INTRODUCTION

The Maternity Coalition advocates for the consumer of maternity services. Within the Terms of Reference of this inquiry, the Productivity Commission needs to consider important competitive aspects related to the provision of maternity care.

Childbirth has significant social implications for individuals, families, and the community, and in most cases is a normal physiological event. Maternity care is unique within the spectrum of essential health care services provided in all Australian communities as a woman's pregnancy, birth and the nurture of a newborn are not usually related to illness. Only a minority of women and/or babies require medical services as part of their maternity care.

According to the World Health Organisation, the most appropriate primary care providers of maternity care are midwives, acting on their own professional authority. This is reflected by maternity service arrangements in the UK, Netherlands, New Zealand, and Canada, for example.

In Australia, public funding for basic maternity care is only provided for doctors and hospital based care. This creates an anti-competitive environment, protected by Medicare and the health funding agreements between the federal and state governments, which exclude midwives from providing their expertise to pregnant women, particularly during pregnancy.

It is our contention that the monopoly currently enjoyed by the medical profession, as the primary provider of maternity care, should be dismantled in the public interest. The exclusion of midwives from primary care is not beneficial for childbearing women. The Maternity Coalition seeks: equitable access for all women to the basic maternity care of their choice; and, equal pay or reimbursement for equal work for doctors and midwives when providing basic maternity care.

SUPPORTING DETAIL

The consumer of maternity care is not able to access publicly funded basic maternity services provided by a known midwife. This model of care has been clearly

demonstrated through extensive research as the model most likely to protect the wellness of a woman and child, and most likely to avoid unnecessary reliance on medical intervention. Australian rates of medical intervention during childbirth, including caesarean surgery, are considerably higher than rates in other countries with comparable economies, such as the United Kingdom, the Netherlands, Canada and New Zealand. Australian mothers and babies do not experience better outcomes as a result of reliance on costly medical or surgical interventions.

Australia's protection of the medical profession as the main providers of basic maternity services, and the subsequent restriction of practice for the midwifery profession, is not in the public interest. Substantial evidence exists to demonstrate that midwife led primary care is safe, and reduces the need for costly interventions during childbirth. We believe that the reforms we are proposing would lead to a reduction in health expenditure for provision of basic maternity care, as well as reducing costs associated with morbidities associated with these interventions.

The economic implications of the reform we are proposing can be assessed in terms of:

- better use of current funding for basic maternity services
- better access to a full range of basic maternity services in all communities including rural and remote
- ongoing improvements in the services that are provided for women and babies who need specialist medical care
- minimal investment is required to make the shift from the current medically based system to a system that provides options in basic maternity care.

Basic maternity services require skilled midwives who manage their own caseloads (group of clients) within a supportive group practice system, and who are able to refer their clients to specialist obstetric or other medical services if and when the need arises.

The economic investment is in a skilled workforce, not in expensive machinery or drugs or surgical procedures. Midwives in Australia are educated to provide holistic care from early pregnancy to several weeks after birth, for well women. They are also trained to detect abnormalities and refer women for specialist opinion or treatment. Midwifery

skills are under utilised in the current health system. Reform of maternity services to enable midwives to act in a primary care role would have a positive impact in all communities and assist in relieving pressure on medical services.

Midwives are specialists in healthy pregnancy and birth, which can be experienced by about 80% of women. Approximately 250,000 women per year in Australia require basic maternity care. Of these, it is anticipated that about 20% may require some level of medical care, while all require midwifery care.

At present, as a direct result of the funding monopoly, Australian women have little choice in maternity care with options such as birth centres, 'know your midwife' programs and homebirth. Each of these options has been under threat in recent years, despite high consumer demand. Women in New Zealand, Canada, the Netherlands and UK are able to choose midwifery care. For example, in New Zealand, following reforms to maternity service provision, 75% of women now choose a midwife as their primary carer. This compares with less than 1% in Australia having a similar level of midwifery care. The New Zealand approach has contributed to a downturn in health expenditure.

Our proposal for reform will in no way restrict services to women who need expert medical attention. A small proportion of women will require specialist obstetric or other medical attention for conditions that develop during the episode of care, or for pre-existing conditions. Some of these women will need transfer of care from a primary care midwife or other provider to a specialist unit, such as a regional secondary level hospital or tertiary referral centre in the large cities. Others are able to be cared for within a collaborative arrangement between the primary carer and a medical specialist practitioner and a local hospital.

The Australian College of Midwives *National Midwifery Guidelines for Consultation and Referral* (ACMI 2004) provide a consistent national statement on the midwife's responsibilities in collaborating with other maternity service providers.

The reforms we are proposing are timely, as medical workforce shortages are becoming more acute particularly in rural and regional areas. Removal of anti-competitive restrictions to midwifery will help bring appropriate basic maternity services to all

communities. Well women having babies would not be disadvantaged by the lack of medical services, as midwives could in many instances provide the required care in the local community and refer to medical care in the nearest location where this was required.

FUNDING

Any proposed reform must take into account the continuum of care required by each woman and infant for each maternity care episode. Funding for maternity care in Australia today is achieved through a mix of commonwealth and state/territory managed funds. It has been our experience that proposals for changes to funding are not acted upon, as responsibility for action is passed from state to commonwealth agencies, and vice versa.

Current commonwealth policies and processes are contributing to the lack of access to choice, quality, and economic effectiveness in the following ways:

- The support of an inappropriate and anticompetitive monopoly for doctors providing maternity care by excluding midwives from access to Medicare provider numbers or similar rebate for the same services provided, despite the midwife's ability to provide equivalent services in most circumstances
- Cost shifting between state and federal health budgets occurs in many communities as public hospitals require women to be seen prenatally by doctors who charge their fee to Medicare (commonwealth funding) rather than the hospital providing midwife-led prenatal services within the its budget (state funding)
- Providing large subsidies via the health insurance rebate for private maternity care services which are unaccountable for their outcomes, and are frequently manifestly over-servicing clients, as is indicated by extraordinarily high rates of caesarean surgery in private hospitals
- Allowing state expenditure of commonwealth health funding on unpopular, inadequate and expensive models of maternity care in public hospitals that give women no continuity in their care

- Recent developments in Medicare reform show an escalation in cost shifting, not from state to commonwealth budgets, but supporting the private practices of specialist obstetricians in the way they charge their clients. A report from The Age ‘Abbott's go-ahead to cut patient fees’ by David Wroe, Canberra, May 31 2004 reads:

  > “Couples having a baby are set to save more than $1000 after Health Minister Tony Abbott gave doctors the green light to shift costs from their patients to taxpayers under the Government's Medicare safety net.
  > As The Age reported last month, many specialists – particularly obstetricians - plan to change the way they bill to inflate the component patients can claim back from the Government. This could save patients thousands of dollars at taxpayer expense, leading some experts to predict a blow-out in the cost of the $440 million safety net.
  > Mr Abbott told The Age the Government would not stand in the way if doctors chose to save their patients money. "If a doctor was to charge his existing fees in a different way, and if that was to mean that some people were in the safety net, that's just the way things happen," he said. "It's entirely up to them. We do not believe in . . . dictating to the medical profession how they run their practices."”

The Maternity Coalition acknowledges the importance of medical expertise in health care. However, in basic maternity services there is no evidence to support an exclusive restriction of public funding to the medical profession. Primary maternity care provided by midwives is equally safe, is acceptable to the consumer, and is more appropriate use of scarce workforce resources, freeing up the obstetric specialists to practise their specialty rather than being relied upon predominantly for basic care provision, which is currently the case.

Although these are only some of the elements obstructing modernisation of Australia’s maternity services, it is clear that funding is the key to the development of a lasting solution.

SOLUTIONS

The Maternity Coalition seeks funding reform that incorporates the following:

- Basic Maternity Care Provider Payment: We propose that a new fund be established to cover the provision of basic maternity care for all women having babies. This fund would redirect money that is currently available to medical practitioners for normal pregnancy and birth items from the Medicare schedule, and make these funds available to both midwives and doctors providing equitable basic care. Similar reforms have already occurred with recent changes to Medicare Plus to enable people with chronic conditions to access allied services such as podiatry, physiotherapy and clinical psychology.
- Community Maternity Services Funding: We propose that the Australian Health Care Agreement set aside a proportion of state health care funding as tied grants for the introduction of community-based midwifery care. This funding would support the changes needed for a major shift in both professional practice and community expectations after the basic maternity care provider reform described above. In the first year of implementation, directed funding could be for the equivalent of 2 to 5% of births, which would provide an adequate incentive, without undue burden on those states and territories which have not already developed community midwifery services. In following years directed funding could be increased at a prescribed rate, enabling successful integration and careful forward planning. The choice of model of care would be the consumer's, taking into account her own needs and preferences, and availability of service options.
- Accountability: We propose that the Commonwealth require that all services receiving direct or indirect taxpayer funding be required to provide timely and publicly accessible data on outcomes. Currently in many states no outcome information is available to the public from facilities providing maternity services. This secrecy is inconsistent with goals of safety, accountability, or the control of costs.

The following discussion is submitted in response to the Terms of Reference and Issues Paper of the Review of National Competition Policy Arrangements.

TOR point 3: "Consider the extent of the benefits the reform program has delivered to date" and Issues Paper page 1: "assess the initial and ongoing impacts of NCP and related reforms undertaken to date"

We have seen no reform in maternity service provision as a result of the implementation of the National Competition Policy (NCP).

We are aware of various state and territory reviews of legislation that were intended to comply with the state's obligations under the NCP. The issues we raise in this submission have previously been raised by stakeholders such as the Australian College of Midwives in the Victorian Government's Reviews of the Nurses Act (1998) and Health Practitioner Legislation (1999), and in the national review of the Trade Practices Act (2002).

In its submission to the Review of the Trade Practices Act, the Australian College of Midwives (Victorian Branch) wrote:

> Despite such government reviews [1998 and 1999], the restrictive trade practices and unfair impediments to competition in the marketplace have been maintained in the field of maternity services. In this submission we will outline our major concerns, as they apply to the Trade Practices Act, and specifically as relevant to the Terms of Reference. We will argue this from a position of fair competition:
>
> - the consumer's right to choose from a range of appropriate services
> - the midwife's ability to provide a service
> - evidence of safeguarding public wellbeing through primary care being provided by midwives.
>
> We recommend to the Committee that an outcome of the Review should be a major reform of maternity funding: that all women are able to choose either a midwife or a doctor as their basic or primary care provider. All women in pregnancy and birth require basic primary care, and further specialist medical attention is required only by those with medical or obstetric complications.
>
> This choice, which is fundamental to the definition of a midwife and to international research and literature on midwifery, is not available to most Australian women, as a result of the Medicare monopoly of funding which places the medical doctor, and not the midwife, as the basic maternity care provider.

TOR point 4.(b) "areas offering opportunities for significant gains to the Australian economy from removing impediments to efficiency and enhancing competition, including through a possible further legislation review and reform program, together with the scope and expected impact of these competition related reforms." And Issues Paper page 1: "report on areas offering further opportunities for significant gains to the economy from removing impediments to efficiency and enhancing competition."

The reforms we seek would offer opportunities for significant economic and health gains. While economics alone can never be the driving force in any health related decisions, the health gains associated with the reforms we seek are clearly demonstrable. This point is fundamental to the arguments supporting statutory regulation of health professions, including midwives.

According to Professor Allan Fels, then Chairman of the Australian Competition and Consumer Commission (ACCC),

> "competition policy is based on the premise that consumer choice, rather than the collective judgment of the sellers, should determine the range and prices of goods and services that are available. Or in other words that competitive suppliers should not pre-empt the working of the market by deciding themselves what their customers need, rather than allowing the market to respond to what consumers demand."

The role of the ACCC includes

> "looking at health professionals' conduct to determine whether it promotes or hinders patients' interests in being able to choose among a variety of service and price options according to their needs."

(from *The Trade Practices Act and the Health Sector*, Australian College of Health Service Executives, 1998.)

Legislation review and reform needs to include the state legislation covering midwifery practice, as well as federal legislation covering health funding allocation.

TOR Considerations point 5 a) "to focus new review and reform activity on areas where there is clear evidence of significant potential gains"

As discussed above, we believe the proposed reform to competition in basic maternity care is an area in which there is clear evidence of significant potential gains. These gains will be

- to the community, in ensuring equitable access to evidence based models of maternity care, and consumer choice of the care provider

- to the community in attracting and retaining a skilled workforce consisting of midwives as well as doctors
- to the community, in improving physical and psychosocial health outcomes in maternity care
- to the professions, in more appropriate use of the skills of obstetricians as specialist providers, and midwives and general medical practitioners as basic or primary care providers
- to the nation, in better use of funding allocated to maternity care which is an essential service in all communities.

POPULAR SUPPORT

While some resistance to these measures is predictable, midwife-led services such as birth centres are very popular with women, and re-establishment or retention of rural and regional maternity services is of great importance to communities. An essential component of maternity services is to have medical referral back up for midwifery managed services to ensure that all women receive the care they need. Such support is typically more forthcoming from salaried obstetricians than from obstetricians in private practice, as those on salaries do not have personal financial incentives in relation to the medical care women receive during pregnancy or birth.

Leadership in bringing a primary preventative family-focused approach to maternity services, while addressing the current disempowerment of women in birth and motherhood would, if well presented, have broad electoral appeal.

CONCLUSION

The Issues Paper states ***"a central feature of the NCP has been its focus on reform that is 'in the public interest'. In this context, explicit recognition needed to be given to social, environmental, equity and regional objectives, when assessing particular reform options".***

As argued above we, as a maternity consumer advocacy organisation, state emphatically that the current funding arrangements for basic maternity services are not 'in the public interest', and that the reforms we seek will be a step towards protecting consumer interest. Our position is based on current available evidence. Additionally, ***"the introduction of competition (through a variety of mechanisms) in the provision of some social infrastructure services (such as health...)"*** would assist in improving the psychosocial outcomes of childbearing for women, leading to an improved use of health related services and resources.

Consumers and midwives have developed the National Maternity Action Plan (NMAP, 2002), which presents a tested vision for reform that recognizes the evidence-based benefits to women who have access to continuity of care by midwives during pregnancy and birth, with referral to medical care as needed. NMAP has received strong support from professional and consumer groups, including representatives of the medical community.

The Maternity Coalition urges the Inquiry to emphasise the need for reform of maternity services to ensure equity for childbearing women, midwives and the medical profession in this significant area of health.

REFERENCES

ACMI 2004. *National Midwifery Guidelines for Consultation and Referral*. Australian College of Midwives Inc. ACT. http://www.acmi.org.au/text/corporate_documents/ref_guidelines.htm

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