RESPONSE TO THE PRODUCTIVITY COMMISSION'S REVIEW OF NATIONAL COMPETITION POLICY REFORMS

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Introduction

An oral presentation was made by Joy Johnston on behalf of Maternity Coalition at the public hearing in Melbourne, 7 December 2004. The Notes from that presentation are included (Appendix 1).

The commissioners Gary Banks (Presiding), and Philip Weickhardt asked several questions on matters raised in our submissions. We have noted these questions, and have sought to address them in this response.

The Maternity Coalition is seeking all means by which we can draw attention to the urgent need to protect maternity consumers through the protection of midwifery practice which is at present unnecessarily restricted. We call upon the Productivity Commission in its review of national competition policy reforms, to use whatever means are available to ensure the protection of consumer access to primary (basic, as opposed to obstetric specialist care) maternity care by a midwife.

Why are things [consumer access to options in maternity care and restrictions to midwifery led models of care] the way they are?

The medical profession enjoys an anti-competitive advantage over the midwifery profession [a monopoly] in the provision of maternity care, which effectively prevents women from accessing the same basic service from a midwife. The monopoly of basic maternity care has in part developed and been maintained by:

- the exclusion of midwives from access to rebate under Medicare, or, similar funding being made available for the same services provided by medical practitioners

and

- the subsidisation of private obstetric maternity care through the private health insurance rebate and Medicare Safety Net.

What are the (plausible) underlying reasons for the anticompetitive status quo?
Broadly, such restriction on competition is justified because it is thought to improve safety in childbirth, and because it is supposed that extending the Medicare rebate and other public subsidies for maternity services to midwives as well as doctors would increase government costs. Both arguments are unfounded.

Although midwife care is denied Medicare and other subsidies, the restriction of competition means ultimately that the government and the consumer will be paying more for obstetric/maternity care because of the lack of competition from midwives in the care of low risk/normal births [the majority of cases]. There is no evidence that maternity care routinely provided by doctors is safer. The lack of price competition allows both public and private obstetric charges to be higher than would otherwise be the case, as there is no competitive alternative.

Arguments that restricted competition is intended to contain the fiscal cost of maternity care are unsupportable. A pregnancy is a limited period; birth must be achieved within a reasonable time; and the number of women giving birth, and thereby claiming rebate on care would not be expected to change dependent on the profession providing the service.

Under Australian health systems a pregnant woman's care (monitoring of her health and the development of the baby) is usually provided by a doctor, who charges a fee which attracts a (partial) refund under Medicare. A pregnant woman makes a booking for birth in a hospital which provides acute care (during labour, birth and several days after birth). Acute care funding for hospitals is accessed through State and Territory health funding arrangements, with public hospital admission being at no cost to the consumer. Private hospitals receive extra funds via fees charged to the consumer, which may be covered with private health insurance. Private obstetric services receive support from the Federal Treasury in the form of Medicare rebates; the Medicare 'safety net'; and a 30% rebate through taxation on the cost of private health insurance.

Although the professional service of monitoring a woman's health and the growth and development of a fetus in pregnancy is within the scope of the midwife's practice, Medicare has made maternity services provided by midwives more expensive to the consumer than the services provided by doctors. There is no Medicare or similar scheme for midwifery services; no 'safety net' applicable; and only a small number of private health insurance schemes will rebate members for a midwife's services. The government's provision of Medicare rebates for basic maternity care to medical practitioners, and not to midwives, has established an unintended professional restriction on midwives' practice.

There is no logical or practical argument, or research evidence, that can support restricted consumer access to midwifery led models of care, as outcomes from such care are at least as good as other models. The restrictions, which are widely entrenched, having existed for many years, are primarily due to the medical monopoly of maternity care funding and medical control of access to hospitals.

In addition to the competition argument, we believe we have a further imperative to achieve change in the public interest. Consumers of maternity services must be able to access the care of a midwife throughout the pregnancy-birth continuum, as there is a

growing body of reliable evidence which supports midwife led care for most women in preference to medical management.

Costs *vs* Cost-shifting

We wish to draw attention to the practice of cost-shifting in maternity care provision from State government funding to federal funding. This is a Medicare-driven phenomenon. Many public hospital maternity services have cut back or closed their prenatal services for pregnant women. These women are then advised to make prenatal appointments with doctors – the cost of the prenatal care being thereby shifted from the hospital's budget (State government funding, and at no cost to the consumer), to the Federal Medicare budget, with most doctors charging in excess of the Medicare rebate.

Since almost all practising midwives are employed by hospitals, and are able to provide prenatal screening and counselling services, such cost-shifting minimises the opportunity for the midwifery profession to provide basic maternity services during the woman's pregnancy.

Another consequence of the closure of midwife led prenatal services in public hospitals is that some women, particularly those from marginalised socio-economic groups, may avoid prenatal care. The reasons for such avoidance seem to include cost, as well as issues of gender and choice of care provider.

Professional Indemnity Insurance

The issue of midwives' inability to procure professional indemnity insurance, while not caused by the anti-competitive restrictions in funding, is closely related. The monopolistic maternity care environment which exists throughout Australia has resulted in few midwives being willing to take the financial risk of practising independently in a small market. The fees that midwives are willing to charge their clients are minimal, especially when compared with obstetric providers, in an effort to make midwifery services competitive with other providers of maternity care.

Due to the small market midwives are unable to afford the fees charged by medical defence organisations to doctors providing maternity services (specialist obstetricians or general practitioner obstetricians) for their indemnity arrangements. The withdrawal of professional indemnity insurance for midwives by the only Australian company offering the insurance was purely a commercial decision: too few midwives (about 80 across Australia), paying an annual premium of under $1,000 did not create a viable pool to support any future claims. Combined with world events that affected all aspects of the insurance industry, insurers have since being unwilling or unable to underwrite policies for independent midwives – they are not an attractive market for the insurance industry.

We note here that independent midwives present a relatively low risk scenario in the insurance market. Midwives are able to be the leading responsible professional carer only when both mother and baby are well, and do not require medical or surgical intervention. When an independent midwife is caring for a woman and her baby, and a complication is suspected, the midwife is required to refer her client for medical consultation in a timely manner. The process of referral is well understood by independent midwives, and by maternity hospitals and doctors. National Midwifery Guidelines for Consultation and Referral, published in 2004 by Australian College of

Midwives, are available at
http://www.acmi.org.au/text/corporate_documents/ref_guidelines.pdf.

Furthermore we note that, when in recent years as a result of widespread problems in the insurance industry, medical practitioners faced large increases in the fees charged by the defence organisations, substantial government grants and loans were made to maintain the doctors' indemnity arrangements for private practice. Fees charged by doctors to their private clients have (since mid 2004) come under the Medicare safety net, shifting the cost of doctors' private practices to Medicare. As discussed earlier in this paper, this produces a huge financial inequity between doctors and midwives, even when the doctors are providing the services that are clearly within the scope of the midwife's practice.

Is a monopoly reasonable?

Preventing competition between midwives and doctors by restricting access to government funds can only be supported by the Australian Treasury if there is evidence that the consumer(s), mothers and babies who are the end users of maternity services, obtain substantial benefit from or are protected by the restricted access. In the case of maternity care, the monopoly which exists restricts consumer access to all providers who are not doctors. This restriction cannot be supported, as no such evidence exists. In fact, the evidence is to the contrary – that the best care for women and babies is achieved with midwives providing primary care, and collaborating appropriately with specialist medical providers.

Australia's maternity system which uses specialist obstetricians instead of midwives as primary carers is inefficient, and wasteful of health funding.

Legislation in most Australian states and territories protects the title 'Midwife', and applies penalties to any person who uses the title or holds out to be a midwife without being appropriately registered in the state or territory in which the legislation applies. The protection of the title midwife is meaningless if a midwife cannot practise as a professional midwife without restriction. We consider that the legislative protection of the title midwife also implies that a consumer should be able to access a midwife within the society covered by that legislation.

By contrast, the Netherlands has long-standing legislation protecting the practice of midwifery as the first level of care for all women in pregnancy and birth. Specialist obstetricians are consulted only when the need arises. The caesarean rate in the Netherlands is 14% of all births, less than half Australia's.

Comment was requested on incidence of caesarean births, and variations in performance in different hospitals

Rates of caesarean births in Australia have been rising steadily over time, and are likely to continue to rise. There is considerable variation in rates between hospitals. Private hospital rates tend to be higher than public, even though the larger public hospitals in more densely populated areas provide care for women with complex medical needs, and therefore more likely to require surgical births.

There is a growing acceptance of caesarean birth as an open 'choice' to be made for reasons of convenience or preference of either the pregnant woman or the surgeon. We consider such surgery that is performed without a valid clinical reason to be cosmetic, and that those choosing such an option should not be entitled to public funding.

The head of the Australian Institute of Health and Welfare's (AIHW) National Perinatal Statistics Unit (NPSU), Dr Elizabeth Sullivan, commented on caesarean births in the recent report (AIHW 2004[1]):

"Of mothers giving birth in 2002, 13% had previously had a caesarean section. The majority, 79%, of mothers with a history of caesarean section, had another caesarean section in 2002.
"The steady upward trend in caesarean rates of the last 10 years continued with the proportion of women having caesarean sections increasing to 27% in 2002 compared to the 19% recorded for 1993," Dr Sullivan said.

More information was requested on New Zealand, in addition to that in our earlier submission.

We have sought advice from the following sources:

Dr Sally Tracy, midwife academic and public hospital midwifery service manager in Sydney, stracy@ozemail.com.au

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Cost Comparisons in New Zealand

Table 4. Total maternity expenditure for New Zealand over the last seven years 1993-2000

Fiscal year	$NZ Million
1993/94	318.0
1994/95	369.5*
1995/96	343.9
1996/97	362.1
1997/98	354.9
1998/99	351.4
1999/2000	348.9

[1] AIHW 2004. Australia's Mothers and Babies 2002
http://www.aihw.gov.au/media/2004/mr041216.html (downloaded 6 January 2005)

Source: Health Funding Authority New Zealand 2000.

* Note the increase in 94/95 – Legislation covering payments was subsequently reformed, with Section 88 of the Act, to prevent double-billing for the same service.

Several New Zealand reports are noted in Appendix 2. Australian States and Territories provide similar reports. We have included comparable data from Victoria in 2000-02 in Appendix 3, giving information on a similar number of births. While noting that the perinatal mortality rates are similar for Victoria and New Zealand, some of this data may not be useful as a direct comparison, as there are variables in statistical recording methods that need to be taken into consideration. We do not have access to the information that would enable us to draw conclusions on this matter.

New Zealand's national maternity care system has been based on each woman's entitlement to basic maternity services, with the same funding entitlement applying to midwives and doctors providing the same item of service. The woman chooses a Lead Maternity Carer (LMC), either a midwife or a doctor, who is responsible to ensure that all basic maternity care is provided, and to refer to specialist medical services if appropriate. Approximately 70% of the women giving birth in NZ have a midwife as their LMC.

We regret that, as a volunteer organisation, we do not have access to all the information in order to make a reliable cost-outcome comparison between Australian and New Zealand maternity care.

CASE STUDY: PROFESSIONAL INDEMNITY AND ITS IMPACT ON INDEPENDENT MIDWIFERY PRACTICE

The following case study gives a brief overview of recent events that have brought about loss of access by women in the Northern Territory (NT) to services provided by independent midwives[2]. Independent midwives are the only practitioners in the NT who provide one-to-one primary care throughout the pregnancy-birth continuum for women, with the option of giving birth at home.

This case study demonstrates that competitive forces in maternity care, particularly the monopoly of maternity funding enjoyed by the medical profession, are preventing midwives from offering services that are safe, cost effective, and valued by the consumer. It shows that, without immediate government intervention to protect the access of consumers to professional midwifery services, such options are being lost; that such a loss is detrimental to public health, and cannot be supported under national Competition Policy.

We acknowledge that the issues in this case study are complex, and do not wish to claim that a solution will be achieved merely by addressing anti-competitive monopolies in maternity care. However, competition issues are a key element, and a solution is unlikely to be found without systematic and thorough reform of national funding arrangements for maternity care.

Background

Midwives in the NT are registered under the Health Practitioners Act 2004, with professional statutory regulation undertaken by the Nursing and Midwifery Board. Under the Act, all health practitioners are required to make a declaration that professional indemnity arrangements are in place to cover their practice. Since there has been no professional indemnity insurance available for independent midwives since 2001-02, the introduction of this Act made it illegal for independent midwives to continue offering their services for any aspect of midwifery practice[3].

In December 2004, in response to protests by consumers and midwives, the NT Health Minister Peter Toyne announced that the government would provide a homebirth midwifery service, employing midwives directly through the Health Department. As employees of the government these midwives will receive vicarious liability cover. This process is being implemented.

Women who choose homebirth are now unable to engage independent midwives. Some women have gone to other states where independent midwives are practising; others have given birth in their homes unattended. Either of these options is unreasonable. The former is unnecessarily disruptive and costly; the latter is far from an ideal situation, and may put the mother and her baby in life-threatening situations which would not have

[2] The term independent midwife refers to a midwife who is self-employed, and whose professional services are paid for directly by the consumer.

[3] The midwife's scope of practice includes counseling, prenatal health checks, teaching, attendance in labour and birth, postnatal care and guidance in parenting, baby care, lactation, health, sexuality, gynaecology, and family planning. This is autonomous professional practice, which does not require any supervision.

occurred had a midwife been in attendance. In the interest of protecting public wellbeing, midwives must be able to practise in any setting.

A possible flow-on effect to other states and territories

The Northern Territory has been the first state / territory government to enforce the requirement for professional indemnity insurance. Other states have legislation which either recommends such insurance or gives the governing board discretion in the enforcement of such requirement. As we argue in the case of the Northern Territory, we consider that any such enforcement, which would in effect be the cessation of any midwife's right to practise on her/his own authority, would expose the public to unacceptable risk, and unacceptable restriction of the right to exercise choice in such matters.

Appendix 1

Notes for oral presentation by Maternity Coalition, 7 December 2004

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This summary is consistent with our written submission to the review.

The Maternity Coalition considers that there is an urgent need for reform of legislation which impacts on the provision of maternity care in Australia. We represent consumers of maternity services in this review.

The medical profession enjoys a monopoly in the provision of maternity care, which effectively prevents women from accessing the same basic service from a midwife. The monopoly of basic maternity care has in part developed and been maintained by:

- the exclusion of midwives from access to rebate under Medicare, or, similar funding being made available for the same services provided by medical practitioners

- the subsidisation of private obstetric maternity care through the private health insurance rebate and Medicare Safety Net.

Basic maternity services are essential for all women in pregnancy, and all mothers and babies during childbirth. These services are within the scope of the midwife's practice in all Australian states and territories. The medical monopoly restricts consumer choice, and does not result in any health benefit for a mother or her child. The monopoly can only be supported in the minority of cases requiring specialist medical care.

With approximately 250,000 births in Australia annually, the medical monopoly of maternity services is an example of a long standing structural problem that prevents the Australian health care system from offering the consumer a reasonable range of basic maternity care options.

We contend that basic maternity care must be delivered from a consumer perspective, with the mother and child central, rather than from a general health services framework which fragments care.

Pregnancy and birth are not an illness. In the majority of cases, a midwife primary carer, with access to referral pathways if and when specialist medical intervention is needed, appropriately cares for women giving birth. We argue that the absence of this basic care option is not in the public interest, does not deliver better health outcomes, and is not appropriate use of health funding.

Review of NCP

The review is to consider areas offering opportunities for significant gains to the Australian economy by removing impediments to efficiency and enhancing competition, including the possibility of a legislation review of current arrangements pertaining to health services.

Discussion Draft

In the Media Release accompanying the Discussion Draft, the Commission's Chairman stated that:

> "The Commission argues that there would also be a substantial payoff to extending nationally coordinated reform to the important area[s] of health care…It is now generally accepted that Australia's health system is beset by structural problems that require nationally coordinated action…An independent review of the whole system is needed to provide a roadmap for reform."

The Discussion Draft itself contains the following salient recommendations:

- A more targeted program of legislation review should be put in place and be limited in its scope to areas where reform of anti-competitive legislation is likely to be of significant net benefit to the community.[4]

- Competition related measures will only be a small part of what is required to deliver better outcomes in health care.[5]

- An integrated health services reform program within an agreed national framework would add much needed impetus in addressing the long standing structural problems that are preventing the health care system from performing to its potential.[6]

- The Council of Australian Governments ("CoAG") should initiate an independent public review of Australia's health care system as a whole. The review should include a consideration of health financing (including Federal/State responsibilities and their implications).[7]

The Discussion Draft does not explicitly discuss or recommend a review of maternity services. However, it is clear that the reform needed in maternity services fits with the principles driving the recommendations for reform in health care more generally.

The Commission notes that the scope to achieve better outcomes is indicated by variations in performance of the same service across jurisdictions.[8] Differentials in rates of infant mortality is one set of statistics given by way of example.[9] There are, similarly, many examples of variations in performance and health outcomes across a range of maternity related services, not just between jurisdictions but also between neighbouring hospitals.

The Commission also explicitly acknowledges the importance of giving consumers of health services the ability to exercise choice. The Commission notes that for most human services, including health, the notion of choice goes well beyond mere choice of

[4] at p.230
[5] at p.287
[6] at p.241
[7] at p.291
[8] at p.244
[9] at p.245

service provider, to include the location, type and mix of services. This could not be more true than of maternity care.[10]

Maternity care is a significant aspect of health services, and is responsible for the most number of hospital 'bed days' across all health conditions annually. Maternity care is clearly an area that requires scrutiny under the terms and conditions of this current review. We urge the review to conclude that national competition policy reform of basic maternity funding in the interest of consumer safety, access and choice, is needed within the government's health reform agenda.

[10] at p.254

Appendix 2: Maternity-related reports from New Zealand

Report on Maternity and Section 88 http://www.moh.govt.nz

Report on Maternity: Maternal and Newborn Information 2002
http://www.nzhis.govt.nz/publications/maternityreport.html

In New Zealand in 2002, 53,037 mothers gave birth.

	No.	%
Mothers	53,037	
Liveborn babies	53,589	
Perinatal deaths:		
Stillbirths	401	0.7
In-hospital neonatal deaths	187	0.3
Type of birth:		
Normal births	35,909	67.7
Caesarean sections	12,0531	22.7
Operative births	5075	9.6

for information on payment and modules etc go to
http://www.nzhis.govt.nz/publications/maternityreport99.pdf

Appendix 3

Birth Outcome data from Victoria, 2002

In Victoria in 2002, 61,959 mothers gave birth*.

	Number	**Rate per 1000 births**
Mothers	61,959 (62,681 babies)	
Perinatal deaths**	678	10.7
Stillbirths**	452	7.2
Neonatal deaths**	226	3.6
Type of birth		**Rate %**
'normal' (vaginal)		59.9%
Caesarean		27.4%
Operative vaginal (forceps and vacuum)		12.8%

* Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2003. Hospital Profile of Perinatal Data 2002.
** AIHW 2004. Australia's Mothers and Babies 2002 http://www.npsu.unsw.edu.au/ps15.pdf