REPORT OF THE

STANDING COMMITTEE ON CONSTITUTIONAL AFFAIRS

IN RELATION TO

A PETITION REQUESTING THAT COMMUNITY BASED MIDWIFERY BE INCLUDED IN STATE HEALTH SERVICES

Presented by the Hon Murray Nixon JP MLC (Chairman)

Report 48

STANDING COMMITTEE ON CONSTITUTIONAL AFFAIRS

Date first appointed:

21 December 1989

Terms of Reference:

1. The functions of the committee are to inquire into and report on:

   (a) the constitutional law, customs and usages of Western Australia;

   (b) the constitutional or legal relationships between Western Australia and the Commonwealth, the States and Territories,

   and any related matter or issue;

   (c) a bill to which SO 230 (c) applies but subject to SO 230 (d);

   (d) any petition.

2. A petition stands referred after presentation. The committee may refer a petition to another standing committee where the subject matter of the petition is within the terms of reference of that standing committee. A standing committee to which a petition is referred shall report to the House as it thinks fit.

Members as at the date of this report:

Hon Murray Nixon JP MLC
Hon Ray Halligan MLC
Hon Tom Helm MLC (resigned from the Committee on November 9 1999)
Hon Kenneth Travers MLC (appointed to the Committee on November 10 1999)

Staff as at the date of this report:

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A PETITION REQUESTING THAT COMMUNITY BASED MIDWIFERY BE INCLUDED IN STATE HEALTH SERVICES

1 INTRODUCTION

1.1 THE PETITION

1.1.1 On November 12 1996, Hon Jim Scott MLC tabled a petition *(Tabled Paper # 879)* requesting the Legislative Council to "ensure State Health Services include Community-Based Midwifery as a part of Maternity Services and make recommendations for appropriate coverage under Medicare."

The petition expressed concern that women do not have sufficient choices with regard to the process of childbirth, such as where and with which professionals they undertake childbirth. The petitioners submitted that recognition is not given to the fact that continuity of midwifery care throughout pregnancy, childbirth and the post natal period makes a vital contribution to the future health of the family and the community.

1.1.2 The petition was retabled by Hon Jim Scott MLC on May 9 1997 *(Tabled Paper # 442)* and August 18 1998 *(Tabled Paper # 90)*, and again requested that community-based midwifery be included as part of State Health Services.

2 THE PETITIONERS' SUBMISSIONS

The Fremantle Community Midwifery Project

2.1 The Committee received a considerable amount of information from the petitioners, and in particular from Community Midwifery WA Inc. (Midwifery Inc) which currently administers the Community Based Midwifery Program (the Midwifery Program).

2.2 The Midwifery Program commenced operation in January 1996, at which time it was allocated $200 000 per year for two years under Phase Two of the Commonwealth's Alternative Birthing Services Program (the ABSP). Initially, the Midwifery Program was jointly managed by the South Metropolitan Health Authority of the Health Department of Western Australia and the Multicultural Women's Health Centre. From

July 1997 the Midwifery Program has been administered by Midwifery Inc. The Midwifery Program is housed in rooms at Woodside Maternity Hospital.

2.3 On September 24 1998 Midwifery Inc informed the Committee that they had been advised by the Health Department of Western Australia that a further two years funding had been approved from the ABSP. The current funding is $220 000 per annum. This meant that the Midwifery Program had secure funding until June 2001 to provide 70 births per year. The Committee was also advised by the petitioners that there is a proposal from the Metropolitan Health Service Board currently before the Health Department of Western Australia to seek additional funding to increase that number to 150 births per annum.

2.4 On July 29 1999 the petitioners provided the Committee with a copy of a letter dated May 20 1999 they had received from the Acting General Manager of General Health Purchasing with the Health Department of Western Australia, Mr Gordon Stacey. In that letter Mr Stacey advised that the proposal for additional funding would be considered by the Health Department of Western Australia in the 1999/00 purchasing allocation budget.

2.5 Mr Stacey also stated that the Health Department of Western Australia is supportive of the services provided by the Midwifery Program and recognises the need to expand the program given the increasing number of applications being received to be part of the program. Mr Stacey stated that the Health Department is keen to offer birthing options other than hospital and has given the proposal high priority.

2.6 Mr Stacey concluded by stating that "the Health Department of Western Australia will allocate funding to additional cases that are eligible and need to commence the program before the proposal has been considered by the Health Department of Western Australia Purchasing Fund Committee."

2.7 The services provided by the Midwifery Program, as stated in an evaluation of the Midwifery Program published in December 1997, include:

- antenatal education for women with special needs;
- alternative birthing services providing about 70 community midwife managed home births or domino births[1] per year. These services include all antenatal

[1] Births where a midwife assists a woman to labour at home, goes with her to the hospital for the birth, and returns home with her several hours after the birth.

care, attendance at the labour and birth, and postnatal care to day ten, at which time the client is discharged from the program;

- the provision of information on pregnancy and birth options, particularly for women from non-English speaking backgrounds; and

- the use of bi-lingual and/or bi-cultural workers to increase the access to antenatal services and care to women from non-English speaking backgrounds.

2.8 The Committee was advised that although the majority of the funding the Midwifery Program receives is directed to providing the services outlined in paragraph 2.7, there was also an education component for midwives in the funding. The Committee was advised that the current funding covers the salary of one non-accredited midwife per annum to learn and gain experience in community midwifery. There was also a small administrative component in the funding.

2.9 The Committee was advised that prior to June 30 1999 there were three midwives on the program and that from July 1 1999 that number had increased to nine. It was considered that ten midwives would be sufficient for 150 births, although the Committee was advised that this figure had not been tested. The Committee was also advised that as at March 1999 the Midwifery Program had trained six midwives to qualified Australian College of Medical Administration standards.

2.10 The Committee was informed that prior to June 30 1999 the midwives were contracted to the program on an annual salary but as from July 1 1999 they are being paid on a fee per client basis. That fee is $1 800 and is itemised into various fee structures for antenatal care, attendance at labour and birth, and postnatal care.

Status of the Midwifery Program

2.11 Midwifery Inc submitted that the Midwifery Program should no longer be considered a pilot project as it had shown its worth as a sustainable program. Midwifey Inc believed that the Midwifery Program should be incorporated as a safe and viable choice for women among the range of maternal care and birthing options offered by State Health Services.

Medicare Cover

2.12 The petitioners submitted that research shows that continuity of midwifery care throughout pregnancy, childbirth and the postnatal period makes a vital contribution to the future health of the family and the community. The petitioners also submitted that midwifery care is the most cost effective care available to women and their families. The petitioners expressed concern that despite these findings, State Health Services do not include community based midwifery as part of their maternity services.

2.13 Midwifery Inc advised the Committee that at present[2] in Western Australia a woman has to pay as a private patient if she wishes to have midwifery centred care. A number of private health funds provide refunds for midwifery care, however at present only HBF refunds almost all of the costs of homebirths or birth centre births with a midwife. This information was obtained from the petitioner's submission dated November 15 1996. Refer to the facsimile letter attached as Appendix A received from the principal petitioner on July 29 1999 which sets out the Health Fund Rebates for midwifery care.

2.14 The petitioners submitted that a woman who is not insured with a private health fund is currently required to pay between $1 000 and $1 800 (depending on the midwife) to have a home birth with a midwife. The home birth is not covered by Medicare. The petitioners claim that this is unfair given that the woman and her family would presumably have been paying the required Medicare levy.

2.15 Midwifery Inc submitted that more recognition is required of each woman's right to choose to have a homebirth or a midwife-assisted hospital birth with the provision of the highest possible standard of health care available. Midwifery Inc claimed that this could most effectively be achieved with changes to Medicare that:

- offer rebates to women who choose a midwife as their primary carer; and
- include midwives as practitioners to enable midwives to transfer clients to hospital and continue to manage their care under normal circumstances.

2.16 Midwifery Inc also expressed the view that there needs to be a guarantee of payment by Medicare to midwives visiting their clients in hospital. The petitioners submitted that the State Government should request the Federal Government to enact these changes.

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[2] Note that this information was current at May 13 1997, although the principal petitioner stated in her letter of July 29 1999 that "to the best of my knowledge there has been little if any change in these conditions."

Accreditation for Independent Midwives

2.17 Midwifery Inc submitted that one of the major hurdles to be overcome in relation to the professional practice of midwives was the current lack of accreditation for community or independent midwives. In February 1998 Midwifery Inc advised the Committee that Woodside Hospital had recently suspended accreditation rights, based on legal advice it had received regarding non delegable liability.

2.18 Midwifery Inc accepted that a hospital board has an obligation to provide appropriate treatment, however it expressed the opinion that the issue of delegation of duty of care and its application was arguable.

2.19 The Committee was subsequently advised in September 1998 that following the decision by Woodside Hospital to withdraw accreditation rights, all public hospitals had withdrawn this provision. Midwifery Inc submitted that this was due to a perception that hospitals provide a non delegable duty of care to admitted patients.

2.20 As a result of the withdrawal of accreditation rights and in response to the need to provide midwives in independent practice with the ability to manage their clients' care following the transfer of clients to hospital, a working party was convened by the Metropolitan Health Service Board (the MHSB) to consider the issue.

2.21 The working party recommended to the MHSB that midwives in independent practice be employed under a casual employment arrangement when they go to hospital with their clients whereby, in the event of transferring a client from a home birth to a hospital or for a booked domino birth, the midwife would be employed as a temporary casual staff member for the duration of the client's hospital stay. This would negate the issue of non delegable duty of care. The Committee was advised that, as at July 1999, casual employment contracts had only been initiated at Woodside Hospital (for ten midwives employed on the Midwifery Program), Armadale Kelmscott Memorial Hospital (for two midwives employed on the Midwifery Program) and King Edward Memorial Hospital Birthing Centre (for three independent midwives).

2.22 Midwifery Inc submitted that this was unsatisfactory as it did not allow women who chose to have a midwife as their primary carer the opportunity to access a normal range of maternity services with their chosen practitioner.

Hospital Transfers

2.23 The Committee was advised that all women who participate in the program must have a hospital booking prior to their delivery date to enable ease of transfer to hospital if required.

2.24 The Community Based Midwifery Program Evaluation of December 1997 indicated that the transfer rate to hospital for home births was 20.4%. The Committee was advised that the transfer rate is calculated on the basis of booking a home birth and then during the pregnancy or labour or post-partum being transferred to hospital. The Committee was advised by Midwifery Inc that this is a lower transfer rate than that which is cited in the literature for home births generally.

2.25 The Committee was advised that the reasons for transfer to hospital vary but that most transfers involve complications that indicate a delay in labour eventuating in a caesarian section, a breech births or twins. Other factors are a retained placenta, various complications that should not be a part of a home birth situation, or the fact that the woman wanted epidural pain relief. The Committee heard evidence from Dr Thiele that "the conclusion reached by my colleague and me in evaluating the Midwifery Program is that the transfer rate is indicative of the safety and effectiveness of the midwives in being able to identify problems and act appropriately to ensure a safe outcome, so they were able to identify difficulties in advance and to move people into the situation that was required."[3]

Insurance

2.26 Midwifery Inc advised the Committee that all contracted midwives are required to carry a minimum of $1 000 000 professional indemnity insurance as a requirement of their contract. Midwifery Inc holds copies of current insurance certificates for all contracted midwives to ensure that this requirement is complied with.

Legislative Scheme

2.27 The *Hospitals and Health Services Act 1927* (the Hospitals Act) and the *Hospitals (Services Charges) Regulations 1984* (the Regulations) (which reflect the provisions of the Medicare Agreement) set up a scheme pursuant to which patients admitted to public hospitals are classified as either public or private patients.

[3] Transcript of evidence from Dr Thiele to the Committee, March 24 1999, p7.

2.28 The legislative scheme does not contemplate nursing services being provided to a public patient in a public hospital other than by hospital staff. Neither does it contemplate a patient being admitted to a public hospital as a public patient and being charged for nursing services. Public patients must receive hospital services free of charge.

2.29 The legislative scheme does not contemplate hospital services being provided to a private patient in a public hospital other than by hospital staff except for professional and dental services "provided by a practitioner". The Hospitals Act defines "practitioner" as a "medical practitioner" or "any other person practicing in the field of health or medicine declared by the Minister under section 3 to be a practitioner for the purposes of this Act". Nurses have not been declared to be practitioners by the Minister.

The *Hospitals and Health Services Act 1927*

2.30 The petitioners submitted that section 2(1) of the Hospitals Act should be amended to include a definition of "registered midwife". The definition suggested by the petitioners was "a midwife registered in accordance with the *Nurses Act 1992* and includes a midwife who practices in the community."

2.31 The petitioners also proposed an amendment to section 18(1a) of the Hospitals Act to provide that:

"The board of a hospital may provide any facility in the hospital for the use of a practitioner *or a registered midwife* for carrying out any hospital, medical or other service." (italics added).

2.32 The petitioners submitted that this would allow for primary or midwifery lead professional care within hospitals; for example for antenatal care, in the labour ward, and for post natal care. The petitioners expressed the view that this would allow community midwives automatic practitioner access to hospital services and provide the circumstances for better transition for domino births and transfers to hospital generally.

2.33 The petitioners also proposed an amendment to section 31(1) of the Hospitals Act to provide that:

"A person is to be admitted as a patient to a public hospital if in the opinion of *a registered midwife* a medical or other officer in charge the person requires treatment of the kind provided by the hospital." (italics added).

2.34 The petitioners submitted that this would provide a guarantee to pregnant women who require transfer to hospital for a domino birth or transfer in an emergency situation that they would be admitted as a public patient.

2.35 The petitioners also submitted that section 12A(1) of the Hospitals Act should be amended to provide that:

"The Minister, with the approval of the Treasurer of the State, may establish and maintain a scheme to make financial provision in respect of the retirement, invalidity or death of practitioners *or registered midwives* engaged for the purposes of this Act or on the staff of any public hospital..." (italics added).

2.36 The petitioners expressed the view that this would allow for appropriate superannuation and retirement benefits for midwives for the times that they are hospital staff.

The *Hospitals (Service Charges) Regulations 1984*

2.37 The petitioners submitted that the definition of "registered midwife" proposed to be included in the Hospitals Act should also be included in the Regulations. That definition is set out at paragraph 2.30 of this report.

2.38 It was also submitted that regulation 7(1)(a)(ii) should be amended to provide that a public in-patient shall, for the purpose of the payment of charges, be classified as a patient:

"in respect of whom the hospital concerned provides in a hospital bed accommodation, maintenance, nursing care and appropriate professional services and such other necessary services as are available *including the services of a registered midwife."* (italics added).

2.39 The petitioners submitted that this amendment would provide for midwifery care free of charge to patients once they were admitted to a hospital and would make registered midwives part of the hospital service.

The *Poisons Act 1964*

2.40 The petitioners submitted that a definition of "registered midwife" should also be included in the *Poisons Act 1964* (the Poisons Act). The proposed definition is the same as the definition the petitioners submitted should be included in the Hospitals Act and is set out at paragraph 2.30 of this report.

2.41 The petitioners submitted that section 20(2) of the Poisons Act should be amended in Schedule 1 to allow for registered midwives, in addition to medical practitioners, pharmaceutical chemists and veterinary surgeons to dispense poisons of plant origin in the course of their caring for women in labour.

2.42 The petitioners also submitted that Schedules 3 and 4 of section 20(2) of the Poisons Act should be amended. The poisons referred to in Schedules 3 and 4 are those which are dangerous or are so liable to abuse as to warrant their availability to the public being restricted to supply by medical practitioners, pharmaceutical chemists, dentists or veterinary surgeons and those which should, in the public interest, be restricted to medical, dental or veterinary prescription or supply. They also include substances or preparations intended for therapeutic use, the safety or efficacy of which requires further evaluation. The petitioners submitted that registered midwives should also be able to prescribe and supply these substances as part of the therapeutic care of their patients.

2.43 The petitioners submitted that section 23(2) of the Poisons Act, which sets out those persons authorized to sell poisons, should be amended to include a new subsection which would allow registered midwives to have in their possession and to use or supply in the lawful practice of midwifery any poison, drug of addiction or specified drug.

2.44 The petitioners also submitted that section 6 (b) of the Poisons Act should be amended. Section 61 deals with evidence of qualifications in any legal proceedings under the Poisons Act. Under that section, a certificate that any person is or is not, or was or was not, on a certain date or for a certain period a medical practitioner or a registered pharmaceutical chemist, dentist, veterinary surgeon or a person who holds a licence, permit or authority under the Act shall be *prima facie* proof of the fact stated in that certificate if the certificate purports to be signed by:

- the registrar of the Medical Board of Western Australia in the case of a medical practitioner;
- the registrar of the Pharmaceutical Council of Western Australia in the case of a registered pharmaceutical chemist;
- the registrar of the Dental Board of Western Australia in the case of a registered dentist;
- the registrar of the Veterinary Surgeons' Board in the case registered veterinary surgeon; and

- the Commissioner of Health in the case of a person who holds a licence, permit or authority under this Act.

The petitioners submitted that a new subsection should be included in the Poisons Act to include in the above list the registrar of the Nurses Board of Western Australia.

2.45 The petitioners submitted that the inclusion of this subsection would protect midwives from prosecution for the unlawful holding of drugs by showing they are legally entitled to do so by providing their certificate of registration, as is the case with other legally entitled parties.

3 COMMUNITY BASED MIDWIFERY PROGRAM EVALUATION - DECEMBER 1997

3.1 As stated at paragraph 2.2, the Midwifery Program commenced operation in January 1996 at which time it was allocated $200 000 per year for two years from the ABSP. A further two years funding of $220 000 per annum was subsequently approved by the ABSP, resulting in the Midwifery Program having secure funding until June 2001 to provide 70 births per year. The Midwifery Program is housed in rooms at Woodside Maternity Hospital.

3.2 An evaluation of the Midwifery Program was prepared by external consultants Dr Bev Thiele and Carol Thorogood for Midwifery Inc. The evaluation was for the period January 1996 to October 1997 and the report was published in December 1997. The principal purpose of the evaluation was to "gauge the pattern of birthing preferences on which women of Western Australia act when presented with a range of genuine options".

Birthing Services

3.3 The statistics for usage, client profiles and birth outcomes for the Midwifery Program were compiled for the period of its inception on January 1 1996 until October 31 1997. During this period there were 168 bookings and 120 births. The overwhelming majority of the bookings and births were for home births. There were only 18 domino births. The transfer rate to hospital for home births was 20.4%.

3.4 Clients were more likely to be over 30 years old rather than under, married and having their first or second baby. The majority were white Caucasians from English speaking countries. No Aboriginal women went on the program during the evaluation period, however there was one African woman and seven women from Asian countries on the program during that time.

3.5 The report noted that it was difficult to ascertain unmet demand for places on the Midwifery Program because of missing data. However from January 1 1996 to June 30 1996, 24 women were refused entry to the Midwifery Program, and since then there had been an increase in the number of women who had been unable to book with the Midwifery Program. This was either because of an increasing demand for places or because the Midwifery Program was unable to accommodate the demand.

Consumer Satisfaction

3.6 A survey and questionnaire were developed to assess consumer satisfaction with the Midwifery Program. In the majority of cases, the women made extremely positive comments about the quality of care they received and about their midwives. The women expressed feelings of self-confidence in the ability to give birth as they had planned. They felt safe, were active participants in their care and had adequate access to information about pregnancy and childbirth.

Budget Analysis and Cost Effectiveness

3.7 The report indicated that the Midwifery Program remained within budget, however notes that it was not possible to undertake more than a cursory cost/benefit analysis or to provide a reasonable level of cost comparison between different models of birthing services because the data was not available.

3.8 The report did note, however, that the costs of the Midwifery Program compared favorably with the estimates of the costs of similar birthing services provided by the Health Department of Western Australia and the Commonwealth. The report indicated that a birth provided by the Midwifery Program costs on average $1 605 which, it noted, was cheaper than the average cost of an uncomplicated delivery of $1 905 calculated by the Department of Human Services and Health in 1995.

Accreditation

3.9 The report noted that an essential element of the Midwifery Program was to increase the number of Australian College of Midwives (ACM) accredited community midwives in Western Australia. Six accrediting midwives have been employed by the Midwifery Program. Of these five have achieved accreditation with the ACM and one is awaiting the results of the application.

Antenatal and Multicultural Education

3.10 One of the aims of the Midwifery Program was to improve women's access to a range of 'alternative' birthing services and existing parenting and childbirth material. The report noted that the Midwifery Program failed to generate much interest from women from non-English speaking backgrounds. Bi-cultural and bi-lingual workers were employed to approach local communities but despite this demand for the service was poor.

Conclusion

3.11 The report concluded that the Midwifery Program "has achieved its main objectives and demonstrated that community based midwifery-led care is safe, satisfying and provides a viable model of maternity care, whether the birth is at home or in hospital." The evaluation endorsed the Midwifery Program and recommended that both Federal and State funding bodies continue their support for alternative models of maternity care.

Recommendations

3.12 The report recommended that the Commonwealth:

- continue to provide specific purpose incentive funding to the State to support a range of alternative birthing services which are midwife based;
- reconsider strategies to provide alternative birthing services for Aboriginal and non-English speaking women utilising established community-based resources and agencies; and
- find ways in which the model of care offered by the Midwifery Program can continue to be offered and extended to other health regions.

3.13 The report recommended that the Health Department of Western Australia:

- examine ways in which obstetric backup for the Midwifery Program can be provided through the public health system or investigate other means of increasing doctor support for, or participation in, the program;
- explore options to have the Midwifery Program funded through its recurrent budget;

- make a submission to the Federal Government for Medicare rebates to be provided for women who choose to be cared for by a midwife in private practice; and

- retain the Midwifery Program as part of mainstream maternity services in Western Australia.

4 THE MINISTER FOR HEALTH'S SUBMISSIONS

4.1 The Committee received a letter from the then Minister for Health, Hon Kevin Prince MLA dated December 5 1996 commenting on the matters raised in the petition. The former Minister advised the Committee that decisions on the incorporation of independent midwifery services into public hospital services are not entirely within the domain of the Health Department of Western Australia.

4.2 The Committee was advised by the former Minister that individual hospital Medical Advisory Committees have the authority to approve the accreditation of independent midwives and to develop programs which facilitate midwifery birthing services. The former Minister also advised the Committee that Medical Advisory Committees in public hospitals generally report to Boards of Management which are independent of the Health Department.

4.3 The former Minister stated that many medical professionals who participate in Medical Advisory Committees are reluctant to support the incorporation of community-based midwifery services for a variety of reasons including workplace and safety issues.

4.4 The former Minister also stated that the Health Department endeavours, through policy implementation and regulation, to influence the management of hospitals to put the issue of independent midwifery services on the agenda of their Medical Advisory Committees.

4.5 The Committee was advised by the former Minister that the issue of Medicare coverage of independent midwifery services was a Commonwealth matter on which he was unable to make a decision. The former Minister indicated that he would continue to raise the matter in his communications with the Federal Minister for Health.

4.6 The Committee made further inquiries with the former Minister in June 1997. In response to a series of questions asked by the Committee, the former Minister advised that:

- Woodside Hospital, Armadale/Kelmscott Hospital, Swan Health Service and King Edward Memorial Hospital facilitate the accreditation of Midwives

in Private Practice (MIPP), otherwise known as Community-Based Midwives or Independent Practising Midwives. In the hospitals where MIPP have been accredited, the midwives are generally permitted to practise subject to the particular policies and guidelines of the hospital;

- Woodside Hospital and the Family Birth Centres at Armadale/Kelmscott Hospital, Swan Health Service and King Edward Memorial Hospital provide services in which a MIPP cares for a client through to a hospital delivery. Woodside Hospital is the only health service which permits MIPP to provide continuing care to their clients, upon the advice of a general practitioner or an obstetrician, following a homebirth transfer; and

- the *Select Committee Report on Intervention in Childbirth* (1995) estimated that the average cost for a hospital delivery was $2 573 in 1993/94. The Health Department of Western Australia has not officially costed homebirths.

4.7 The former Minister for Health also provided the Committee with a copy of the Health Department's *"Policy on Homebirth in Western Australia"* dated July 15 1992 (the Homebirth Policy) and *Guidelines for the Hospital Accreditation and Clinical Privileges for Independent Practising Midwives in Western Australia* dated July 1992 (the IPM Guidelines).

Policy on Homebirth in Western Australia

4.8 The Homebirth Policy was formulated as a result of requests from hospitals, midwives, medical practitioners and regional health directors within Western Australia and were developed in accordance with the National Health and Medical Research Council (the NHMRC) Guidelines on Homebirth dated October 31 1991.

4.9 The Homebirth Policy Statement includes the following points:

"• Women have the right to choose a homebirth and should have access to a high standard of service and a team of appropriately trained health professionals, both community and hospital-based.

- Homebirth practitioners should be a midwife registered with the Nurses Board of WA, or a medical practitioner registered with the Medical Board of WA.

- Women considering a homebirth should be given accurate information and the opportunity to discuss their choice with: midwives; medical practitioners and

other parents, in order to make an informed choice about the place of birth for their baby.

- Hospitals with maternity beds in Western Australia should develop accreditation and clinical privileges for independently practising midwives.

- A hospital booking should be made by the woman intending to have a homebirth. In the event of potential for complications either during the pregnancy, labour/delivery or postnatal period, transfer to hospital should be considered.

- In the event of a complication occurring the independent practitioner should arrange direct admission to the labour ward of the hospital where the woman is booked. Midwives should have the ability to refer directly to a specialist obstetrician or paediatrician.

- The baby should be examined thoroughly by the homebirth practitioner and routine observations undertaken. If there is any indication of an abnormality or a health problem then the baby should be referred directly to a paediatrician or nearest medical practitioner."

4.10 The Homebirth Policy also includes Procedures for the Care of the Newborn and Guidelines for Risk Factors for both the mother and the baby.

Guidelines for the Hospital Accreditation and Clinical Privileges for Independent Practising Midwives in Western Australia

4.11 The IPM Guidelines defines an Independent Practising Midwife (IPM) as:

"A midwife registered with the Nurses Board of Western Australia, accredited with the Australian College of Midwives Inc. who has notified the Health Department of Western Australia as required under Section 5, Midwifery Regulations (1982). The independent practising midwife has a private contractual agreement with the woman and works independently of a hospital, community health service or any health-related organisation."

4.12 It is noted in the introduction to the IPM Guidelines that among the many factors which have contributed to the need for IPMs to be accredited and to have clinical privileges at maternity hospitals in Western Australia is the increasing demand from consumers of maternity care. Increased community awareness of the benefits of midwife centered care has led to the establishment and growth of birth centres, and the need for independent

practising midwives to have the option to deliver women in hospital rather than at home, as occurs in other Australian states.

4.13 The introduction also states that women should have the opportunity to select the birth attendant and birth setting of their choice. It states that accreditation and the granting of clinical privileges to IPMs gives women the option of having a midwife as the primary carer responsible for pregnancy, labour/delivery and postnatal care, and delivering in a hospital.

4.14 The introduction concludes by stating that a small number of hospitals in Western Australia have already developed and implemented systems for the hospital accreditation and granting of clinical privileges to IPMs. However the report goes on to state that health regions and hospitals with maternity units need to adopt these or similar guidelines at regional or hospital level to ensure that women are provided with a range of options for maternity care and childbirth which assures the safety and well being of them and their babies.

4.15 The general IPM Guidelines for Hospital Accredited IPMs are as follows:

- the IPM has the responsibility of caring for and giving advice to the woman during normal pregnancy, labour/delivery and the postnatal period;
- the IPM should seek professional liaison with one or more medical practitioners with obstetric privileges at the hospital;
- the IPM must refer the woman during pregnancy for at least one consultation with the nominated medical practitioner;
- the IPM must maintain appropriate records of pregnancy, labour/delivery, postnatal and neonatal periods and keep these records for twenty five years after the birth event;
- in the event of concern or complication arising either during the pregnancy, labour/delivery or in the immediate postnatal period, a medical practitioner should be consulted immediately;
- the IPM will liaise with the senior midwifery staff and the supporting medical practitioner on duty, and may request assistance and support from hospital staff as required; and
- the IPM shall complete hospital charts and records in accordance with hospital policies and standards.

4.16 Also included in the IPM Guidelines are specific guidelines for antenatal care, labour and delivery care and postnatal and neonatal care.

4.17 The Committee was advised by the Health Department of Western Australia that the IPM Guidelines are currently being reviewed. The first meeting to consider the proposed changes to the IPM Guidelines was held on July 15 1999. It is anticipated that it will be some time before the new guidelines are introduced. Until that time, the IPM Guidelines referred to above are to be followed.

5 THE COMMONWEALTH DEPARTMENT OF HEALTH AND FAMILY SERVICES' SUBMISSIONS

5.1 In a letter to the Committee dated August 22 1997 the Commonwealth Department of Health and Family Services advised that as part of the 1997/98 Budget, funding for the ABSP was being continued for a further two years.

5.2 The Committee was also advised that new funding agreements were being negotiated between the Commonwealth and the States and Territories for all public health specific purpose payments, including the ABSP. Once the Agreement between the Commonwealth and the States had been negotiated, States would then have the discretion to decide on the most appropriate distribution of funds to individual services or projects in their jurisdictions.

6 THE NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL REPORT - 1996

6.1 In 1996 the NHMRC produced a detailed report entitled *"Options for effective care in childbirth"* (the NHMRC report). As part of its report, the NHMRC described recent initiatives for care in childbirth which it believed deserved special comment. Those initiatives are outlined below.

6.2 Hospital privileges for visiting midwives

6.2.1 The NHMRC report stated that visiting midwives may be granted admitting privileges with associated responsibilities in a manner analogous to the granting of privileges to medical officers.

6.2.2 The accreditation process is based on an assessment of the midwife's competency, experience and professional standing. In this service, a woman attends an obstetrician who screens for risk factors. Subsequent antenatal care for women without significant risk factors is provided by the midwife. Consultation with the obstetrician occurs again in the 36th week of pregnancy, or earlier if problems occur.

6.2.3 Combined care with the obstetrician allows joint care for women with significant risk factors and, over time, a cooperative model of midwifery and obstetric care can evolve which recognises the contributions each profession has to offer child-bearing women and their families.

6.2.4 In *Guidelines on Homebirth* (1991) the Health Care Committee of the NHMRC drew attention to a requirement for changes to legislation to allow midwives limited rights to order pathology and ultrasound tests, which have become a part of the assessment of a healthy woman with a normal pregnancy.

6.2.5 The Colleges of General Practitioners, Obstetricians and Gynaecologists and the Australian Medical Association do not accept that midwives at their present level of training have the knowledge and background for ordering and interpreting these tests.

6.3 Midwifery clinics

6.3.1 Clinics where healthy women are cared for by midwives have become a part of traditional antenatal services in many hospitals. Women attend for a first visit and are selected or offered care by a midwife if few or no risk factors are identified. A further consultation with a medical officer usually occurs in late pregnancy.

6.3.2 At these clinics, the woman consults with the same midwife at each visit. However unlike birthing centres with a midwifery unit, too often this care does not extend to the birth. Thus women see one midwife at the clinic and then others in the delivery suite and postnatal wards. This does not provide continuity of care which should be a goal of all models of care.

6.4 Private midwifery-obstetric practice

6.4.1 There are few accounts of a joint private practice run by midwives and obstetricians. This option has, however, been reported for a medical practice containing a mix of low and high risk patients. In the report on this pilot project, the authors noted that autonomous obstetric care by either midwife or doctor excludes the complementary expertise of the other. The midwife and obstetrician jointly provided antenatal care. Postnatally, the midwife visited her patient on two occasions and most of the midwifery care was provided by hospital staff.

6.4.2 This model is really a variant of the midwife-obstetrician clinic but with the important extension to the delivery suite. The midwife and the obstetrician therefore shared antenatal care, and on most occasions the pregnant woman was able to consult either or

both at each antenatal visit. After admission to hospital in labour, the midwife provided care in the delivery suite in conjunction with the obstetrician.

6.4.3 The report recommended that small teams of midwives work with a number of general practitioners in a geographically defined section of the metropolitan area. It was considered that this model of maternity care would grow rapidly, providing its evaluation showed it to be safe and acceptable to women.

6.4.4 The report recognised funding as an important factor in the development of this model of care.

7 COMMITTEE HEARING

7.1 On Wednesday, March 24 1999 the Committee conducted a hearing into the matters raised in the petition. The witnesses who attended the hearing were:

- Dr Beverley Thiele, Senior Lecturer in Women's Studies, Division of Social Sciences, Humanities and Education, Murdoch University;
- Ms Bronwyn Key, Convenor of Community Midwifery WA Inc.;
- Ms Tracey Riebel, Project Administrator, Community Based Midwifery Program;
- Ms Renai Adamson, Consumer Representative, Birthplace Support Group Inc;
- Ms Belinda Whitworth, Senior Purchasing Manager, Health Department of Western Australia;
- Ms Clare Chamberlain, Planning Officer, Health Department of Western Australia; and
- Mrs Penny Brown, Acting Principal Nursing Adviser, Health Department of Western Australia.

7.2 The Committee heard a substantial amount of evidence from the witnesses concerning a range of issues relating to community based midwifery.

Introduction

7.3 In her opening address to the Committee Ms Riebel re-iterated the request stated in the petition that the State Government, through its health services, provide community based midwifery care as a mainstream service. Ms Riebel explained that the request came about through community demand. Ms Riebel stated that the services should not be seen to be elite or available only to certain people, but should be available to all women who chose not to be a part of the hospital-based system.

7.4 Ms Riebel stated that community based midwifery services offer women continuity of care through ante-natal, labour, birth and post-natal periods in their own homes. The women can choose to give birth either in their home or in hospital, but all their other care is conducted in the home. Ms Riebel stated that this is conducive for a number of women, particularly those with young families. It was also culturally conducive to women who come from cultures where birthing is designated women's only business.

Demand for the Services

7.5 Ms Adamson told the Committee that women join the program for a number of reasons. These include:

- the continuity and quality of care offered by the program;
- the support provided to special needs women; that is women who have had previous birth traumas or some kind of emotional trauma;
- the quality and volume of information provided by the midwives;
- the assistance provided to women and their partners in making the transition to parenthood; and
- cultural reasons.

7.6 The Committee was advised that the services provided by the Midwifery Program had been in very high demand, and that there is currently a greater demand than there are places available. The Midwifery Program currently has funding to provide 70 births a year, although this figure may be increased to 150 births per year if the proposal from the Metropolitan Health Service Board currently before the Health Department of Western Australia for additional funding is successful. As at the end of 1998 there had been a total of 195 births on the program.

7.7 Ms Reibel informed the Committee that in 1998 there was an over demand of 18 places above places offered on the program. Although figures for 1999 were not yet available, Ms Riebel estimated that there would be a higher demand in 1999 as the program had expanded to cover the entire metropolitan area. Ms Riebel advised the Committee that the inquiry rate for 1999 was approximately 15 per cent above the inquiry rate at the same time last year.

Cultural Background of Participants

7.8 Ms Riebel noted that the number of women from different cultures who had been on the Midwifery Program had been insignificant. Ms Riebel expressed the belief that there was a potential market for increasing the number of women from different cultural environments, however, and stated that the biggest difficulty had been accessing those women.

7.9 The Committee was advised that women from a range of cultural backgrounds had been on the program at some time. They tended to be of European origin, with a high representation of Dutch women due to the fact that home births are the norm in The Netherlands. However there were also women of Malay, Chinese, Indonesian and African descent on the program.

7.10 In answer to the Chairman's question: "Have any Aboriginal women participated in the program?", Ms Riebel replied: "To date, only one person has officially been identified as Aboriginal."[4] The Committee was advised that the Midwifery Program had negotiated with the Aboriginal health worker representing Community and Women's Health at Fremantle Hospital and Health Service to make connections with indigenous women through various community based organisations. Ms Riebel advised that the discussions were continuing but that there were many difficulties involved in negotiating with indigenous communities on such a sensitive matter. Ms Riebel acknowledged that to date the Midwifery Program had not had a great deal of success in attracting indigenous women.

7.11 Dr Thiele added that the participation of indigenous women on the Midwifery Program was one aspect of the evaluation which was given serious consideration as part of the funding agreement with the ABSP. The conclusion was that it was an extremely difficult request to make of the program. Dr Thiele stated that there are enormous difficulties associated with reaching a variety of ethnic communities with diverse ideas about birth

[4] Transcript of evidence from Ms Riebel to the Committee, March 24 1999, p6.

values and what is required in practice. Dr Thiele submitted that these difficulties could not be solved by the midwifery group.

7.12 Dr Thiele commented that the Midwifery Program is a small-funded service delivering its services mainly to the white Anglo-Saxon community. Dr Thiele stated that if the Federal Government had a view about the delivery of health services to the Aboriginal community, it may need to address issues such as whether Aboriginal communities need Aboriginal delivery of programs rather than trying to have a birthing service like the Midwifery Program do everything.

7.13 Dr Thiele commended the Midwifery Program for its continuing attempt to reach out to the Aboriginal population, however expressed her opinion that it should not be judged on its failure to do so.

Selection Criteria for Participants

7.14 Ms Riebel advised the Committee that when it took over the daily management of the Midwifery Program in late 1997, the management steering committee developed a selection policy regarding the over demand factor the program was experiencing.

7.15 The selection policy required the program to give priority to women of different cultural backgrounds, particularly women from non-English speaking backgrounds. Priority was also to be given to women from low socio-economic backgrounds, however the program was not to discriminate against anyone who applied.

7.16 Selection criteria for participants were subsequently developed which incorporated the policy matters referred to in paragraph 7.15 and which also included the midwives' caseload and the applicant's location in relation to other clients. Ms Reibel stated that the selection process is fair and transparent, although she acknowledged that the process is fraught with difficulty as, in her opinion, everyone who applies deserves a place.

Health Department of Western Australia's Submission

7.17 Ms Whitworth advised the Committee that "the Health Department's view of the overall program from the current contract management point of view is that it has been more than satisfied with the quality, professionalism and the outcome of the service provided."[5] The Health Department of Western Australia did not want to see the program fold as a pilot project, and had been encouraging and working with the

[5] Transcript of evidence from Ms Whitworth to the Committee, March 24 1999, p14.

midwives involved in the program to see if there were ways in which they could offer their services to others.

Objectives of the Midwifery Program

7.18 Ms Key advised the Committee that a major objective of the Midwifery Program was to secure on-going funding so that there could be long-term planning for sufficient periods to cater for all the women in the metropolitan area, and possibly country areas, who wished to use the service. It did not matter whether the funding was provided by the Commonwealth or the State or both, as long as it was on-going so that there was no cost to the consumer.

7.19 The Committee was also advised that the Midwifery Program supported Medicare rebates for midwives in private practice. The Committee was told that even with the services provided by the Midwifery Program there would always be women who would choose to have a midwife in private practice. On that basis, it was important that Medicare provided rebates for women who chose to utilise the services of an independent midwife.

7.20 A further objective of the Midwifery Program was to review the practitioner status of midwives and the ability of midwives who are working independently as the lead professional carer of pregnant women to have access to public maternity units for the transfer of patients.

8 FURTHER REFERENCES

8.1 Legislative Assembly of Western Australia Select Committee on Intervention in Childbirth Report 1995, presented by Dr Hilda Turnbull MLA and laid on the Table of the Legislative Assembly on September 21 1995.

8.2 The Committee notes that there is a current Inquiry Into Childbirth Procedures by the Senate Community Affairs References Committee. It is anticipated that the Committee will report by December 30 1999.

9 CONCLUSIONS

9.1 The Committee believes that since it commenced operation in January 1996, the Midwifery Program has demonstrated its worth both in terms of the number of women choosing to participate in the program and the results that have been achieved.

9.2 The Committee believes that the experience of the Midwifery Program has shown that there is a high demand in the community for community based midwifery services. The Committee concludes that the Midwifery Program should no longer be considered a pilot project and that State Health Services should include community based midwifery as a part of its maternity services. Adequate, on-going funding should also be made available to the Midwifery Program to allow for long-term planning to cater for all the women who wish to use the service.

9.3 The Committee notes the petitioners' request "for appropriate coverage under Medicare." The Committee accepts the petitioners' claim that changes to Medicare that offer rebates to women who choose a midwife as their primary carer would allow more women to have a homebirth than under the current system where a woman must pay as a private patient if she wishes to have midwifery centred care. The Committee concludes that there should be changes to Medicare to offer rebates to women who choose a midwife as their primary carer.

9.4 The Committee further concludes that as coverage under Medicare is a Federal matter the State Government should negotiate with the Federal Government to enact these changes to Medicare.

10 RECOMMENDATIONS

Recommendation 1: State Health Services should include community based midwifery as a part of its maternity services.

Recommendation 2: Adequate, on-going funding should be made available to the Midwifery Program to allow for long-term planning to cater for all the women who wish to use the service.

Recommendation 3: The State Government should negotiate with the Federal Government to enact changes to Medicare to offer rebates to women who choose a midwife as their primary carer.

_____

Hon Murray Nixon JP MLC

Date:

APPENDIX A

APPENDIX A
HEALTH FUND REBATES FOR MIDWIFERY CARE

HEALTH FUND REBATES FOR MIDWIFERY CARE

Grand United

- $15 per antenatal postnatal visit, max. 10 each per pregnancy.
- Upto $250 for Homebirth or Public hospital birth with accredited midwife (member of ACMI). *
- Yearly limit $550.
- Home nursing benefits upto $20 per visit upto 6hrs, upto $50 per home visit exceeding 6hrs.
- Combined yearly limit $550 per membership person for home nursing and midwifery. *.
- for Life Ultra Maxicare members.

National Mutual

- $40 per postnatal visit, max. 10 per pregnancy.
- Upto $300 for Homebirth or Public hospital birth with fund accredited provider, though presently not accrediting any more providers.
- Home nursing benefits upto $15 per visit upto 6hrs, upto $60 per day, annual limit upto $1,800 "if a doctor certifies that the nursing (not midwifery) is in place of hospitalisation".
- Combined yearly limit $550 per membership person for home nursing and midwifery. *. for Life Ultra Maxicare members.

Medibank Private

- No rebates for midwifery or home nursing.

= 12 months pre -existing membership required.
* 9 months pre -existing membership required.

No replies from Australian Health Services Alliance, Mercantile Mutual and BHP health funds.

Denise Hynd RM, IBCLC.

HEALTH FUND REBATES FOR MIDWIFERY CARE

women and their families should justify at least equal rebates for midwifery care as for medical care in pregnancy and childbirth from both health funds and Medicare. Sadly questions of equity and cost effectiveness do not presently influence access and rebates for health care as indicated below:

FUND	Basic	Intermediate	or Top Cover Rebates.

Australian Unity

- May rebate the full cost of private midwifery care with fund accredited midwife. on application by each member.
- Otherwise upto $30 per antenatal & $40 per postnatal visit. max. 6 each per pregnancy.
- $400 for birth at home or "registered birthing facility" with fund registered midwife ($620 per pregnancy).

HBF	no cover	$1060	$1400

- for Homebirth or Public hospital birth with fund & ACMI accredited midwife.
- may accept transfer of membership from another fund.

HIF	$600	$1000	$1300

- for Hospital plus ancillary covered members only.
- for Homebirth (?and public hospital birth) with accredited midwife. =.

NIB

- $13 per antenatal/postnatal visit. max. 10 each pregnancy.
- $220 for Homebirth or Public hospital birth with registered midwife. *
- Yearly limit $750.

AHBS

- Upto $20 per antenatal/postnatal visit, max. 10 each per pregnancy,
- Upto $550 for Homebirth or "registered birthing facility" birth with fund registered midwife.
- Yearly limit $750 for TE, P members only. (not S or SE).