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**Medicare Rebates for Midwives: An Analysis of the 2009/2010 Federal Budget**

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From 2010, midwives in Australia will be able to prescribe subsidised drugs and bill their services to Medicare. The 2009/2010 Federal Budget, released on 12 May 2009, provides funding for the recommendations of the Commonwealth Government's Maternity Service Review.<sup>1</sup> This paper analyses the key elements of the 2009/2010 Budget, the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009. The three key reforms are funding of antenatal, intrapartum and postnatal care by midwives in private practice under the Medicare Benefits Schedule, through the Pharmaceutical Benefits Scheme, and Commonwealth-supported professional indemnity insurance. Also funded is the "development of new national cross professional guidance to support multidisciplinary care"<sup>2</sup>

Access to Medicare, Pharmaceutical Benefits Scheme and government-supported professional indemnity insurance will be restricted to 'eligible' midwives<sup>3</sup>. Eligibility is conditional on being "appropriately qualified and experienced", "working in collaboration with doctors", under an "advanced midwifery credentialing framework"<sup>4</sup>. None of these criteria are defined in the budget. "Eligibility" is yet to be fully defined in legislation. The draft legislation states that:

*those requirements may include one or more of the following: (a) a requirement to hold particular qualifications in midwifery; (b) a requirement to have particular experience in midwifery; (c) a requirement to be credentialed by a particular body<sup>5</sup>.*

Currently, access to Medicare varies for different professions (medical and others) although most require registration through their state or territory Board and membership of a professional organisation (through which they demonstrate continuing professional development requirements). Any additional credentialing is administrated and determined within the profession. No other profession is required to be "working in collaboration" with another professional groups as a separate requirement to their professional codes of practice and competencies.

Using the International Confederation of Midwives definition, midwives are able to provide care on their own responsibility<sup>6</sup> in line with evidence on best practice care for women<sup>7 8 9 10</sup>. Under the ANMC National Competency Standards for the Midwife, midwives are equipped with the necessary skills to provide continuity of primary maternity care to women through pregnancy, birth and to six weeks postpartum from entry to practice<sup>11</sup>. While some registered midwives may have had limited opportunities to practice to full scope, or may be newly graduated and require support, it is important that the professional development needs of midwives are addressed without re-defining midwifery practice by identifying "full scope" as "advanced practice".

There are a range quality and safety mechanisms used internationally. In Canada midwives register once they have met extensive competency standards as a demonstration of their ability to practice the full scope of midwifery in a number of practice contexts. This mechanism includes the ability and willingness to provide homebirth care. Midwives in Canada must demonstrate this prior to registration. The process of peer review for midwives is also used in New Zealand where midwives have provided care across the full scope of practice for almost two decades. New Zealand midwives are also mentored into practice as a Lead Maternity Care provider over their first year of practice.

In Australia, mechanisms for safety and quality have been developed over the last decade. The Australian College of Midwives has developed a continuing professional development program (MidPLUS), a peer review process (Midwifery Practice Review) and the National Midwifery Guidelines for Consultation and Referral. Codes of Ethics, Conduct and National Competency Standards for the Midwife have also been developed by ANMC. The midwifery profession, through

registration and Midwifery Practice Review, is able to provide assurances that midwives are safe for the context of their practice and held accountable for their care and outcomes.

In rural and remote areas, where the budget reforms have possibly the greatest potential to redress lack of services, the definition of 'eligibility' will determine their effectiveness. Midwives are well placed to provide care in underserved regions and may have strong clinical experience, but possibly less access to higher education and no previous opportunity to work in continuity models. Therefore, it is possible that they may not fulfill the criteria of being an 'eligible' midwife limiting the value of the government's initiatives in rural and remote areas.

There is a need for strong midwifery leadership and a clear role for the profession and the professional body in the process of determining eligibility. An excessively narrow definition of eligibility for Medicare access, or a sufficiently obstructive pathway to meet eligibility criteria would exclude competent midwives and undermine the Health Minister's stated goal of offering women choice.

The Budget papers and Review Report refer extensively to 'collaboration', particularly between midwives and doctors. Collaboration has not yet been defined: the Department of Health and Aging is engaging the National Health and Medical Research Council to work on these definitions and develop processes for interaction between professions to support multidisciplinary care<sup>12</sup>. While the National Health and Medical Research Council is seen by government as an independent body, selection of individual medical practitioners, midwives and consumers to work on this project and the proportions of each stakeholder group will impact on the outcome.

Under Midwifery Practice Review, midwives in private practice will be required to identify functional pathways for consultation and referral including visiting rights to hospitals. However, there is potential for access to these pathways to be blocked by other professionals unsupportive of a specific midwife or midwifery generically. The impact of these blocks would be to restrict access to Medicare. This will be particularly important in rural areas, where private midwives may be dependent on access to a single local hospital. No specific funding is allocated for development of multidisciplinary guidelines for consultation and referral and there are significant differences in approach to development of guidelines between obstetricians (developed within the profession) and midwives (developed in consultation with a wide range of stakeholders and evidenced-based). Doctors do not have an obligation to collaborate with midwives as a requirement of Medicare access making collaboration from some medical practitioners difficult to facilitate. Success in implementation of the Budget initiative will be dependent on effective state-wide processes in each jurisdiction in establishing all public maternity units as available for consultation and referral from midwives in private practice.

Antenatal, intrapartum and postnatal care by a midwife in private practice are to be funded under Medicare. Midwives will have a variety of business options including working in their own practice, private midwifery group practice or working in a multidisciplinary practice. The Department of Health and Aging has indicated that new Medicare items will be developed for this care, and that funding will not be a single payment for the whole maternity episode<sup>13</sup>. It is otherwise unclear how funding will be structured, and whether this structure will drive continuity of carer.

The Budget also provides for a

*Government-supported, subsidised professional indemnity insurance scheme for eligible midwives ... working in collaborative arrangements in hospitals and healthcare settings.*<sup>14</sup>

The cost of professional indemnity insurance will be subsidized by the government through a private insurer<sup>15</sup> with provision for high claims.

Despite receiving a large number of submissions (over 400) to the Maternity Service Review from individual women requesting access to homebirth services, intrapartum care at home by private midwives will not be Medicare funded or insured under these Budget measures<sup>16</sup>. The Review Report identified homebirth as “a sensitive and controversial issue”, which “risks polarising the professions”<sup>17</sup>. The safety of homebirth was not identified as an issue in the Review Report presumably signally acceptance of the large and growing body of research which demonstrates the safety of homebirth for low risk women. The decision not to extend indemnity insurance to cover homebirth by private midwives, possibly for inter-professional political reasons, has grave implications. Under national regulation, midwives will be required to have professional indemnity insurance for all practice. The exclusion of private practice homebirth from government subsidized indemnity insurance effectively means that the provision of private midwifery care for homebirth will be unlawful from July 2010 when national regulation is enacted<sup>18</sup>. It is difficult to understand the motivation for this approach when “maintaining Australia’s high level of ‘safety’”<sup>19</sup> could readily be addressed by providing eligibility criteria for access to indemnity insurance. Homebirth is the one area of maternity services in which medical control of midwives has not occurred. The need for the government to minimise controversy from the medical profession may have taken precedence over safety. The likely consequence of an inability for women to have private midwifery care for homebirth is an increase in women birthing alone (unassisted homebirth or “freebirth”)<sup>20</sup> with the attendant risks, under-reporting and invisibility.

The current reform process is a turning point for the midwifery profession and maternity services nationally. Women may experience an increase in access to continuity of care services by private practicing midwives providing hospital based intrapartum care. The breadth of access to this care will depend on the definition of both ‘eligibility’ and ‘collaboration’. This may have the most profound impact in regional, rural and remote areas. Disappointingly, the Budget and National Registration processes will result in women being unable to legally employ a midwife for planned birth at home. This has grave safety implications for women and babies, as well as undermining women’s right to make informed choices. Given that the midwifery profession is being, in a practical sense, defined by these developments, it is essential that the profession is closely engaged in determining its future.

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- <sup>3</sup> Commonwealth of Australia (2009) Budget Papers No. 2. Part 2: Expense Measures – Health and Aging. [http://www.aph.gov.au/budget/2009-10/content/bp2/html/bp2\\_expense-16.htm](http://www.aph.gov.au/budget/2009-10/content/bp2/html/bp2_expense-16.htm) accessed May 27 2009. p 284.
- <sup>4</sup> Commonwealth of Australia (2009) Budget Papers No. 2. Part 2: Expense Measures – Health and Aging. [http://www.aph.gov.au/budget/2009-10/content/bp2/html/bp2\\_expense-16.htm](http://www.aph.gov.au/budget/2009-10/content/bp2/html/bp2_expense-16.htm) accessed May 27 2009. p 284.
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- <sup>12</sup> Teleconference between Maternity Coalition National Executive and Department of Health and Aging Australia (Judy Daniels and Rosemary Bryant) June 2 2009.
- <sup>13</sup> Teleconference between Maternity Coalition National Executive and Department of Health and Aging Australia (Judy Daniels and Rosemary Bryant) June 2 2009.
- <sup>14</sup> Commonwealth of Australia (2009) Budget Papers No 2. – Part 2: Expense Measures – Health and Aging. [http://www.aph.gov.au/budget/2009-10/content/bp2/html/bp2\\_expense-16.htm](http://www.aph.gov.au/budget/2009-10/content/bp2/html/bp2_expense-16.htm) page 2 accessed May 27 2009.
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- <sup>18</sup> Australian Health Workforce Ministerial Council (2009) exposure draft Health Practitioner National Regulation Law June 12 2009 p 47, 56.
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