TRADE PRACTICES ACT REVIEW

June 2002

Submitted by:

Australian College of Midwives Incorporated
(Victorian Branch)

PO Box 647
(1/127 Grattan Street)
Carlton Victoria 3053
Tel: 9349 1110
Fax: 9349 1142
e-mail: acmivic@webrider.net.au

acmi vic letterhead

Secretary
Trade Practices Act Review
C/- Department of the Treasury
Langton Crescent
PARKES ACT 2600
Email: TPAReview@treasury.gov.au
Telephone: (02) 6263 3900
Facsimile: (02) 6263 3939

21 June 2002

The Australian College of Midwives Incorporated, Victorian Branch (the College) is pleased to take the opportunity to submit comment to the Review of the Trade Practices Act.

The College is the professional body which represents the midwifery profession in Victoria, and is a Branch of its national organisation which is a member of the International Confederation of Midwives (ICM).

The comments in this submission are consistent with those submitted by the College to the previous reviews of State legislation by the Victorian Government under the conditions of the national Competition Policy Agreement (Review of the Health Act 1958, the Review of the Nurses Act 1993, and the Health Services Policy Review). We are happy to provide the Committee with copies of our submissions to those reviews if requested.

Despite such government reviews, 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.

Much of the current Trade Practices Act Review is beyond the scope of the midwifery profession. The points which we have chosen to highlight in this submission are those which we consider to be of importance to midwives and consumers - the women, babies, and families in our care.

This submission has been prepared by Joy Johnston and Fran Sheean.

Yours truly,

Fran Sheean Hon President

Background:

The Government has identified concerns that have led to the establishment of the current review. Briefly, these concerns as they apply to the maternity service 'industry' are:

Broad government issue:	Application to maternity care:
• that Australian businesses increasingly face global competition and need to compete locally and internationally;	The Australian midwifery profession, and services provided by midwives in this country, are increasingly being compared with international standards and evidence based practice. Restrictive trade practices in funding for maternity services significantly restrict the ability of the Australian midwife to provide services at a best practice level.
• that excessive market concentration and power can be used by businesses to damage competitors;	The excessive market concentration and power in this instance has historically been established within the Government's funding arrangements for maternity care.
• the need for businesses to have reasonable certainty about the requirements for compliance with, or authorisation under, the Act.	In this instance, without reform of funding arrangements and opening up more competition, it is possible that the ability of the midwife to compete in the maternity services market place will be lost. We believe that this would have serious consequences for the consumer, in removing an option of safe and effective care.

The issue, under the review's terms of reference, which we will address is 1c.
"promote competitive trading which benefits consumers in terms of services and price;"

Introduction:

The health system in Australia, both private and public, is inherently anti-competitive towards midwives, and restrictive of those consumers who seek midwifery care. The Australian College of Midwives (Victorian Branch) believes that the review of the Trade Practices Act needs urgently to address this anomaly. Whereas midwives are recognised by state, national and international authorities as being appropriate, cost effective primary carers for most women through the childbearing episode, the various restrictions (including professional and financial) placed on midwives result in very few midwives being able to practice midwifery fully without restriction. Most midwives are limited to acting as assistants to obstetricians, within a medical model of care. Most women are unable to access primary midwifery care throughout the continuum of pregnancy, birth and the postnatal period.

Under the Trade Practices Act, restrictions on competition are unlawful unless it can be shown that:

- The benefits of the restriction to the community as a whole outweigh the costs
- The objectives of the legislation can only be achieved by restricting competition.

The costs of restricting access to the community in the matter of midwifery care include increasing rates of costly medical intervention which cannot be supported on the grounds of protection of the public.

According to Professor Allan Fels, 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.)

Maternity care is a unique situation within the health care spectrum. At least 60% of all pregnancies result in a normal birth with no complication before during or after. Midwives are in attendance at virtually all births. Doctors are not required to be in attendance unless there are medical complications, yet funding for maternity services, and policies within the healthcare networks are almost uniformly based on a presumed need for medical intervention. Midwifery care is a resource which is hugely undervalued, and unnecessarily restricted.

The majority of women receiving maternity care do not need costly and potentially invasive medical procedures; midwives being the appropriate lead carers. This fact is increasingly recognised in Australian and global trends in so called 'wellness' midwifery models of care.

Maternity care for each pregnancy is of a discrete duration, as opposed to medical conditions which may become chronic. Pregnancy and birth are not an illness. Midwives are specialists in maternity care, and able to work collaboratively with other professionals if illness occurs during the episode of care. Yet the health care system in Australia uses medical general practitioners (GPs) and obstetric specialists to provide the majority of the prenatal care for well women. Maternity care for birth in public hospitals is often wasteful in the use of medical practitioners rather than midwives. This is related more to the Medicare payment system, used for antenatal care when the clinics have been privatised, or when women are seen in the community under 'Shared Care' arrangements between the hospitals and GPs, than to any evidence that it is an appropriate or cost effective or otherwise desirable system. The casemix funding for all births provides a medical component, yet does not provide for the services of a midwife as the responsible professional who is in attendance at the time of birth, and who determines when and if medical attention is required.

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 within the funded public health provisions, without bias towards one provider or the other.

We believe that such reform will address the unnecessary restrictions that exist in the present system to the practice of midwifery; that it will be at least cost neutral, if not initially positive in saving public money; and that it is a safe option, supported by good research evidence.

Models of midwifery care are currently available for women in major metropolitan and some larger country hospitals, in Birth Centres, Team Midwifery, and other 'Midwife Care' options including 'caseload' which means that a midwife provides primary care for a group of women, attending them antenatally, during labour and birth, and postnatally. Approximately only 5% of women are reported to be cared for in midwifery models of care[1]. This small number appears to be mainly due to a lack of availability of midwife-led options, as well as societal, financial, and professional bias towards doctor-led options.

In no other 'condition' are well people expected to visit medical specialists for primary health care. Yet this is the main option for women with private health insurance. Rates of medical intervention have been shown to be greater than average in the privately insured group of women, who receive care from a specialist obstetrician[2]. This phenomenon, described as the 'inverse care law', is obviously a huge waste of resources, and much of the cost is borne by the tax payer.

On the other hand women who choose midwifery care must in many instances move outside the mainstream health care system, and employ a midwife privately. This is an expensive option for the woman, as she is not able to seek rebate for the midwife's fees, even though she is entitled to free care (which is actually more expensive to the community) within the public health system. Approximately 100 women give birth in their homes each year in Victoria, with professional midwives in attendance. The statistical outcomes of these homebirths have been consistently excellent, and the midwives involved have demonstrated competence in their practice.

At a time when care that was previously provided in hospital is now being increasingly provided in the home, it is unreasonable to use anti-competitive legislation to restrict midwifery practice in the home, and to restrict the consumer from access to such care. These anti-competitive restrictions against midwives and those who wish to access midwifery care need to be addressed at a national Government level.

DETAIL OF OUR SUBMISSION:

We therefore submit to the Review that:

1. The consumer's right to choose from a range of appropriate [maternity] services is restricted by government funding and professional arrangements that affect competition.
2. The midwife's ability to provide a service is unfairly restricted by government funding and professional arrangements that affect competition, and
3. There is compelling and reliable evidence that primary maternity care being provided by midwives safeguards public wellbeing through improved service outcomes.

1. The consumer's right to choose from a range of appropriate [maternity] services is restricted by government funding and professional arrangements that affect competition.

Pregnancy and birth are not an illness. Yet the maternity service consumer, a woman who is pregnant or giving birth, is dealt with in the Australian health system in most instances as if she had a medical condition. Restrictions that have been placed on the provision of medical services are unreasonable in the case of maternity services. The New Zealand Government addressed the restrictions to consumer access to midwifery in the Nurses (Amendment) Act 1991, bringing about major reform of maternity services in that country.

The midwife is the most appropriate primary care professional to be assigned to the care of women and babies in basic maternity services, with access to medical specialist services when required. This fact is well defined, and has been agreed to by key health authorities in the endorsement of the Definition of a Midwife[3] (ICM 1990 – Appendix 1).

Many consumers today are increasingly aware of options for care, and of the expected outcomes, rates of complications, and other statistical information. In 2000-2002, the Australian College of Midwives and the Maternity Coalition collected more than 7,000 signatures to a petition to State and Federal Ministers for Health, which states:

> "We the undersigned petition you to provide access for all women to choose a midwife as their primary caregiver during pregnancy and birth within the health system (public and private) whether in the community or hospital."

This petition supports our contention that maternity service reform is urgently needed in an attempt to ensure elimination of unnecessarily restrictive trade practices.

The Maternity Coalition has subsequently facilitated the development of the National Maternity Action Plan, which has been widely endorsed by professional and community bodies and individuals throughout the country. The Executive Summary of this plan is attached as Appendix 2. The plan addresses the issues that are contained in this submission, from a professional and consumer interest point of view, rather than from a competition point of view.

The review's aim upon which we have chosen to focus on in this submission, to "promote competitive trading which benefits consumers in terms of services and price" is unattainable unless the issue of equity of access to models of maternity care is addressed.

Matters which impede competition include

- Medicare funding for non-acute consultations with medical practitioners in the community monopolises the market for antenatal care of pregnant women. A midwife cannot provide a similar service without charging a considerably greater fee than the client pays the doctor.
- The mix of federal and state funding for acute care, at the time of birth, also restricts access to midwifery models of care.
- Government support and incentives for private health insurance have further restricted women's access to midwifery models of care, as private hospital maternity services are predominantly the domain of specialist obstetricians.

A consumer who chooses a midwife as her primary carer in pregnancy and birth faces fees charged by the midwife, which cannot be rebated through Medicare. A few private health insurance companies rebate fees for midwifery services.

A recent development in midwifery that further restricts consumer access to midwife primary care is that professional indemnity insurance is not available for midwives who work as sole practitioners attending births in the home. Without professional indemnity insurance, many midwives have withdrawn from practice. This has further increased the restriction of access to midwifery services.

2. The midwife's ability to provide a service is unfairly restricted by government funding and professional arrangements that affect competition.

The restrictions to the practice of midwifery that are in place in the Australian healthcare system cannot be argued to be necessary from a standpoint of public interest or protection. These restrictions have developed over time. The defining of midwifery by the International Confederation of Midwives (Appendix 1), together with reliable evidence of the outcomes from various models of care in different settings allow us to assert the appropriateness of the midwife as a primary maternity care provider.

The same arguments that have been developed for restricted access of consumers as purchasers of midwives' services apply to midwives being able to supply those services.

Many Australian rural communities face closure of hospital maternity services. Such hospitals may have fewer than 100 births annually, and their birthing services have been maintained by GPs who were committed to attending all births. These hospitals experience difficulty providing uninterrupted medical and surgical cover. We strongly disagree with the closure of such services, and we believe that midwives should be able to act as the responsible professionals in these situations, for the majority of births. Careful screening of women who develop complications in pregnancy, or who have

conditions requiring specialist management, means that only the women who require such attention are required to travel the greater distances to larger medical services. The closure of maternity services in rural towns is a consequence of the funding monopoly that restricts the practice of midwives.

3. There is compelling and reliable evidence that primary maternity care being provided by midwives safeguards public wellbeing through improved service outcomes.

It is not our intention in this submission to attempt present the evidence to support midwife primary care models of care. This material can be supplied if the Committee requests it.

Levels of evidence in health care are classified from Level 1, being most reliable, and obtained from systematic review of all relevant randomised controlled trials, to Level 4, being least reliable, obtained from descriptive works, case studies, and opinion of respected authorities.
Level 1 evidence concludes:

- Midwife led models of care are safe for low-risk women[4]
- Wherever possible, women should be offered continuity of care, including continuity of carer[1]
- All low-risk pregnant women should be offered the possibility of considering a planned homebirth[5].

Conclusion

We conclude that the Trade Practices Act, and particularly Part IV Restrictive Trade Practices, Ss 45 A, B and C, when applied to maternity services, has not been implemented satisfactorily by governments, resulting in continued unfair impediments to competition in the marketplace.

We call on the Review to draw attention to this fact and to set processes in motion to remedy the situation.

References:

[1] Halliday J, Ellis I, and Stone C, 1999. WUDWAW Report on models of antenatal care. PDCU Victorian Government DHS.

[2] Roberts CL, Tracy S, Peat B. 2000. Rates for obstetric intervention among private and public patients in Australia: Population based descriptive study. *British Medical Journal*. Vol 321 (7254). Pp 137-141.

[3] ICM 1990. Definition of a Midwife. Quoted in Code of Practice for Midwives in Victoria (Nurses Board of Victoria 1999)

[4] Hodnett ED 2000. Continuity of caregivers for care during pregnancy and childbirth. [Review] Cochrane Database of Systematic Reviews.

[5] Olsen and Jewel 2001. Home versus hospital birth. [Review] Cochrane Database of Systematic Reviews.

Appendix 1:

Definition of a midwife

The definition of a midwife was adopted by the International Confederation of Midwives (ICM) and the International Federation of Gynaecologists and Obstetricians (FIGO) in 1972 and 1973 respectively, and later adopted by the World Health Organisation (WHO). This definition was amended by the ICM in 1990 and the amendment ratified by the FIGO and the WHO in 1991 and 1992 respectively, and now reads as follows:

A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.

She has an important task in health counselling and education, not only for the women, but also within the family and the community.

The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.

Appendix 2:

NATIONAL MATERNITY ACTION PLAN FOR THE INTRODUCTION OF COMMUNITY MIDWIFERY SERVICES IN URBAN & REGIONAL AUSTRALIA

Prepared by

The Maternity Coalition
Association for Improvements to Maternity Services
Australian Society of Independent Midwives
Community Midwifery WA
Community Midwifery Program, Western Australia

February 2002

EXECUTIVE SUMMARY

The National Maternity Action Plan (NMAP) has been prepared by a broad coalition of consumer and midwifery organisations from across Australia. It proposes a strategy for Federal and State governments to enable comprehensive implementation of community based midwifery services in both urban and regional/rural Australia.

The NMAP calls on both Federal and State governments to facilitate substantial change to the way in which maternity services are provided, by making available to all women the choice of having a midwife provide one-on-one primary maternity care through the publicly funded health system.

Universal access to community based midwifery care will ensure significant savings in health dollars and bring Australia into line with international best-practice in addition to meeting community demands for a range of readily accessible and appropriate maternity services.

Community midwifery is informed by international best practice standards that acknowledge midwives as "the most appropriate and cost effective type of health care provider to be assigned to the care of women in normal pregnancy and birth, including the risk assessment and the recognition of complications" (World Health Organisation, 1999, Care in Normal Birth).

Midwife-led care has been proven to result in fewer women needing expensive obstetric interventions, such as caesarean surgery and operative deliveries. Research also shows that such care contributes to long term breastfeeding, improved adjustment to parenting, and lower incidence of post-natal depression.

Widespread access for pregnant women and their families to community based midwifery care would:

- Provide women with the choice of a midwife as their lead maternity carer in line with international best practice
- Improve maternal and infant outcomes
- Reduce the need for costly obstetric interventions in childbirth for the majority of pregnant women
- Produce significant savings in health funding

This paper discusses the following:

- Reasons why reform of maternity services is urgently required
- What midwife-led care provides for women and babies

- Details of a successful best-practice community based midwifery program in Australia and how similar programs could be readily set up in other States and locations
- Recommendations to governments regarding implementation of community based midwifery programs.

RECOMMENDATIONS

The national consumer and midwifery organisations involved in preparation of this plan strongly recommend the following, to ensure that Australian maternity services are able to meet the diversity and needs of individuals and the broader community in the twenty first century:

That Federal and State/Territory governments commit to urgent reform of maternity services with a view to ensuring all pregnant women have the option of accessing one-on-one primary care from a qualified and registered community midwife for the duration of her pregnancy, birth and the newborn period via the public health system.

That Federal and State governments work cooperatively to establish and maintain community midwifery programs to deliver midwife-led care in both urban and regional areas within the public health system, as a matter of priority.

That the Western Australian Community Midwifery Program, with its emphasis on community management and consultation, be used as a proven and successful template for community midwifery programs to be established in all other States and Territories.

That Federal and State governments commit to ongoing expansion of midwife led services in response to growth in consumer demand for these services.

That Federal and State governments work cooperatively to identify and eliminate barriers that currently limit or preclude midwives providing competitive and cost-effective primary health services to healthy pregnant women and their babies.

That the Federal government review the Medicare Schedule to include midwives as legitimate experts in the provision of maternal care for women.

The plan may be accessed at:

www.communitymidwifery.iinet.net.au/nmap/html

The final revised document will be launched in every State and Territory by mid-2002.
Barbara Vernon, PhD Hon President, The Maternity Coalition Inc
(vernon@webone.com.au)