity

Conclusion

Thank you for the opportunity to provide feedback on the *Expanding eligibility under the Midwife Professional Indemnity Scheme for low-risk homebirths discussion paper.* The ANMF urges the Australian Government Department of Health and Aged Care to consider alternative approaches to supporting safety and quality in maternity care and defining eligibility for home birth. Midwifery practice, and access and choice afforded to women, must not be diminished in efforts to find a solution to PII for homebirth in Australia.