Maternity Coalition's Response to the Productivity Commission's Position Paper on

Australia's Health Workforce,

September 2005

In making this submission Maternity Coalition seeks to represent the interests of consumers who are recipients of maternity-related health care. Our interest in the health workforce is therefore limited to regulated maternity care providers, midwives and doctors, and especially those at the primary care (rather than specialist) end of the maternity care spectrum. Maternity care is an essential service, and must be provided at a primary care level for all women having babies, with suitable arrangements for referral to specialist care for the minority who need such care.

We speak on behalf of mothers and their babies, as well as fathers, and families. We want maternity services that enhance health for all mothers, babies and families. We believe that changes to maternity health workforce structure and planning are urgently needed and in the public interest.

It is essential that the federal government leads the reform of basic maternity service provision from a policy perspective, so that change can be effective for the consumer. We believe maternity services offer a potential area for reform that will produce more sustainable and responsive workforce arrangements to provide safe and effective care for mothers, babies and families who require maternity services anywhere in Australia.

In our recent submission to the government's Inquiry into Health Funding, Maternity Coalition made the recommendation that the federal government take funding responsibility for the whole episode of primary maternity care from early pregnancy to six weeks post birth. This change would address the current phenomenon of cost-shifting between state and federal funding sources, and would enable maternity care to be client-focused and equitable for all pregnant women.

Our proposals are based on the understanding that primary maternity care may be provided by either doctors or midwives, and we suggest a Medicare (MBS)-type funding scheme that would provide equal pay for equal work.

Recommendation:

We recommend that the midwifery workforce be given full recognition for their scope of practice, with equal recognition for midwives and doctors as providers under the Medicare Benefits Schedule (MBS).

Such reform will result in more equitable access for consumers to primary maternity services provided by midwives or GPs, more effective use of the specialist obstetric workforce, and improvements in recruitment and retention of midwives to practise as primary maternity carers in communities.

National Health Workforce Strategic Framework (Box 3, pXXX)
Our recommendation that the midwifery workforce be given full recognition for their scope of practice, with equal recognition for midwives and doctors as providers of the same basic services under the MBS is consistent with all seven core principles in this framework.

We consider that this reform would require initial policy changes, and would 'evolve over time', allowing workforce changes to be implemented in a systematic and carefully monitored way. An outcome of such reform would be improved access for consumers of maternity services to an appropriately skilled and competent workforce, better retention and recruitment of a skilled midwifery workforce in all communities, and better collaboration with medical specialists in cases where their skill and expertise is required.

Appropriate use of maternity workforce:

We note from the PC's Position Paper, Table 8.2 p124, that the midwife or GP is listed by Duckett (Reference 2005b) as being a potential or current task substitute for the obstetrician in maternity care.

We support the principle of appropriate use of midwives and GPs within their scope of practice, as well as more appropriate use of obstetricians as specialist care providers. Australia's midwifery workforce is grossly underutilised, and the specialist obstetric workforce is inappropriately directed towards basic care that is better managed by midwives and GPs. There is a large potential for midwives to take responsibility for primary care, as well as the collaborative midwifery roles in medically led hospital care that currently exists.

We seek greater consumer access to the services of midwives throughout their maternity care, consistent with strong evidence supporting continuity of care by a known midwife (Reibel et al 2002).

Maternity services in rural areas:

Women in rural areas have in recent decades experienced closure of local maternity hospital services that were previously staffed by midwives and GPs. This phenomenon has placed rural women and their babies at increased risk in most instances, as they are required to travel long distances to give birth, and separated from their usual community support arrangements at the time of birth. The de-skilling of rural maternity practitioners (midwives and GPs), which can occur quickly after closure of smaller maternity hospital facilities, is detrimental to workforce planning in many ways. The protection of local primary maternity services in all areas, with effective services and support for those whose needs cannot be met locally and therefore need to go to larger centres is consistent with the policy direction proposed by the PC in its Position Paper. This issue has been addressed in the Victorian Health Department's policy statement 'Future directions for Victoria's maternity services' (DHS 2004).

Competition:

We presented arguments and supporting evidence to the Productivity Commission in its review of national competition reforms with an oral submission in December 2004 in Melbourne, and in a written submission January 2005. Our submissions to that review centred on ensuring consumer access to primary maternity care by a midwife, which is currently limited by anti-competitive protection of maternity services provided by doctors.

The monopolisation of maternity care by obstetricians, and the disappearance of both midwives and GPs as primary maternity care providers in Australian health care has been driven partly by the MBS, as well as other professional and funding factors. This monopoly is not in the public interest, and does not lead to better outcomes or healthier mothers and babies.

Specialist obstetrics:

Most obstetricians, understandably, work in larger population centres where they have access to well equipped and staffed hospitals and operating theatres. Consumers who require specialist medical care in pregnancy and birth are well off in cities and many larger towns, with many hospitals providing world-class services. However these women are in the minority, with most women being well in pregnancy and birth, and are safely cared for by midwives and GPs as primary carers. Consumers who seek community based, low-tech primary care are often unable to access such care, whether they live in metropolitan, regional or rural areas.

Specialist medical care is needed only by those who experience illness or complication in pregnancy or birth, or by newborn babies who are ill. This statement is not intended to demean the role of the specialist; rather it is to clarify it. International obstetric experts have debated the respective roles of obstetricians and midwives in childbirth, and evidence has led to and underpinned the statement that "It is inherently unwise and perhaps unsafe for women with normal pregnancies to be cared for by obstetric specialists, even if the required personnel were available." (Enkin et al 2000) Yet Australia's Medicare funding, and government support for private medical services through tax rebates and the Medicare safety net has, in the case of maternity services, directed consumers to basic maternity services provided by obstetric specialists – "unwise and perhaps unsafe"! This is unacceptable.

Primary maternity care:

Normal maternity care spans a pregnancy and the ensuing six weeks, approximately 10 months in total. Maternity care is unique in the spectrum of health care, as most women are not ill, and the 'condition' can not become chronic.

The midwife is the most appropriate leading care provider for women with uncomplicated pregnancies and births. Pathways exist in primary maternity services for referral and transfer of care when appropriate (ACMI 2004). The GP obstetrician and specialist obstetrician, and hospitals, provide secondary levels of care which, with the midwife, provide safe and effective maternity care options wherever they are available.

All pregnant women require basic maternity care. They may choose either a doctor or a midwife as their primary carer. Both professions are recognised and regulated by statute in all states and territories. Yet the doctor's fees attract a Medicare rebate, while the midwife's fees for the same services do not. The lack of government funding for a basic and essential service such as a midwife's care has resulted in excessive medicalisation of maternity care, and an effective monopoly for the medical profession over the midwifery profession. There is no evidence that the consumer is in any way protected or advantaged by the medical monopoly of funding.

Current Medicare funding prevents consumer access to maternity services provided by midwives. We strongly object to this state of affairs.

Ordering tests and prescribing medicines:

Maternity Coalition notes that, as well as the monopoly of government funding through MBS, consumers are further restricted in access to primary maternity services provided by midwives because tests and medicines must be ordered/prescribed by doctors.

There is a small number of standard tests, investigations and medicines that are widely accepted in basic maternity care for all women. Midwives in other countries, such as New Zealand, Canada, and many European countries, are able on their own authority to manage these as part of their normal practice.

Midwives in Australia who attend birth as primary carer either in hospital or the home take responsibility for drugs (synthetic oxytocics) that are used to prevent excessive blood loss. These drugs can only be obtained on a doctor's prescription, but the doctor who prescribes the drugs usually does not have any involvement at the time of their administration. In most cases a midwife who practises in community settings diagnoses and administers the oxytocic on her/his own authority. Yet there is no state or federal law covering a midwife's management of prescription medications. Reform of MBS for maternity care should include these matters.

Registration, Credentialing, Accreditation of courses:

Recent change in state legislation has led to the replacement of the Nurses Board with a Nurses and Midwives Boards in NSW. Other states and territories are planning similar reform. This reform is long overdue, and we welcome such change.

Maternity Coalition supports reform of legislation covering registration and licensing of health professionals, and we support uniform national standards and processes for registration with mutual recognition across state borders. We support uniform national standards for credentialing and accreditation.

Legislation governing midwifery practice varies from state to state, and Victorian legislation (Nurses Act 1993) does not have any requirement that a midwife be appointed to the Nurses Board. This is a clear example of the need to reconstitute the membership of registration boards to better reflect public interest, as mentioned in the Position Paper Chapter 7 Registration: Key Points (p103).

We do not support delegation of the work of a midwife or GP in primary maternity services. It is essential that the person acting in such a role is responsible and accountable for all professional acts.

References:

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