Joint Submission to the

Productivity Commission's Review of National Competition Policy Arrangements

The Australian College of Midwives
The Australian Nursing Council

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1. Introduction

The Australian College of Midwives Inc (ACMI) is the national professional organisation for Australian midwives. The College has a fundamental commitment to developing and maintaining professional standards for midwives and to providing

professional and educational frameworks to ensure high quality, safe and effective midwifery care is provided to women and their families.

The Australian Nursing Council (ANC) is the peak national body established for the purpose of bringing a national approach to the regulation of the disciplines of nursing and midwifery. The ANC works in collaboration with the state and territory nurse regulatory authorities in the development of national standards for statutory nurse and midwifery regulation. The goal is to establish standards that are flexible, effective and responsive to the health care requirements of the Australian population.

Both the ACMI and ANC welcome the opportunity to make a submission to the Productivity Commission's Review of National Competition Policy Arrangements. We wish to respond in particular to the Terms of Reference 4b and 5a by highlighting for the Commission opportunities for significant gains in services to consumers from removing impediments to efficiency and enhancing competition in the health sector, specifically in maternity care and nurse practitioner sectors.

We are mindful in making this submission that some reform has already commenced under the auspices of National Competition Policy in relation to legislation restricting competition in areas such as the professions. We also acknowledge that in the Issues Paper the Commission has identified further reform in this area as needing consideration. In the view of the ACMI and the ANC, there is a strong case for dedicated attention to be paid to health professionals, with a view to ensuring that principles embodied in the competition policy reforms over the past 8 years are applied to the benefit of consumers of health services.

The objectives of ensuring cost effective service provision, improving the delivery of services, improving the allocation of scarce public resources, and enhancing access to services by the community, particularly for disadvantaged groups, are particularly relevant to the health sector. As Australia's ageing population continues to place increasing demands on our health services and budgetary resources, the imperative to find efficiencies in the delivery of health services while still providing quality health care to people when and where they need it will only continue to grow.

This submission does not endeavour to present an analysis of the potential benefits from extending competition policy reform to the entire health sector. Rather it provides some tangible areas of health service delivery where increased application of competition policy principles and practices would meet the above objectives. These areas include:

- the provision of antenatal care to pregnant women
- hospital admitting rights for midwives in private practice
- the introduction of nurse practitioner roles across the health sector.

In all of these areas, government organisations (health departments, area or district health services and hospitals) are key players, as well as private health care organisations and professionals. In that sense competition related reform would generally fall outside the purview of the Trade Practices Act. Nonetheless significant gains in terms of effectiveness, equity and efficiency of service provision could be made through the application of NCP type principles and reforms to the health sector, and particularly the maternity care sector. .

2. The provision of Antenatal Care to Pregnant Women

Midwives are experts in normal pregnancy and birth. Doctors are experts in complications of pregnancy and birth. In Australian maternity services over the past 15-20 years doctors have come to dominate the care of women without complications, and in the process have in effect limited women's access to midwives as experts in normal pregnancy and birth.

There is strong international and Australian evidence that the provision of antenatal care to women by midwives is safe, cost-effective and beneficial to women and babies, particularly when the antenatal care is provided by a midwife whom the woman gets to know well and who goes on to provide intrapartum and postnatal care. Women who receive continuity of care by midwives (including antenatal and intrapartum care) have been found to be:

- less likely to be admitted to hospital antenatally;
- less likely to have their labour induced
- less likely to have a labour of longer than 6 hours
- less likely to have drugs or epidural analgesia for pain relief during labour
- less likely to require an operative delivery or episiotomy
- less likely to require a caesarean section
- less likely to have a baby with a 5 minute Apgar score below 8/10
- less likely for their newborns to require resuscitation
- less likely to experience postnatal depression

They were also found to be

- more likely to attend antenatal education programs;
- more likely to give birth vaginally
- more likely to have intact perineums,
- more likely to successfully initiate and sustain breastfeeding
- more likely to feel positive about their birthing experience and their early parenting [1, 2,.3, 4,5,6,7, 8]

Approximately 250,000 women give birth in Australia each year. Of these fewer than half are able to access antenatal care from midwives, and fewer than 5% can access midwives providing continuity of care throughout pregnancy, labour, birth and early parenting. This is despite widespread acknowledgement among health policy makers and service providers of research evidence demonstrating the benefits to women from continuity of care provided by midwives, with referral to medical back-up as the needs of individual women dictate.

Women in socio-economically disadvantaged groups are particularly affected by this limited access to midwifery care, as many can not afford the services of a GP given low rates of bulk billing. Some disadvantaged women, such as Indigenous women, receive little or no antenatal care for a variety of reasons.

A major barriers to increasing women's access to midwifery antenatal care stems from the funding arrangements between the Commonwealth and State/Territory governments for this care. Because General Practitioners are eligible for Medicare Provider Numbers, they are able to offer women antenatal care as part of their private

practices and do so in large numbers (estimated at approximately 50% of antenatal care). Funding for midwives to provide antenatal care is only available through state government funding to hospitals or through private hospital clinics.

Only about half of hospitals in a large state like Victoria can afford to offer women antenatal care from midwives, and where this is provided it is typically fragmented for women. In hospital based antenatal clinics women typically experience numerous different midwives and doctors through their antenatal care, and further unknown midwives and doctors during their labour and birth. This fragmented care reflects the employment structures based on a nursing model of rostered shiftwork. It also reflects the barriers to midwives 'competing' in the private market to provide safe and effective antenatal care to women through lack of access to Commonwealth antenatal care funding currently made available only to GPs and specialist obstetricians.

While the concept of 'competition' in the maternity services area is seen by some as being an anathema due to the inherent need for doctors and midwives to work collaboratively, there would nonetheless be significant potential benefits to the community from the application of competition principles to the availability of funding for antenatal care services. New Zealand provides an instructive model on this point. In New Zealand, Section 88 Maternity Notice of the New Zealand Public Health & Disability Act 2000 provides for the Lead Maternity Carer (LMC) to be paid a set fee by the State regardless of whether they are an obstetrician, general practitioner or midwife. This fee encompasses all maternity services. With the implementation of Section 88 the NZ Ministry of Health has introduced standardised maternity contracts that enable a primary maternity provider to offer specified Lead Maternity Care and other primary maternity services, thus ensuring both price equity amongst providers (LMCs), and equity of access for all women. The Federal government should implement funding reforms in maternity provision, similar to that which have been introduced in New Zealand.

3. Hospital Visiting Access for midwives in private practice

Australian midwives experience significant barriers to private practice even when they fully comply with:

- national professionals standards of midwifery education and practice,
- the requirements of the nurse and midwifery regulatory authorities and
- relevant state laws and policies.

One significant barrier to private midwifery practice is lack of Visiting Access to hospitals. Hospitals, both public and private, in all state and territories reserve the right to grant access to health professionals to care for their patients only when the individual health professional is deemed to satisfy hospital management that they are fit and competent to provide specified care. This is appropriate practice. However, the problem with this system is that the committees which are given responsibility for assessing requests for Visiting Access from health professionals, such as doctors, midwives and allied health, are typically made up mostly or wholly of doctors.

In Australia at present, no midwife in private practice has Visiting Access to a hospital, either public or private (there are around 420 maternity hospitals in Australia). This situation in part reflects the lack of professional indemnity insurance for midwives since July 2001, since holding a suitable PII policy is a requirement of

Visiting Access privileges. Yet the situation was not much different prior to 2001, when only a handful of hospitals, mostly in NSW granted Visiting Access to a limited number of midwives in private practice.

The implications of this situation for women who chose to engage the services of a midwife in private practice are profound. As primary carers, such midwives are legally and professionally responsible for identifying if and when individual women, develop a need for medical attention during either pregnancy, labour or birth, or the early postnatal period. They are also responsible for arranging for women who develop complications to access appropriate medical care. Access to appropriate medical backup is essential to safe provision of midwifery care to women. Yet as soon as an independent midwife arranges for the woman to receive medical care at a local hospital, the midwife is deemed by the hospital to be merely a support person for the woman, and is prevented from continuing to provide the professional midwifery care and support she has been contracted by the woman to give.

Transfer to hospital under such circumstances can be very stressful for the woman. Nor is there research evidence to support the routine application of such restrictions to midwives in private practice. Both Australian and international research on clinical outcomes for women receiving continuity of care from a midwife (the model of care provided by midwives in private practice) confirm that the such care is high quality, safe, and that transfer to medical care is made appropriately for the minority of women who need it. Repeated refusal by hospitals across Australia to even consider applications for Visiting Access from midwives let alone grant them reflect professional prejudices and uninformed judgments rather than evidence based assessment of the public interest. Such practices are uncompetitive and not in the public interest.

Again New Zealand provides a constructive alternative approach to this problem through the introduction of mechanisms that support fair competition in the provision of services to consumers. Midwives have access to the hospital system with consumers (women) who have chosen their services. When the need for transfer/admission to a hospital is deemed necessary there is a mutual respect for the midwife to gain access to the system to continue to provide care to the woman in collaboration with doctors. There is acceptance of the midwife's role as the primary care midwife, and the midwife retains the right to request consultation with other professionals as necessary. This approach makes works to maximize the likelihood of the woman receiving appropriate care from the appropriate health professional throughout her pregnancy and labour/birth.

4. The introduction of nurse practitioner roles across the health sector.

It is the role of the Australian Nursing Council to inform the regulation of nursing and midwifery practice. The competition policy issues pertaining to these unique scopes of professional practice are shared by both professions. Currently within Australia major impediment is imposed upon midwives who are restricted from practicing independently as previously articulated. Restriction upon midwives in working to their full scope of practice is multifactorial in origin, attributed to professional indemnity insurance issues, legislative issues and the functionality of privileges committees.

These committees comprise in very large part members of the medical profession who hold a monopoly in determining visiting rights of independent practitioners. This is a long standing issue for independently practicing midwives that severely limits their ability to work to their full scope of practice to legitimately provide their proven expertise in optimizing health outcomes for women and their families. This particular anti-competitive issue can be juxtaposed with the newly evolving role of the nurse practitioner across Australia.

Health care professionals in Australia are subject to both Commonwealth and state and territory legislation. The Commonwealth legislation that impacts so significantly on health care occurs through the funding of Medicare, the Pharmaceutical Benefits Scheme and professional indemnity insurance. Professional indemnity insurance is a requirement for independent practice by any health professional in all jurisdictions and is essential for practice outside of the public health system.

Amendment to health acts and regulations are currently proceeding at state and territory jurisdiction level to facilitate a pathway for the newly evolving role of the nurse practitioner in Australia. This legislation provides for prescribing and referral rights and admitting privileges to health-care facilities. In Victoria, nurse practitioners are supported through legislation to practice in both public and private health sectors. Similarly, the South Australian Government has approved a process for clinical and admitting privileges for nurse practitioners. This is not the case in all jurisdictions and as such, severely limits the potential of the nurse practitioner to contribute to the health and wellbeing of the Australian community, mirroring the circumstance of the independently practicing midwife.

5. Conclusion

Mr Graham Samuel, Chairman, ACCC said in a speech on 31 May to the 2004 *Canberra and Region – Focus on Business Conference* that one of the main reasons the Australian economy has been so successful over the past decade is because of the commitment to competition policy and our willingness to continue the reform process He noted that National Competition Policy has brought the disciplines of competition to sectors previously exempt from competition such as the professions. While he acknowledges that this does not mean that all legislation restricting competition in the professions should be scrapped, he stressed that where it remains it should clearly be in the public interest. He also observed that while there is a need to protect public safety and confidence, self regulation can be open to abuse because it gives professions the power to manipulate the market towards their own interests, rather than those of the consumer.

The ACMI and ANC urge the Productivity Commission to consider the issues raised in this submission in light of these imperatives. Restrictions to professional practice of midwives is neither in the public interest generally (in terms of efficient use of taxpayer resources) or in the interests of women and their families as consumers of maternity services. Pressures on the obstetric and GP workforces mean that it is likely in the future that there will be fewer doctors to maintain the current levels of medical involvement in the care of healthy women at low risk of a poor outcome. Midwives should have the scope to practice in the antenatal and intrapartum ‘markets’

on an equitable and open basis commensurate with their internationally recognised expertise in the care of healthy women.

The opportunity to redress the anti-competitive stance that is currently perpetuated in respect of midwives and which is likely to be replicated for nurse practitioners is fully supported by the ACMI and the ANC. Recognition of the contribution made by midwives and nurse practitioners to the heath and wellbeing of the Australian community requires support through legislative amendment and changes to institutional privileges committees to enact the improvement in health outcomes that the community demands and deserves.

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