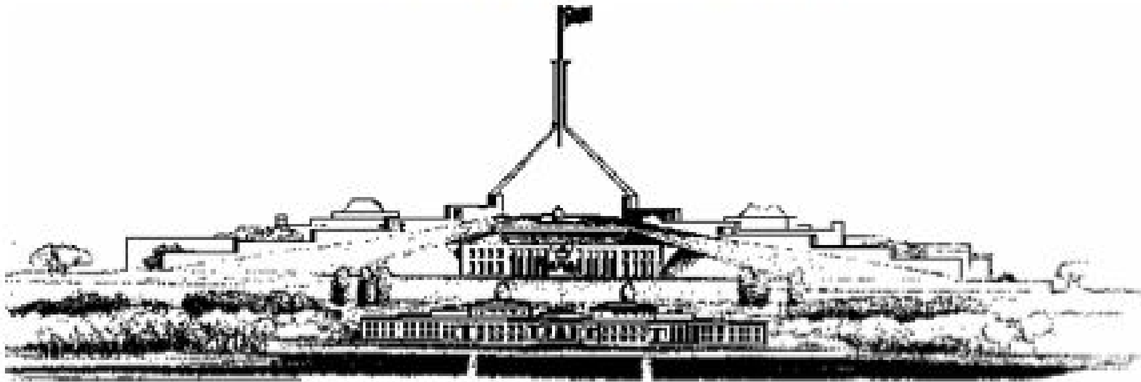
COMMONWEALTH OF AUSTRALIA

PARLIAMENTARY DEBATES



THE SENATE

PROOF

HEALTH LEGISLATION AMENDMENT (MIDWIVES AND NURSE PRACTITIONERS) BILL 2009

MIDWIFE PROFESSIONAL INDEMNITY (COMMONWEALTH CONTRIBUTION) SCHEME BILL 2009

MIDWIFE PROFESSIONAL INDEMNITY (RUN-OFF COVER SUPPORT PAYMENT) BILL 2009

Second Reading

SPEECH

Monday, 15 March 2010

BY AUTHORITY OF THE SENATE

SPEECH

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Speaker	Boyce, Sen Sue	Question No.	

Senator BOYCE (Queensland) (9.06 pm)—As has been pointed out to you, Madam Acting Deputy President Moore, and as you would very well know, the Senate Community Affairs Legislation Committee, of which I am a member, conducted two inquiries into this legislation. We did not do that for lack of something to do; we did that because the first piece of legislation that was brought to us was in many ways unsatisfactory and, in fact, was being changed as we were inquiring into it. The regulations which went with that legislation were not available for either the first or second inquiry that we conducted. Our committee has often commented on and often criticised the lack of understanding of the regulations that underpin the laws being made. That was one of the biggest problems with this process.

I would like to join Senator Adams in congratulating the women of Australia—the mothers, the mothers-to-be and the midwives—on their extraordinary reaction to what they saw as an attack on their rights. In the second inquiry, as Senator Fierravanti-Wells pointed out, over 900 submissions were received in a very short time as well as hundreds of form letters and other individual letters. The first inquiry we held received just under 2,000 submissions, again in quite a short period because at the time the government was telling us that it was urgent that we complete the inquiry and get the legislation passed. Those submissions were received primarily from midwives who provide home birth services and of whom we know there are only about 200 in Australia—so do the sums on that—from parents and from organisations that support homebirths. In that first inquiry they were faced with a mishmash of legislation, the consequences of which were completely unknown.

The outline of this legislation would have meant that privately practising midwives performing home births would to all intents and purposes have become quasi-illegal. They would not have been able to have professional indemnity, and without professional indemnity they could not have been registered under the proposed National Registration and Accreditation Scheme for the Health Professions and therefore, if they had practised, they would have been practising completely outside the system. As Senator Adams pointed out, this would have meant that about 200 independent midwives could have been deregistered when this scheme came into play on 1 July 2010 and that if they had continued working they may very well have been fined up to $30,000 each.

Having met the state and territory health ministers, Minister Roxon announced a two-year exemption from holding indemnity insurance for privately practising midwives who could not obtain cover for attending a homebirth in September last year, which was after the first reporting period. So they have a two-year 'amnesty', for want of a better word, until June 2012 while the minister works at what to do. Minister Roxon was quoted at the time as having said:

> I was concerned that as an unintended consequence of the national registration and accreditation process that homebirthing may be driven underground, that that would not be a good outcome.

It is something of a minor understatement, I would have thought, to suggest 'that that would not be a good outcome'. At the same time, that phrase 'unintended consequences' comes up again as the government seeks to suggest that legislation is urgent and necessary without having done the homework. The government adds insult to injury by suggesting, as Senator Parry outlined earlier, that the coalition has in any way been responsible for the slowness of this legislation being passed. That is absolutely laughable and, I would suggest, unethical. We are not the ones who developed this legislation; we are the ones who pointed out that it was poorly developed and that no one had a clue what it was going to be like when it was implemented. So at least we got through that first hiatus and got the amnesty in place so that midwives can, at least until June 2012, go back to practising the way they have been, by which time one hopes that the minister will have decided how to deal with this issue.

I must admit that I am somewhat startled by some aspects of this debate. This government claims to have something of a monopoly on being pro-woman, but I do not think that this bill in its first draft or even, given the uncertainties and concerns, in its second draft, could be considered in any way pro-woman. Minister Roxon's talk about the 'unintended consequences' without having thought about what they mean is neither reasonable nor acceptable. Ms Justine Caines of Homebirth Australia in the evidence she gave, I believe, to the second inquiry—I am starting to get a bit confused here, Madam Deputy President—said:

> We have no problem with the national registration. Some in our world—

She means the home birth world—

> have said, 'there shouldn't be a requirement to have indemnity insurance.' Well, to me, indemnity insurance is a professional requirement but also, very much, a consumer right.

That is the point that I think has been completely missing from any of the discussion that this government has had around this bill. Indemnity insurance is a consumer right within what should be a well-developed, professional, well-regulated health system. Pregnant women are not sick. I think that is a point that needs to be made over and over again. Pregnant women, their partners and other members of their families that they choose to involve should be able to have their child where they choose. Of course we must have requirements in place so that if there are any difficulties or problems they can be dealt with by medical intervention. But women for a very long time have been having children without medical intervention.

I must admit that I was not aware until after the did this inquiry—I do not have the same depth of experience as Senator Adams on the topic of midwifery; my only claim here can be having given birth to three children—of the practice of free birthing. In home births a medical professional, generally a midwife, is involved in both the pregnancy and the delivery of the baby, while free births are conducted without that involvement. There may be a doula—someone who has some basic knowledge or who has helped other people to deliver babies—which is the sort of midwife you may have had 200 or 300 years ago. Often these babies are delivered without the assistance of anyone with any medical experience.

I personally find the idea of a free birth quite worrying, but some women choose to do that. What we do is lump together the statistics about homebirths and free births and suggest that the dangers represented by free births are the same whether you have a midwife or the next-door neighbour helping. This of course is not the case and we need to clarify this. One of the things that Senator Adams and I, as the coalition senators in the first inquiry, suggested was that we needed a more wide-ranging inquiry into the topic of homebirths. It is not well understood in Australia because, in my view, the topic has been taken over by the medical profession. The medical model of how to go about a pregnancy has been the dominant model in our country. I do not think that should happen any longer. We need to recognise that women choose. They should have the choice and will have the choice irrespective of what our laws say about where they have a child. I cannot quite imagine the situation where we will start arresting women at 8½ months pregnancy and take them off to have births according to the way the AMA thinks that all births should be conducted. It is not on, it is not reasonable and it is condescending.

There were some very serious concerns about the way the medical profession presented a number of their problems. They had concerns about nurse practitioners having prescribing rights; they had concerns about nurse practitioners having referral rights; they had concerns about midwives having referring rights. The view was that it should always go back to a GP who would be the case manager, irrespective of the wishes of the women involved, particularly in terms of pregnancy. It was interesting to get an insight into why some women simply do not want to go to hospital to have a baby. It came back to their previous experiences in hospitals. Some of them were just not going to darken the door of a hospital again, no matter what, and there is no way we can force them to.

At the same time we have done very little to encourage the development of birthing centres. These are generally very small and overbooked. People are very lucky to get the chance to have this sort of halfway access—halfway between a homebirth and having a baby in a full hospital setting. We have done nothing there. That is partly because it has not been encouraged. In fact, it has been actively discouraged by many of the doctors involved in the industry. I hate the idea that we might turn this into something like male doctors versus women midwives or pregnant women, but at times there was a sense in the inquiry that professionals have had control of this business—let's call it women's business, shall we—for a long time and have been very reluctant to share it. They had used all manner of excuses to stop the development of sharing. In some cases what they did was quite condescending. Suggesting that a trained midwife, who was a member of the college, needed the oversight of a GP to know her job is offensive and wrong. Midwives have a very rigorous accreditation system. It requires that midwives work in a collaborative way with others in the medical profession and the health profession, and that happens. It does not require doctors telling midwives that they need a collaborative arrangement for this to happen, but the problem has not gone away. It seems to me that, until there has been a certain amount of more pressure applied and a certain level of success achieved by midwives and nurse practitioners doing the job that we need them to do, we will not get better action in this area.

I hope that we will simply have the evidence to suggest that the concerns of GPs, obstetricians and gynaecologists that we will have an epidemic of over-referring, an epidemic of overprescribing and an

epidemic of poor outcomes in pregnancies will prove to be completely wrong and that the women who have done an extremely good job for many years in assisting women to give birth will continue to do so. There is of course another aspect to this. For a start, homebirths, if they are healthy and safe—and, of course, the job any midwife would want to undertake would be to ensure that was going to be the case or they would refer the woman to a hospital if it were not—are much cheaper than hospital births. They do not use the same health resources that hospital births do. Not only that but, given the right encouragement, there will be more than sufficient midwives available to assist women who want to have their pregnancies dealt with outside of a full hospital setting.

We have a shortage of obstetricians and gynaecologists—we know this. We have a shortage of most specialists. I heard today, in fact, that there is a two-year waiting list to see a rheumatologist in Townsville. I know that is not entirely relevant to this topic, but there are not enough GPs, obstetricians and gynaecologists to go around, so further developing the existing resources of midwives and nurse practitioners would make economic and sensible use of resources rather than simply fighting to ensure that a monopoly is maintained in a particular area.

The other question, as I think Senator Macdonald mentioned, was the problems for women in rural and remote areas. I have spoken at length with a group of women from the state electorate of Southern Downs in Queensland—an electorate represented by Mr Lawrence Springborg, who is very supportive of the women who came to see me and whom I also spoke to about this problem. If you live a long way out of town, what is your chance of having a baby delivered by an obstetrician and gynaecologist? If you live a long way out of a small town, your chances are even less. The women of the Southern Downs were concerned that people had to come to town one week, perhaps two weeks early and wait to have their baby.

Senator Adams—Four.

Senator BOYCE—Four weeks in some cases, Senator Adams tells me, so that they could use this medical assistance to have their baby. But these women wanted that to be the default position. They only wanted to do that if some harm was likely to happen to themselves or to their baby. They are very sensible and, in the main, very fit, active women that we are talking about. They are farmers. They are not going to risk their child, but they are fit healthy women. They want to have a midwife who can assist them and who can be confident that she is not going to be sued by anybody and that she can do the job that needs to be done—and that there will be more midwives coming up to replace those as people age. This is a constant problem in many of our not just remote areas but smaller rural areas where it is difficult to get a GP and where families have to be broken up often for weeks and weeks on end—four weeks as Senator Adams mentioned—so that the baby can be born in a venue considered to be medically suitable surroundings.

The other group that is particularly affected by this problem is Aboriginal women. It has been put to me that many Aboriginal women are having babies without any assistance whatsoever except from older women in their group. They are simply frightened to see obstetricians, gynaecologists and GPs who are, in the main, white and obviously strange and obviously are going to examine them in what could be considered culturally inappropriate ways without any training to support them in undertaking that examination. One of our solutions is for there to be more Indigenous doctors—GPs, obstetricians and gynaecologists—but it is not just about having more. It is also about recognising that in some cultures, and the Aboriginal culture qualifies because of the remoteness from hospitals of many Aboriginal people, the remoteness and cultural sensitivity mean that people would be far more comfortable with a midwife to deliver the child, a midwife to support them and a midwife to accompany them if in the unlikely circumstance they needed to go to a hospital for that delivery to take place. The coalition will be supporting this legislation because it is an improvement on where we have been. We hope that we can have more and better amendments for this legislation as the program proceeds.