Australian College of
Midwives

ACM: For midwives. With women. For the future.

Consultation on expanding eligibility under the Midwife Professional Indemnity Scheme for low-risk homebirths

ACM Submission

Issued 14 August 2024

Consultation on expanding eligibility under the Midwife Professional Indemnity Scheme for low-risk homebirths

The Australian College of Midwives

The Australian College of Midwives (ACM) is the peak professional body for midwives in Australia; and welcomes the opportunity to provide a written response to the ***targeted consultation on expanding eligibility under the Midwife Professional Indemnity Scheme for low-risk homebirths***. ACM represents the professional interests of midwives, supports the midwifery profession to enable midwives to work to full scope of practice (SoP), and is focused on ensuring better health outcomes for women, babies, and their families.

Midwives are primary maternity care providers working directly with women and families, in public and private health care settings across all geographical regions. There are 34,318 midwives in Australia and 1,258 endorsed midwives[1]. ACM is committed to leadership and growth of the midwifery profession, through strengthening midwifery leadership and enhancing professional opportunities for midwives.

Terms of Reference

This submission will address the following terms of reference, in relation to the Australian Government Department of Health and Aged Care Discussion paper.

1. Proposals and questions for stakeholder feedback – *Introducing a homebirth product into the MPIS,* questions 1a – 1c.

1. Introducing a homebirth product into the MPIS

- It is proposed that homebirth intrapartum care insurance product be introduced into the MPIS when the current exemption for PPMs expires on 30 June 2025, with the following criteria for suitability:
  - Singleton pregnancy (not multiple e.g., twins)
  - Head is down (cephalic presentation)
  - Pregnancy term is between 37 and 42 weeks
  - Midwife has a documented plan for safe and timely transfer to a hospital with maternity services
  - Midwife has documented no concerns that make homebirth unsafe for the midwife, woman or baby.
  - Where the woman has Category B conditions as listed in the ACM National Midwifery Guidelines for Consultation and Referral, evidence the midwife has consulted with other qualified, competent health care providers with the knowledge and skills to make decisions about the woman's care to determine if homebirth is safe and appropriate
  - Where the woman has Category C conditions as listed in the ACM National Midwifery Guidelines for Consultation and Referral, evidence the midwife has referred and transferred primary responsibility of care to another qualified health service provider or professional who can determine if homebirth is safe and appropriate
  - Comply with the Nursing and Midwifery Board of Australia Safety and Quality Guidelines for privately practicing midwives.

No.	*Questions*
1.a)	Do you think this is an appropriate definition for low-risk homebirth?
1.b)	Would you suggest any changes to the criteria listed above, and if so, why (provide evidence where possible)?
1.c)	Do you have any other comments regarding the inclusion of a low-risk homebirth PII product within the MPIS?

Background

Since 01 July 2010, the Health Practitioner Regulation National Law Act 2009 has provided an exemption to PII for Privately Practising Midwives (PPMs) delivering intrapartum services in the home providing the requirements described in section 284 of the National Law are met. The extension to this exemption is due to end on 30 June 2025, to be replaced by an expansion of the MPIS to include PII for PPMs providing low risk homebirths and intrapartum care outside of the hospital as per the 2024 Federal Budget measure.

Homebirth demographics in Australia

In 2021, 0.5% (n = 1117) of women in Australia gave birth at home[2](Figure 1). By state and territory comparison, 0.3% of women in NSW and ACT gave birth at home, with 1.2% in the NT. By head count, 248 women in NSW, 287 women in QLD and 329 women in WA had a homebirth. In 2021, 15 First Nations women gave birth at home. Most women birthing at home were aged 25-39 years and had one previous home birth. 76% of women birthing at home in 2021 had one or more previous births. Most women accessing homebirth live in major cities or inner regional areas in Australia. 'Other' place of birth includes births that occur at a home other than that intended (unplanned homebirths), without a midwife or other medical professional in attendance (freebirths); births at a community health centre, or babies born before arrival at hospital. In 2021, this was 0.8% nationally (n=1856).

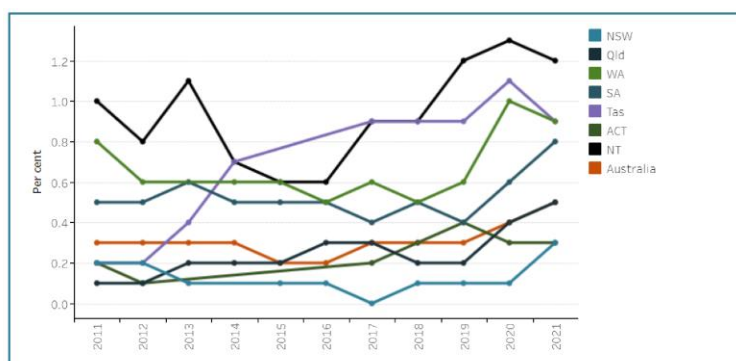

Figure 1. Proportion of women who gave birth, by place of birth (home) and state and territory of birth, 2011 – 2021. NB. Victorian data not included, and WA included women giving birth before arrival prior to 2015 in 'Hospital' data.

What is a privately practising midwife?

Per NMBA, '*PPMs are midwives who practise the midwifery profession in a private capacity. PPMs can be sole practitioners, work in partnership models, operate their own business and/or attend homebirths as the second health practitioner. They can also be employed by a private midwifery business, contracted by a private business or practise in a voluntary capacity. PPMs who are credentialled with a health service can also provide private midwifery care to a woman that is admitted to the health service. Whilst providing private midwifery services in this capacity they are not employees of the health service* [3]'.

Endorsed midwives are midwives who have met the requirements of the Nursing and Midwifery Board of Australia to qualify to prescribe scheduled medicines. Endorsed midwives are the only midwives with access to the Midwife Professional Indemnity Scheme and an endorsement for scheduled medicines is the pathway to access a Medicare Provider Number as a midwife. The Medicare Benefits Scheme provides access to a range of items that enable provision of services which meet the individualised needs of the woman and baby. There are increasing numbers of Endorsed Midwives in Australia (see below):

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	**Total**
As of 31 March 2024,	24	183	21	383	95	21	197	224	110	**1258**

Table 3 – Midwives with scheduled medicines endorsement[1]

Consultation Questions: Overview

The ACM acknowledges the commitment by the Federal Government and the Department of Health and Aged Care to provide a resolution to the existing professional indemnity insurance exemption under the Midwife Professional Indemnity Scheme (MPIS) and Midwife Professional Indemnity Run-off Cover Scheme (MPIS ROCS).

Further, ACM recognises the budget measure sits within a context of legal, regulatory, actuarial, human rights and clinical practice challenges and complexities. We note with concern that the work is being conducted under tight timelines, that ACM was not consulted prior to the announcement of this budget measure and recommends that the work to the progress the professional indemnity insurance for midwives is afforded the depth of review that is required to resolve this highly complex legislative and regulatory reform and to ensure due diligence to enact the required duty of care.

ACM members have significant concerns with regards to this budget measure being related to low-risk homebirth as well as criteria listed in the targeted consultation document (dated July 22, 2024). Members are concerned that a low-risk insurance product, without at a minimum, measures as outlined in our response below, will have the consequence of limiting women's access to their choice of place of birth, and further could limit midwives' professional autonomy. ACM has consulted with members and provides our response below; this includes a member survey overview which had over 370 responses (see appendix 1).

ACM looks forward to continuing consultation with regards to this budget measure to ensure an outcome which provides no unintended consequences, affords women their right to choose, and enables midwives the ability to practise to full scope of practice in the homebirth setting.

a) Do you think this is an appropriate definition for low-risk homebirth?

- ACM agrees the 'low-risk' homebirth criteria bullet points 1-5 (excl. 4) broadly represent 'low-risk' criteria, however they do not constitute a definition per se. Further point 4 in the criteria represents routine midwifery practice and therefore is not required in these criteria.
- ACM agrees with criteria requiring compliance with the Nursing and Midwifery Board of Australia Safety and Quality Guidelines for privately practising midwives. Further, ACM considers that the NMBA Guidelines should be utilised as the vehicle for implementation of this budget measure (see 1b below).
- ACM agrees that the ACM Consultation and Referral Guidelines[4] are an existing framework which can be used in an insurance criteria context, noting that they were not intended to be used to determine place of birth. These research-informed guidelines have been and are utilised nationally; are embedded in jurisdictional policy; are used for reference across health professions to support professional decision making around provision of care, consultation and referral since first developed in 2004; and are used in a regulatory context within the NMBA Safety and Quality Guidelines for privately practising midwives.
- However, ACM does not agree with the current criteria definition for Category B and Category C in the consultation document and strongly recommends that Category B and Category C utilised as criteria within any future insurance product need to reflect the entirety of the ACM Guidelines definitions (as per below).

DoHAC current Consultation Criteria	ACM recommends Consultation and Referral Guidelines definitions		
➢ *Where the woman has Category B conditions as listed in the ACM National Midwifery Guidelines for Consultation and Referral, evidence the midwife has consulted with other qualified, competent health care providers with the knowledge and skills to make decisions about the woman's care to determine if homebirth is safe and appropriate.*	B	Consult	The midwife will consult with a medical practitioner or other health care provider as indicated but only after the woman has provided consent. The indications for consultation will be reviewed and evaluated and used to inform the provision of care. The midwife will continue to provide midwifery care to the woman in collaboration with the medical practitioner or other health care provider(s). Roles and responsibilities of all involved in the woman's care will be discussed. The woman will be involved in all discussions where possible.
➢ *Where the woman has Category C conditions as listed in the ACM National Midwifery Guidelines for Consultation and Referral, evidence the midwife has referred and transferred primary responsibility of care to another qualified health service provider or professional who can determine if homebirth is safe and appropriate.*	C	Refer	The midwife will refer the woman's care to a medical practitioner or other health care provider as indicated but only after the woman has provided consent. The indications for referral will be reviewed and evaluated and used to inform the provision of care. Responsibility of care may be transferred to the medical practitioner. Where appropriate, the midwife will continue to provide midwifery care. Care may be transferred back to the midwife where the woman's condition permits.

Category B and C Criteria: Further Comment

ACM affirms and supports the existing 'Consult' Category B process which includes a range of additional health care providers, including another midwife, as the 'other qualified, competent health care provider' with the knowledge and skills to inform decision making and care planning.

ACM is concerned with regards to the reference (in both B and C criteria) to the health professional referred to as determining if a 'homebirth is safe and appropriate'. As the health care provider may be (for example) a psychologist, dietitian, physiotherapist or other they may not have the scope nor the professional authority to make this decision.

Informed Consent (for both Category B and C current criteria): The current criteria omit the requirement for informed consent which is a requirement of the NMBA safety and quality guidelines. Reference to informed consent in the insurance criteria must be included. In the ACM Guidelines Consult and Refer definitions as above it states…. consult with a medical practitioner or other health care provider…. '*But only after a woman has provided consent*'.

Context of transfer of care Category C: In the context of a category C condition in ACM Guidelines, referral is required either temporarily or permanently, and responsibility of care ***may*** be handed over to 'a medical practitioner or other health care provider'. However, within the current consultation document, the criteria wording is definitive and indicates that the transfer of care is a requirement or given: '*midwife has referred and transferred primary responsibility of care to another qualified health service provider or professional'*. ACM does not agree with this approach. This approach, by omission, removes the role of the midwife/ option for primary midwifery care of a woman with a Category C condition, and is not in line with the ACM Guidelines for referral (see 4.1 below). ACM recommends use of the full ACM Guidelines including its category definitions.

ACM Guidelines 4.1

> - It is important to acknowledge that **regardless of the level of consultation and/or referral, the midwife will continue to provide midwifery care to the woman in partnership and collaboration with the woman herself, and the medical practitioner** (or other health care provider). Even where the indication is to refer (level C), a well-documented plan devised through multi-disciplinary collaboration will enable the woman to continue to receive midwifery care.

During pregnancy or intrapartum period, "risk category" often alters (up or down) or remains the same. The current criteria do not address the implications for both women and midwives in the context of PII where a change in risk occurs during, for example, the late pregnancy or intrapartum period. This needs to be considered in the insurance context.

1. b) Would you suggest any changes to the criteria listed above, and if so, why (provide evidence where possible)?

ACM Recommendation:

1. Use NMBA Safety and Quality Guidelines (which is the existing regulatory requirement for PPMs who practise homebirth) as the vehicle for risk management for MPIS homebirth insurance with the following points/inclusions:

   i. The NMBA Guidelines continued use of *ACM Consultation and Referral Guidelines* as the reference point for Clinical Governance purposes.

      ACM recommends that the NMBA Guidelines form the basis of the insurance criteria for homebirth, inclusive of legal consent document with regards to declining recommended care, to protect the midwife and midwife's employer if relevant, noting the exemption will sunset 30 June 2025.

   ii. Updated *declining recommended care framework* as required (see response in 1.c)

   iii. Update and address the context of the *second midwife/ health practitioner* (see response in 1.c.)

   iv. *Addition of a non-abandonment clause* (as per publicly funded homebirth guidelines) i.e. the midwife is not to abandon the woman during labour at home if/when clinical risk increases, and the woman declines recommended transfer and/or emergency services.

      E.g. SA Health: '*During the antenatal, intrapartum or postnatal period when the woman undertaking a planned home birth is in an unstable clinical condition and where the process of discontinuing care has not been completed prior to the onset of labour: In the situation where the woman is in an unstable clinical condition and does not follow the advice provided by the registered midwife, the registered midwife should not refuse to care for the woman.*'

1. c) Do you have any other comments regarding the inclusion of a low-risk homebirth PII product within the MPIS?

Yes, see below:

a. Declining Recommended Care:

Although not itemised in this consultation, from an insurance perspective, consideration must be given in the context of the MPIS for the insured PPM (and conditions of their registration) if the woman declines recommended care. This may occur in a range of situations e.g. a transfer due to 'prolonged labour' (Cat B/C) and the responsibility of the midwife if in the home (see non-abandonment clause in recommended change 1. b 1.iv above).

ACM recommends a considered approach to declining recommended care which is a woman's right as per the Australian Charter of Healthcare Rights. ACM suggests utilisation of the 'Record of Understanding' Appendix B of the ACM Guidelines, or an updated legal consent form as part of ACM Guidelines, to address the parameters of insurance criteria i.e. if a woman has an identified risk factor, the consent form will outline that the woman waives her right to take any legal action against the midwife and the midwife's employer (if relevant) if she declines recommended care , and there would be no negative regulatory impact on the midwife There is significant risk to both the woman and legal and regulatory/registration exposure to the midwife if this is not resolved, including the increase of freebirth.

b. Second Health Practitioner/Midwife:

Although not itemised in this consultation, ACM recommends consideration in this consultation for the second midwife, which is a requirement of the NMBA Safety and Quality Guidelines, for homebirth. A second health practitioner must be present for the birth of the baby. Prior to a planned homebirth PPMs must *'engage a second health practitioner who has been educated to provide maternal and newborn care, is skilled and current in obstetric emergency management, adult basic life support and newborn resuscitation, and ensure this practitioner is present for the birth of the baby'*.

- There is currently no requirement for the second health practitioner to be an endorsed midwife
- There is currently no requirement for the second health practitioner to hold professional indemnity insurance. '*As midwives (including PPMs) must not practise midwifery unless they hold appropriate PII, second health practitioners must comply with all requirements of the guidelines to be eligible for the PII exemption for delivering intrapartum services in the home'.*

ACM recommends that:

- The second midwife/health practitioner should not come under the primary endorsed midwife's insurance.
- That the second midwife is not required to become endorsed; that if required to become endorsed further to the update in this MPIS, there must be a realistic transition period in view of the 5,000hours of practice requirement and the post graduate qualification.
- That there must be consideration given to the cost impost, if the second midwife is required to take out insurance. Further, currently this is not a requirement, and there is no insurance product for a non-endorsed midwife as it stands

- Note: a tiered insurance system based on number of homebirths attended per year could be considered, which would work well for second midwives, especially in rural and regional areas who only provide a limited number of second midwife roles/year.

c. **Midwifery scope of practice and autonomy**

Health practitioners working to full scope of practice is a Government priority as highlighted in the Unleashing the Potential of our Health Workforce: Scope of Practice Review. It is imperative that a midwifery insurance product does not restrict a midwife's scope of practice. Per the Nursing and Midwifery Board of Australia's (2018) Midwife Standards for Practice:

The midwife, as registered by the Nursing and Midwifery Board of Australia (NMBA) and defined by the International Confederation of Midwives (2017), is educated, competent and authorised to provide safe, effective delivery of quality services that promote health and wellbeing for pregnancy, birth, the postnatal period and transition to parenting.

Of note, there is no reference to care of 'low-risk' women in the standards with the only reference to risk in standard 3, element 3.6 where it states that a midwife: *uses relevant processes to identify, document and manage complexity and risk.* Midwives are also expected to communicate where necessary, by collaborating with other health professionals to ensure that care is enacted to ensure the best possible outcomes (Standard 5). Standard 6, element 6.3 requires the midwife to consult, refer and escalate when care of the woman falls outside of their scope of practice.

d. ACM National Midwifery Guidelines for Consultation and Referral. 5th edition: Update

Since first published in 2004, the ACM Guidelines have provided essential guidance for clinical midwifery care across all practice contexts. The guidelines are based on a comprehensive review of the recent relevant research to ensure safe and quality care. The guidelines foster a collaborative, multidisciplinary approach to the provision of maternity care across Australia and are underpinned by respectful woman-centred care. At the time of first publication there was no single, nationally consistent, evidence-based tool to guide midwives in their decision to consult with and/or refer care to a suitably qualified health practitioner.

The current 4th edition needs amendment to ensure that it is contemporary with current practice. For example, in the wake of the global pandemic, the following was included:

- *Identified public health concerns e.g., Influenza H1N1, SARS-CoV-2 COVID-*a

These are all listed as a category C. With the World Health Organization downgrading of the global state of emergency, and vast exposure to COVID and influenza in particular, a category C classification is no longer appropriate and would unnecessarily restrict most women from accessing homebirth.

e. Exemption Extension

In view of legislative and regulatory changes required to enact the transition to a suitable PII product, the requirement to update the ACM Guidelines and further as women will be booking in from October 2024 for a July 2025 homebirth, ACM strongly recommends an extension to the PII exemption sunset clause by a minimum of 12 months to facilitate adequate stakeholder consultation, and any required legislative and regulatory amendments.

f. Cost, viability and context of insurance

ACM is concerned that despite the 100% underwriting of costs for PII for homebirth being insured by Government there is a risk that endorsed midwives' cost of insurance may increase, further limiting the opportunity for a viable business proposition for midwifery in primary care. Further there is a concern that the economic viability of midwifery businesses will be affected due to the potential of reduced access to homebirth care for women who may be a B or C category with midwifery care currently enabled through consultation and referral. This may mean that midwives will need to cease practise and access to care for women would be further reduced, in addition to added pressure on an already depleted midwifery workforce.

The second midwife, who currently does not require insurance, and may only be second midwife at 1-2 homebirths per year may also be required to be insured (and possibly endorsed). This cost implication is a barrier to homebirth practice.

g. Access to Care

Access to care is the first principle listed on the ACSQHS Australian Charter of Healthcare Rights[5]. Access is also one of the four foundational values of the national maternity strategy alongside choice, safety and respect and yet, access to homebirth in Australia is fragmented and becomes more so as geographical remoteness increases. AIHW data demonstrates that of the 11 main models of care, only 21% of women can access midwifery continuity of care. Variations in health literacy and reduced awareness around available models of maternity care further restrict access to care. Distance to care for rural and remote communities, including isolated First Nations communities is also a consideration.

There has been a recent spotlight on the experiences of trauma through the release of the NSW Birth Trauma Inquiry. A study by Sassine (2021) following a national survey on why women choose homebirth in Australia indicated that women who experience mistreatment, birth trauma and negative birth experiences are more likely to seek care by a private midwife[6]. Evidence indicated that further restrictions on homebirth would have unintended consequences that could jeopardise maternal safety where women with risk factors, determined to avoid standard public care, may choose to free birth or give birth with unregulated birth workers. It is imperative that the system to provide access to care for all individuals, considering the needs of populations who require access to privately funded, expert midwifery care.

A staged approach with adequate consultation will ensure access to care is not negatively or unintendedly impacted through the implementation phase of an appropriate homebirth PII product.

h. Hospital Admitting Rights (National)

ACM recommends mandating of universal Hospital Admitting Rights be implemented.

Most hospitals in Australia do not enable visiting rights for endorsed PPMs, despite clinical outcomes for women cared for by PPMs with visiting rights being more positive than national statistics[7]). For example, in NSW, only 2 public hospitals of 81 provide admitting rights. This is a significant barrier to midwives working in private practice in general, and for women's access to midwifery continuity of care.

If a homebirth midwife's clinical decision is that a transfer is required, and the woman consents, currently in hospitals where there are no protocols that include the midwives' admitting rights the accompanying midwife can only act as a support person in the hospital setting. This does not recognise the skills, knowledge and importance placed on the continuity of care relationship of trust as was the intent of engaging a privately practising midwife. Universal Hospital Admitting Rights will provide women with a choice of birthing in hospital or home cared for by their PPM.

Conclusion

ACM acknowledges the commitment by the Federal Government and the Department of Health and Aged Care to provide a resolution to the existing professional indemnity insurance exemption under the Midwife Professional Indemnity Scheme for privately practising midwives. As per the commentary above, ACM would require the adoption of the full B and C criteria definitions in the ACM Guidelines for consultation and referral in the criteria, a mechanism for women to be able to decline recommended care safely and a legal protection for midwives in this regard, a non-abandonment clause, and consideration of the insurance context of the second midwife/health practitioner.

ACM would welcome the opportunity to be engaged for further consultation with the Department to address potential unintended consequences of this budget measure. ACM members have considerable concern (see survey response) with regards to the impact of this budget measure on the existing homebirth practice context, the impact on women's right to make an informed choice for their maternity care, and further potential increase in freebirth rates if the insurance product minimises women's access to care by its very product definition.

ACM looks forward to continuing to work with the Department of Health and Aged Care as this consultation progresses.

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Acknowledgments
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Consent to publish
ACM consents to this submission being published in its entirety, including names.

Consent to provide further information
ACM is available to provide further expert opinion and advice if required.

References

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Appendix A

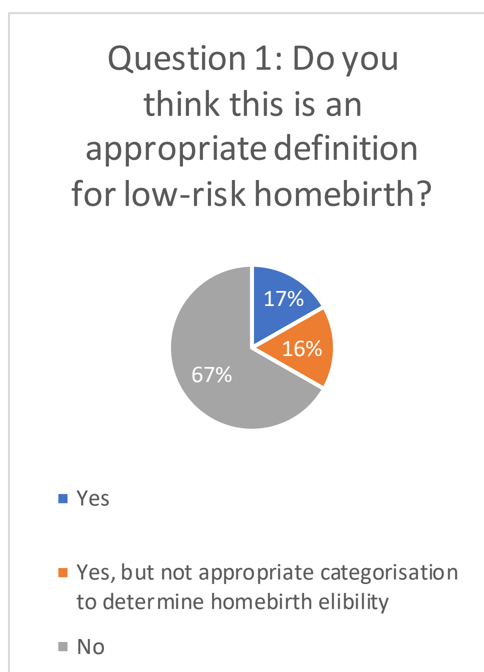
ACM member survey

The ACM conducted a survey to inform this consultation. ACM received more than 370 responses from midwives, midwifery academics and researchers, midwifery students and consumers across every state and territory in Australia.

In response to the question 'Do you think this is an appropriate definition for low-risk homebirth', **66.8% answered no**, and 16.5% supported the proposed 'definition' of low-risk homebirth, however, did not agree that this is an appropriate way to decide on homebirth eligibility.

The following major themes were identified from free-text comments:

- potential for rise in freebirths and associated risks to mothers and babies.
- Criteria for homebirth is unnecessarily restrictive.
- Impact on PPMs, midwifery autonomy, business viability and the midwifery workforce.
- Impact on a woman's autonomy and healthcare rights.
- Birth trauma, obstetric violence and hospital/system avoidance.
- Need for a clause regarding women who choose care outside of recommended guidelines.



In addition to the survey, ACM received a significant number of emails from PPMs including homebirth statistics and case studies. Deidentified data provided, demonstrates successful homebirths with good outcomes for women in Category B and C of the ACM Guidelines, and appropriate and timely consultation, referral and transfers.

For a full report on the survey, email and data responses, please click here.