Review of the National Registration and Accreditation Scheme for health professions

Submission by the Australian College of Midwives (ACM)

October 2014
Table of Contents

INTRODUCTION .........................................................................................................................3

THE AUSTRALIAN COLLEGE OF MIDWIVES ........................................................................3

THE MIDWIFERY PROFESSION IN AUSTRALIA ....................................................................4

CONTEMPORARY AUSTRALIAN MATERNITY CARE .............................................................6

PROBLEMS WITH THE CURRENT MODEL .............................................................................7

OPTIONS FOR FUTURE REGULATION OF MIDWIVES ..............................................................8

  Option 1: Establish a Midwifery Board – the Australian Midwifery Board (preferred option) .........................................................................................................................8

  Option 2: Restructure the NMBA to reflect equal midwifery representation ....................10

  Option 3: Retain the NMBA and include midwifery committees ........................................10

COST IMPLICATIONS OF AN AUSTRALIAN MIDWIFERY BOARD – OPTION 1 ...............11

TABLE 2: PROPOSED BUDGET FOR AN AUSTRALIAN MIDWIFERY BOARD ......................13

RESPONSE TO SPECIFIC QUESTIONS ....................................................................................14

ACCOUNTABILITY .....................................................................................................................14

FUTURE OF REGULATION OF HEALTH PRACTITIONERS IN AUSTRALIA .........................14

COMPLAINTS AND NOTIFICATIONS .......................................................................................16

PUBLIC PROTECTION – PROTECTED PRACTICE, ADVERTISING, COSMETIC PROCEDURES AND A NATIONAL CODE OF CONDUCT .................................................................20

MANDATORY NOTIFICATIONS ................................................................................................21

WORKFORCE REFORM AND ACCESS ....................................................................................21

ASSESSMENT OF OVERSEAS TRAINED PRACTITIONERS ....................................................24

GOVERNANCE OF THE NATIONAL SCHEME .........................................................................27

PROPOSED CHANGES TO THE NATIONAL SCHEME ..............................................................27

  Protected title changes ........................................................................................................27

  Reference to ‘Nursing and midwifery professions’ ................................................................27

  Adequate representation of midwifery ...................................................................................28

SUMMARY ..................................................................................................................................28

APPENDIX 1 LEGISLATION CHANGES REQUIRED ................................................................29

REFERENCES ............................................................................................................................30
INTRODUCTION

The National Registration and Accreditation Scheme (the National Scheme) for the health professions represented a significant achievement that delivers many benefits to the Australian health system. Since its inception with the agreement of all Australian governments in 2008 and implemented in 2010, much work has been done to deliver the National Scheme to the point it is at today overseeing the safe practice and regulation of more than 618,000 health professionals all over the nation.

The National Scheme was established to achieve six key objectives:

- protection of public safety
- facilitation of workforce mobility
- facilitation of high-quality education and training
- facilitation of assessment of overseas-trained health practitioners
- promotion of access to health services
- development of a flexible, responsive and sustainable workforce

This submission is made by the Australian College of Midwives (ACM) in relation to the Review of the National Scheme and the Consultation paper released in August 2014.

The submission begins with descriptions of the ACM, the midwifery profession in Australia and some broader maternity care issues of relevance. We then present a number of options for consideration in this Review. Finally, we address each of the specific questions raised in the Consultation Paper.

The Australian College of Midwives

The Australian College of Midwives (ACM) is the peak, professional organisation for midwives across Australia and is a national, registered not-for-profit organisation. The College was founded nationally in 1984, when midwifery associations in a number of states and territories came together to create a national peak body for Australian midwives.

The College provides a unified voice for the midwifery profession, supports midwives to reach their full potential, and is a key informant for professional practice and education standards.

The ACM is committed to leading and shaping Australian maternity care, to ensure the best possible maternity outcomes for all Australian women and their families. It is guided by research evidence that pregnant women and mothers benefit from having access to midwifery care throughout their childbearing experience.

The work of the College is underpinned by the following values:

- Ethical practice
- Collaboration
- Trusting and respectful relationships
- Respecting diversity and
- Innovation
The midwifery profession in Australia

In the decades prior to the commencement of the National Registration and Accreditation Scheme, there has been an increasing understanding of the differences between nursing and midwifery and the need for midwifery to be developed as a separate profession. This is due to two factors: the first being growing recognition of the internationally defined and accepted scope of practice of the midwife; and the second being increased demand from women to have greater access to midwifery care in line with international trends. As early as 1985, the important distinction between nursing and midwifery was identified in the literature (Barclay 1985).

The Australian Midwifery Action Project (AMAP) in the early 2000s, provided a body of evidence to substantiate the problem of continuing invisibility of midwifery in regulation and education (Barclay et al. 2003; Brodie 2002; Brodie & Barclay 2001; Leap 2002; Leap & Barclay 2001, 2002; Leap, Barclay & Sheehan 2003; Tracy, Barclay & Brodie 2000). This work and others (Bogossian 1998) highlighted how the lack of consistency and evidence of discrepancies in the regulatory standards of midwifery education and practice nationally, questioned the capacity of the statutes to protect the public adequately and ensure that minimum professional standards could be met. The lack of distinction from nursing in both education and regulation, was also shown to limit innovation and development of a more flexible, responsive and sustainable workforce that could improve outcomes through greater access to midwifery services.

For more than two decades the midwifery profession in Australia has argued for greater clarity and understanding of the significance of the title ‘midwife’ in terms of the role, as well as the different body of knowledge and scope of practice of midwives. They argue that the public needs to be aware if they are receiving care from a midwife, a nurse, a doctor or a student of any health profession. Protection of title is of little importance unless the public understand the significance of the title and how they are protected under the Act. The skills and practices of the nursing and midwifery professions are distinct and different. Regulators have a responsibility to properly inform the public and employers to ensure maximum protection of the public and the minimization of harm.

In 2001, in Victoria and South Australia, legislation was changed to enable a direct entry midwifery program to commence meaning that a midwife did not first need to be a registered nurse. Other states followed with NSW changing the Nurses Act (1991) in 2004 to enable a similar course to commence. Such a program is now available in all states and territories (except Tasmania). Direct-entry programs are the predominant way to become a midwife in many countries including the UK, New Zealand, Canada and many European countries.

Direct-entry midwives undertake a 3 or 4 year Bachelor program and, on registration, are able to function to the full scope of the role of the midwife as per the International Definition of the Midwife (ICM 2008). This is a unique aspect of the registration of midwives.

The International Definition of the Midwife states that:
A midwife is a person who has successfully completed a midwifery education programme that is recognised in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.

The Scope of Practice of the midwife is clearly defined (ICM 2008):

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care.

A midwife may practise in any setting including the home, community, hospitals, clinics or health units.

Midwives in Australia are currently educated to this scope (Homer et al. 2008), however, the current lack of consistency in the role of the midwife across the country and evidence of restrictions across all levels of regulation and practice mean that many midwives are unable to practise to this level. This also reflects out of date management systems and nursing leadership that are exacerbated in many parts of rural Australia currently dangerously underserved with maternity care.

It is argued in this submission, that if midwives were able to work to their full scope of practice, increased access to midwifery services for all women would be possible, especially for those in rural, remote and hard to reach settings. In conjunction with this, to ensure the safety of the public, it is, essential that midwives are regulated by midwives through accurate and informed assessment of midwifery practice. This is especially true in the contemporary maternity care environment, not only to ensure the protection of the public, but to address the rights of women to access innovative flexible health service delivery models that are shown to improve outcomes, efficiency and cost effectiveness (Benn et al. 2009; Birthplace in England Collaborative Group 2011; Homer et al. 2014; McLachlan et al. 2012; Overgaard, Fenger-Gron & Sandall 2012; Sandall et al. 2013; Schroeder et al. 2012; Tracy et al. 2013).

The concepts that define the unique role of midwives include:

- Responsible and accountable in their own right for the pregnancy, labour and birth and postnatal care of mothers and babies without complications
- Being experts in normal pregnancy, labour and birth and the postnatal period to six weeks postpartum
- The detection of complications
The co-ordination and facilitation of access to medical care or other appropriate assistance

The management of maternity emergencies as appropriate

The ability to practise in any setting – community, home, hospital, clinics or health centres

A focus on health promotion and disease prevention that views pregnancy as a normal life event

Advocacy for women so that they are respected as partners in their care and their voices are heard

Partnership with women to promote self-care and the health of mothers, infants, and families

Respect for human dignity and for women as persons with full human rights

Cultural sensitivity, including working with women and health care providers to overcome those cultural practices that harm women and babies.

Contemporary Australian maternity care

There have been considerable changes in Australian maternity services in the past two decades, mostly driven by consumer demand and by a large body of national and international evidence (McLachlan et al. 2012; Renfrew et al. 2014; Sandall et al. 2013; Tracy et al. 2013). The National Maternity Services Review (Department of Health and Ageing 2009), commissioned by the Australian Government, recognised in light of the current evidence and consumer preference a case for expanding the range of models of maternity care existed. Reforms resulting from this review have seen the implementation of a number of changes including changing the funding pathways and expansion of the role of midwives into prescribing; all of which takes place within a strong framework of quality and safety.

Across the country, examples of models of care demonstrating workforce reform and increased flexibility where midwives provide midwife-led continuity of care are being developed both in public and private settings. A new cadre of midwife – the Eligible Midwife – was developed as part of the Maternity Services Review to address a gap in the private maternity care sector and this role is now regulated through the NMBA. New models of care where eligible midwives are partnering or contracting into public and private health sectors have emerged which are unique and very different to models of care in the past. These are increasing the access for women to high quality innovative models of care. These policy and practice changes suggest that maternity care will increasingly rely on models of midwifery continuity of care, which have a primary health care and community focus, and have been found to be having lower rates of intervention and morbidity for the women and their infants.

The face of contemporary midwifery has changed rapidly from a model that reflected high tech obstetric focussed practice (Barclay 2008) and fragmented care where women did not know their caregivers to a more woman centred approach which includes continuity of care giver. The demand by women for continuity of midwifery care exceeds the supply of midwives able to practice across the full scope of care (Carroll 2014; Commonwealth of Australia 2009; Dahlen et al. 2011; Maternity Coalition 2013). Innovative models of care have been developed in urban and rural settings and these are highly desirable for women.
Contemporary Australian midwifery practice is ‘woman centred’, based on evidence and addresses the woman’s right to access continuity of care within the context of her family and community (Homer et al. 2008).

Australian midwifery is emerging as an autonomous profession with its own internationally recognised definition, scope of practice, national code of ethics and professional conduct; decision-making framework; continuing professional development and standards review; as well as education and practice standards (ANMAC 2013; ANMC 2006).

It is critical that the practice of midwifery is regulated by those who do understand and recognise contemporary midwifery practice and the newer and emerging models of care. This includes assessments and management of complaints and disciplinary matters, by those who are practising as contemporary midwives along with those who have recent consumer-based experience of childbearing. This will ensure that well informed contemporary judgements about midwifery practice and education standards are made thus contributing to ensuring safety of the public.

Problems with the current model

It has been suggested by some that the current system of regulation of midwives works and therefore should not be altered. The ACM does not agree with this assertion. When the National Law was originally being negotiated, ACM argued strongly for a Midwifery Board and 5 years later, we continue to express this view. The current system over the past 3-4 years has not persuaded us that a Nursing and Midwifery Board is the best way to protect the public, facilitate the development of a flexible, responsive and sustainable workforce and promote access to health services. We highlight our reasons for this stand in this submission. Broadly speaking our concerns are:

- Lack of contemporary practising midwives or consumers on the NMBA who can safely judge the practice of midwives
- Lack of equity on the NMBA in relation to nursing and midwifery representation
- Lack of understanding about the differences between nursing and midwifery from the NMBA and AHPRA and therefore an unsafe blurring of boundaries exists in legislation, regulation and consultation
- Limited understanding of the role of the midwife in Australia and therefore an inability to facilitate standards that promote and support innovative health services or workforce deployment
- Lack of visibility of midwifery within the NMBA filters down to all other agencies, for example, the former Health Workforce Australia omitted any effective midwifery workforce planning as midwifery was overlooked due to the size of nursing and nursing issues.
- A Midwifery Board would have 35,000 registrants which would be the 3rd largest Board (after the Nursing and Medical Boards) and would constitute an adequate workload given the complexities of midwifery practice (eg. the challenges associated with effectively addressing homebirth, Eligible midwives, privately practising midwives and implementing more models of
cost effective and evidence based midwifery continuity of care, especially in rural Australia).

Options for future regulation of midwives

The current NMBA has 12 members including three community members. Notwithstanding our respect for each of the 12 members as individuals particularly with significant expertise in nursing, as a finite group it is considered that their skills and experience of midwifery are insufficient to adequately protect the childbearing public. There are notionally four individuals on the board with midwifery qualifications (although only one place necessitates a midwifery qualification).

Of concern is that current legislation does not require any members of the Board to have any currency of practice in midwifery. In particular, any involvement in contemporary practice that includes midwifery continuity of care across the full scope of practice (either current or previous) is not required.

Thus the current structure does not provide a capacity for the Board to make judgements about contemporary midwifery practice in a manner that assures protection of the public, improve access to health services and supports workforce innovation. The current Community members of the NMBA have an in-depth understanding of issues related to nursing, in particular, the care of patients experiencing ill-health. This is right and proper given the majority of issues are related to nurses. Midwifery is a distinct profession with distinct safety issues and therefore, in the current structure, is not effectively and appropriately regulated. There is no legislation that mandates that community members have an understanding of midwifery care or the unique role of midwives including continuity of care and enhancing public health.

As governments and health services strengthen consumers’ participation in health service planning, increased demand from women for greater choice and equity of access to maternity services, including primary care from midwives, can be expected. In this context the ACM argues that there is an essential need for greater visibility, clarity and recognition of midwifery within legislation, which is key to protecting the public. Three possible options to better protect the public and fulfil this need are provided for consideration. The ACM believe that maintaining the status quo is no longer in the interests of childbearing women in Australia and creates health system risks.

Option 1: Establish a Midwifery Board – the Australian Midwifery Board (preferred option)

The first option, and in our view the priority, is the establishment of a Board for midwifery – the Australian Midwifery Board (AMB). There are currently 35,000 midwives and nurse/midwives on the register with a midwifery qualification making midwifery the third largest profession in the national scheme (after nursing and medicine). We are aware that the financial state of the NMBA is strong and this would enable a Midwifery Board to be established within current reserves. There could be streamlining of systems and processes between a Nursing Board and a Midwifery Board through a Memorandum of Understanding (MOU) such that people who choose to remain registered by both Boards could do so with ease.
A Midwifery Board would have a number of advantages that would enhance protection of the public including:

- Midwifery practice issues would be assessed and regulated by a full Board who are both credible and cognisant of the issues in the provision of contemporary, safe maternity care leading to more appropriate regulation, more appropriate and timely complaints management, access to services and workforce flexibility covering safer staffing of maternity services. This would also mean that the issues associated with privately practising midwives, Eligible midwives and homebirth would receive attention from individuals who are qualified and experienced
- Appropriate and timely complaints management includes the application of the principle of natural justice i.e. to be judged by peers who are competent to make a judgement
- Increased protection of the public through the nimbleness of a midwifery focussed Board thus improving responsiveness to emerging issues associated with rapid escalation
- An increased understanding of the regulatory context for midwives in private practice providing a fee-for-service model
- Community representatives who are aware of the relevant issues for childbearing women and families would be recruited to the Board thereby ensuring accurate assessment of practice-related issues for midwives.
- Cost effectiveness arising from appropriate regulation and protection of the public
- Improved data collection about practising midwives, which will improve workforce planning. Improved data includes the analysis of trends which leads to risk profiling. This then supports regulation to be responsive rather than reactive that is in keeping with the aspirations of Harry Cayton around right touch regulation (Council for Healthcare Regulatory Excellence 2010).
- The issue of midwifery invisibility in the legislation, and its consequences, would cease
- The Nursing Board would be free of the time consuming complexities of midwifery issues and able to concentrate fully on the important issues for nursing.

The financial status of the NMBA as provided in their annual report indicates that funding the establishment of a Midwifery Board is a practical and viable option.

There would also be an opportunity for a Midwifery Board to share infrastructure costs with similarly sized and already regulated Boards. This could be a cost effective solution while still maintaining the autonomy of the boards.

We recognise there are some disadvantages to establishing a Midwifery Board and these include:

- Legislative change is required
- The additional costs for registrants who wish to maintain registration with both a nurses board and a midwifery board.
While there would be additional costs for registrants who wish to maintain registration with both a nurses board and a midwifery board this is already the case. Midwives who are also nurses currently have two sets of costs (albeit with some overlapping) because of having to maintain separate CPD and recency of practice requirements, so it will only be the two registration fees that would be new. The ACM believes that two registration costs are reasonable considering people will have two separate qualifications and registrations, and the improved protections to the public.

Option 2: Restructure the NMBA to reflect equal midwifery representation

If a Midwifery Board is not created, the ACM proposes that, within the current structure, a number of changes will be essential:

- Restructure the membership of the NMBA and state and territory Boards to reflect the regulation of two professions equally
- Require the midwifery members to have current engagement in contemporary midwifery practice
- Require half of the community members to have recently experienced maternity care
- Establish separate midwifery and nursing committees to assess midwifery or nursing related notifications and provide the NMBA with informed contemporary advice and guidance in relation to midwifery policy and practice and nursing policy and practice
- Change legislation to reflect the distinction between the Nursing profession and the Midwifery profession throughout the National Law and associated documents.

The advantage of this approach is that:

- It is relatively simple to implement and would reflect the role of both professions more equitably
- An appropriate range of practising midwives and consumers could be included in decisions that ultimately affect the safety of the public
- The NMBA would provide improved protection of the public for midwifery as well as contemporary management of complaints and appropriate support for workforce reform and flexibility,
- The NMBA would have greater credibility and professional regard in relation to midwifery.

The disadvantages are that:

- Legislative change is required
- The nursing profession may feel that they are disadvantaged in terms of numbers of the Board as an equitable number of places would need to be for midwives and maternity consumers
- It is a cumbersome and inefficient solution.

Option 3: Retain the NMBA and include midwifery committees

If a Midwifery Board were not deemed possible, the ACM proposes that within the current structure, a number of changes are essential:
Increase the number of midwife Board members and require these to have current engagement in contemporary midwifery practice

Require at least one of the community members to have recently experienced midwifery care

Establish midwifery sub-committees of the Board to assess midwifery related matters including notifications and provide the NMBA with informed contemporary advice and guidance in relation to midwifery policy and practice and nursing policy and practice

These sub-committees would include a Midwifery Registration Committee, a Midwifery Policy Committee and a Midwifery Practice Committee. It is understood that legislative change to establish such committees is not required and that this reform could be implemented immediately. The financial status of the NMBA as provided in their annual report indicates that funding is not an impediment.

Processes would be established to ensure that issues came to the Midwifery Committees and are assessed according to contemporary midwifery practice by committees made up of practising midwives from a range of contexts and settings and well as maternity consumers. Recommendations in relation to midwifery would then be made to the NMBA.

The advantage of this approach is that:

- It is relatively simple to implement and would not require changes to the National Law
- Contemporary midwifery advice could be easily sought by the Board.

The disadvantages are that:

- There is no mandate for the Board to adopt the advice or recommendations from the Midwifery Committees
- An additional layer will be created that has cost and bureaucratic implications including affecting the timeliness of decisions
- The problem of midwifery invisibility at legislative level remains

An example of where this is already working is in the Australian Nursing and Midwifery Accreditation Council (ANMAC). In ANMAC, midwifery programs are assessed by a Midwifery Accreditation Committee made up of contemporary practising midwives, midwifery educators, researchers and managers. This ensures strong midwifery involvement in the development of accreditation standards for midwifery programs and in the assessment of midwifery education.

**Cost implications of an Australian Midwifery Board – Option 1**

We understand that the financial status of the NMBA as provided in their annual report indicates that funding the establishment of an Australian Midwifery Board is not an impediment.

In the considerations of the analysis, the following assumptions are made:

- With the establishment of a separate AMB, the reserves would be shared on a pro-rata basis (9.48%)
• The costings are based on the revenue from the 2012-13 Annual report\(^1\)
• Midwifery registrants constitute 9.48% of all NMBA registrants and is used on a pro rata basis for calculations.
• The trend in the reduction of registrants from 2013-14 will continue at the same or similar rate i.e. assume 5%.
• The average income per registrant is derived from the total revenue required divided by the total registrants. This allows for in year variation in the total number of registrants.
• The sitting and other Board fees for smaller boards are used in this calculation i.e. slightly higher than Dentistry, Pharmacy and Psychology.
• Revenue will remain the same as that identified in the budget estimates i.e. 9.48%.

The cost to the national scheme include, the costs of assessing a complaint, Board sitting fees, legal advice, salaries of AHPRA staff, and monitoring compliance. When considering cost implications it is important to note that for nursing and midwifery notifications, very few escalate to State Administrative Tribunal (SAT). Further midwifery notifications are small in comparison to nursing with even fewer escalating to SAT.

The average total number of notifications for the midwife from 2011 – 2013 = 65, there was one notification in the nurse and midwife category in 2013. The average over the same period for nursing was 1,241 notifications.\(^2\) Midwifery represents 5% of the nursing and midwifery notifications on average over the 3 years.

In 2012/13, there were a total of 29 notifications received for midwives and 540 (including NSW) for nursing\(^3\). There were a total of 3 immediate actions for midwives – 1 suspension registration (SAT) and 2 accepted undertakings. For nursing there were 72 immediate actions: 27 suspended registrations (SAT), 2 surrendered registration, 18 imposed conditions, 17 accepted undertakings and 8 no immediate action.\(^4\) The escalation to SAT was slightly lower for midwifery than nursing (10% v 13%).

This demonstrates that the cost burden arising from notifications and escalations to SAT for nursing and midwifery is low but even lower for midwifery.

The total number of registrants on the NMBA for 2012/12 is reported as 345, 955 with 36,185 on the register for midwives. There is a trend for a reduction in the midwifery registrants of approximately 3% from 2013 to 2014. It is anticipated that this decrease will continue at 5% and is reflected in the proposed budget across the next four years.

The current registration fee is $150.00 although the cost per registrant is $155.00 of the NMBA. The reserves are such that this level of subsidy could continue in the short term with a minimal fee increase to $160 per annum.

\(^1\) AHPRA Annual Report 2012/13. p193
\(^3\) AHPRA Annual Report 2012/13
\(^4\) AHPRA Annual Report 2012/13 p153
Table 2: Proposed budget for an Australian Midwifery Board

<table>
<thead>
<tr>
<th>Item</th>
<th>2012-13 NMBA</th>
<th>Pro rata share</th>
<th>Year 1 AMB</th>
<th>Year 2 AMB</th>
<th>Year 3 AMB</th>
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<td>Registrants</td>
<td>345,955</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>Midwifery</td>
<td>36,185</td>
<td>36,185</td>
<td>34,376</td>
<td>32,657</td>
<td>31,024</td>
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<tr>
<td>Cost per registrant</td>
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<td>$155</td>
<td>$160</td>
<td>$160</td>
<td>$160</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td>$(000)</td>
<td>$(000)</td>
<td>$(000)</td>
<td>$(000)</td>
<td>$(000)</td>
</tr>
<tr>
<td>Registration fees</td>
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<td>5,347.1</td>
<td>5,500</td>
<td>5,225</td>
<td>4,964</td>
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<tr>
<td>Interest</td>
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<td>214.1</td>
<td>214.1</td>
<td>214.1</td>
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<tr>
<td>Other</td>
<td>564</td>
<td>56.2</td>
<td>56.2</td>
<td>56.2</td>
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<tr>
<td><strong>Total Income</strong></td>
<td>56,198</td>
<td>5,342.7</td>
<td>5,770.4</td>
<td>5,495.4</td>
<td>5,234.2</td>
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<td><strong>Expenditure</strong></td>
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<td>Sitting fees</td>
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<td>Legal</td>
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<td>Accreditation</td>
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<td>1,000</td>
<td>1,000</td>
<td>1,025</td>
<td>1,051</td>
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<tr>
<td>AHPRA</td>
<td>35,843</td>
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<tr>
<td><strong>Total expenditure</strong></td>
<td>43,285</td>
<td>5,683.4</td>
<td>5,692.9</td>
<td>5,722.7</td>
<td>5,753.3</td>
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<td><strong>Surplus/-Deficit</strong></td>
<td>12,913</td>
<td>340.7</td>
<td>78</td>
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<td>Reserves</td>
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<td>2,084</td>
<td>2,162</td>
<td>1,934</td>
<td>1,415</td>
</tr>
</tbody>
</table>

This illustrates that there is sufficient equity within the reserves and forecast revenue to enable the establishment and functioning of an Australian Midwifery Board and for this to be cost effective. Economies that may be realised through this review of the national scheme have not been reflected.
RESPONSE TO SPECIFIC QUESTIONS

Accountability

Q1: Should the Australian Health Workforce Advisory Council (AHWAC) be reconstituted to provide independent reporting on the operation of the National Scheme?

The ACM is of the view that an independent Council is necessary to ensure that national issues are addressed and to enable a level of transparency to the public. It is felt that an independent Council is more likely to provide the public with confidence that health workforce issues are addressed in a consistent and equitable manner across all states and territories.

The ACM feels that a Council as proposed in the Consultation paper could be unreasonably influenced by their jurisdictional issues and political positioning. Given the political cycle, this could cause difficulties with national consistency and transparency across the country.

If the AHWAC could be fully independent of jurisdictional politics, then the ACM could support such a Council.

Q2: Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues are addressed?

If the AHWAC were an independent body this would be an ideal and important way to address unresolved cross-professional issues. If it were made up of jurisdictional representatives, it is foreseen that this would be a difficult way to manage such issues as individual jurisdictional issues could prevail and override the national good.

Future of regulation of health practitioners in Australia

As stated in the preamble to these questions, the position of the ACM in relation to the National Scheme is for there to be a separate Midwives Board to address the issues of:

- Protection of the public in relation to maternity care
- Promotion to access to maternity services
- Development of a flexible workforce and promotion of access to overseas trained midwives.

Q3: Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions?

Estimated cost saving $11m per annum

The health sector is made up of a range of professions, each with their own issues related to scope of practice, discipline areas, education standards and pathways and particular risks and safety concerns. While the nine low regulatory workload professions have some similarities, they also have considerable differences which would make having a single Board problematic. It is likely that individual groups will feel that their specific issues are not adequately addressed and a lack of expertise in each area could create concerns around the appropriate protection of the public. Public trust and confidence in health practitioners is not likely to be enhanced if the
public feel (rightly or wrongly) that enough expertise in the particular profession is around the table to assure safe quality care.

Determining and monitoring scope of practice for each of the professions is essential especially as a flexible, agile workforce will want changes to accommodate best practice, local needs and international changes. For this to occur safely and efficiently, it is essential that separate Boards are retained to oversee the nine low regulatory workload professions to enable the appropriate skill and expertise is around the table to judge whether changes in scope of practice can occur safely.

There are opportunities to share infrastructure costs as explained in the next section.

**Q4: Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service? Estimated cost saving $7.4m per annum.**

While the ACM supports having separate Boards to oversee the low regulatory workload professions, we recognise that there may be opportunities to share some infrastructure and location costs. This could include registration renewals, maintaining the website, shared processes for consultation and tendering for projects.

**Q5: Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?**

The current fees for nurses and midwives are in the lower end in relation to other health professionals. For the most part, nurses and midwives earn professional salaries and limited additional income from fee for service health care models. ACM therefore support the current fee structure if services of the Board were increased to better meet the needs of the midwifery profession. Currently within the midwifery profession a number of concerns exist around the regulation of the profession. These include a view of low “value for money” in relation to their midwifery registration leading to resentment around the fees that midwives pay. Many view the current regulatory system as a sub-standard service that does not meet the needs of midwives in terms of protection of the public. In particular, application for Eligible midwife has been fraught with problems and had led to a lack of confidence in the effectiveness and efficiency of AHPRA from these applicants.

The separation the Nursing and Midwifery Board into a Nursing Board and a Midwifery Board would create an opportunity to resolve these issues. In terms of cost there may be opportunities for those individuals who chose to be registered on both Boards to be eligible for some form of cost saving.

However, as stated earlier, the ACM recognises that nursing and midwifery are different disciplines and therefore, individuals would need to pay fees to be registered on separate registers as it right and proper. This occurs in other situations where individuals are on two separate registers. For example, a number of physiotherapists have also undertaken direct-entry midwifery training. To be on both registers, these individuals pay two fees as physiotherapy and midwifery are separate professions. This should be the same for nursing and midwifery, notwithstanding that some people may choose to be on both registers. If
administration savings were made with midwives who are also nurses registering on both registers, this could translate to cost savings for registrants.

**Q6: Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?**

The ACM agrees that in order for future professions to be included in the National Scheme, there should be achievement of a threshold based on risk to the public and an associated cost benefit analysis.

**Q7: Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?**

The ACM believes that the National Law should be amended to recognise those professions that appear at present to provide adequate public protection through other regulatory means, however, should be included in the NRAS scheme to enable notifications and greater public protection in relation to health professional matters.

**Q8: Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?**

An independent Council should provide advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council. As stated earlier, the ACM does not agree that it should necessarily be the reconstituted Australian Health Workforce Advisory Council. The Council should consist of representatives from the professions as well as from the broader community sector.

**Complaints and Notifications**

**Q9: What changes are required to improve the existing complaints and notifications system under the National Scheme?**

The ACM raises a number of issues in relation to complaints and notifications, which highlight the deficiencies in the current system and demonstrate the justification for establishment of the Midwifery Board. We provide examples (de-identified to ensure privacy) to explain the issues.

Currently, complaints are managed across the jurisdictions in a manner that is inconsistent and unreasonably slow. The lack of an appropriate representation of midwives on every panel or tribunal assessing midwifery practice is a significant issue and must be addressed to ensure that decisions are safe. For the protection of the public, it is important that contemporary midwives are assessing midwives complaints and notifications. At a national level this is not occurring in a uniform way.

Assessment of midwives by midwives is an essential pre-requisite for review of practice in the quest to protect the public. In many cases, the ACM believe that there is a lack of professional involvement from practising midwives who understand the specific context. protection of the public is therefore compromised. As explained in the preamble, the lack of midwives with contemporary knowledge and expertise on the NMBA and on jurisdictional panels or tribunals means that there is inadequate assessment of the practice of the midwives under review.
The other major issue is the lack of timeliness in the assessment of complaints and notifications. The ACM has received many complaints from members who have had long delays in the complaint or notification being heard and completed. The way in which these are handled differs widely across jurisdictions, again putting the public at risk. The National Scheme was meant to remove inconsistencies however this is still in evidence.

Example 1 below highlights the lack of adequate process, poor communication and lack of professionalism associated with the complaints and notifications.

Example 1
Midwifery Manager X was asked by Midwife Y (who had been notified to AHPRA and had restrictions imposed on her registration) to provide supervision and mentorship. This was not a midwife that Manager X was responsible for and she had no obligations to the midwife.

When Manager X applied to be Midwife Y’s supervisor, there was no process suggested or in place. Midwife Y was asked to come up with someone and submit their details to AHPRA. This seemed very random. AHPRA then agreed to Manager X supervising Midwife Y, but at Manager X’s own expense, and with no guidance at all. Manager X submitted a template devised from supervising midwives in another country, and asked for feedback on its suitability. After some time this was approved and was used. There was no feedback to Manager X or any gratitude expressed for the role she undertook. Manager X wrote to AHPRA after 7 months of supervision and mentorship but never heard back.

Midwife Y was later informed through her legal counsel that the conditions had been lifted but Manager X was never formally informed to cease supervision and mentorship.

The Midwifery Council of New Zealand found that by having a fair, equitable, responsive and consistent approach to complaints there was a direct impact on the timeliness and resolution of complaints. Although this has not decreased the overall number of complaints, the NZ Midwifery profession are better placed to examine outcomes and trends in issues and address these proactively as a profession.

Q10: Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?

The co-regulatory approach in Queensland is in its early days and it is too soon to determine whether it should be adopted nationally. Many aspects of the Queensland approach are viewed very favourably and it may be that this is a good way forward once the system is tested in practice. In NSW, the Health Care Complaints Commission is another system that has been established and has, in the view of the ACM, been superior to the AHPRA systems.

The establishment of these two separate models demonstrate that some jurisdictions have felt that the AHPRA system is currently inadequate therefore warranting the development of an alternative system.

Q11: Should there be a single entry point for complaints and notifications in each State and Territory?
A single entry point for complaints and notifications in each State and Territory for all
disciplines (that is, one entry point in each jurisdiction for all health professions) could
have benefits in terms of consistency and uniformity. The ACM highlights that there
must be transparency in whichever approach is taken, with immediate notification
going to the relevant Board

Q12: Should performance measures and prescribed timeframes for dealing with
complaints and notifications be adopted nationally?

Consistency is essential therefore the ACM agrees that performance measures and
prescribed timeframes for dealing with complaints and notifications should be
adopted nationally. There is an urgent need for common national standards and
benchmarks and transparency of reporting. There is also a need for closing the loop,
that is, notifiers need to be made aware of the outcome in a timely and respectful
manner.

Example 2
Midwife B was reported in state Y by a local hospital. A restriction was placed on her ability to
attend home birth effective immediately. It then took a period of 9 months before there was any
further communication from AHPRA to the midwife during which time her livelihood was
impacted.

Midwife C was reported in state X by a local hospital for a clinical case that was identical to the
case of Midwife B. Midwife C was contacted by AHPRA and asked to provide a statement around
the case. Consideration of this case took approximately 6 weeks. There were no reasons provided
for this very different response.

Q13: Is there sufficient transparency for the public and for notifiers about the process
and outcomes of disciplinary processes? If not, how can this be improved?

Currently, there is insufficient transparency for the public and for notifiers about the process
and outcomes of disciplinary processes in regards to midwifery notifications. The notifiers rarely receive any information indicating what actions have or will be
taken and when.

Example 3
Doctor X at St Elsewhere Hospital notified a midwife who she/he felt had not demonstrated
reasonable practice in the care of a woman during pregnancy. The doctor received no information
about the processes undertaken as a result of the notification and was only told that the
investigation would take 12-18 months to be resolved. The doctor expressed significant concerns
about the lack of timeliness of this given the midwife continues to practice. This lack of
communication has not provided this doctor or health service with any confidence about making
future notifications or indeed any confidence in the capacity of the system to address problems.

The public equally receive very little feedback on the outcome of the notification
and this creates a lack of trust in the system. This is important because if a midwife
has notifications against him or her, the notation on the register is limited and
women may still attend that midwife without knowing what the issues are. This is
compounded when the issues take significant time to be resolved. Care during
childbearing spans 8-10 months so the delay potentially puts the woman and her baby at risk.

Example 4
Midwife A in jurisdiction B had a number of notifications made against her practice over several years. These notifications were serious and significant and involved deaths of a number of babies. However, addressing these was slow and challenging. In the meantime, Midwife A continued to practice and even provided care in State C – which resulted in another neonatal death and a notification. These deaths then became the subject of Coronal Inquiries in both states. It is our view that the public were not aware of the serious nature of the allegations or the specific issues in relation to the care provided and hence some women continued to access Midwife A for care. Finally, Midwife A relinquished her registration as a midwife and now practises as a ‘birth attendant’. Subsequently, legislation in State B has been altered to mean that a non-midwife or doctor cannot provide care during labour and birth.

ACM comments:
This is an unfortunate case that has received considerable media attention. We feel that this case, and the delays and processes associated with the handling of the case, has not helped the public to feel confidence in the regulation of midwifery. ACM believe that a Midwifery Board would be able to address such notifications much more quickly and effectively and thus ensure that the community received information more readily and further lives were not put at risk. Having practising midwives on a Midwifery Board, especially those who understood the homebirth context, would increase the ability of the Board to address the issues more effectively.

Q14: Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?

It would be advantageous for there to be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier.

A mediation process could be reasonably easily established to enable clear communication prior to disciplinary hearing or in situations where there appears to be a communication issue. This could also be a useful way to engage the consumer and could be an effective means to resolve lower level notifications.

If lower-level notifications that did not pose a risk to public safety were able to be resolved in a mediation process, this would free up the Board to address the more important or significant notifications where safety of the public is at issue.

For example, the New Zealand College of Midwives (NZCOM) provides a complaints management process such that consumers may complain about a member of NZCOM. Midwife mediators facilitate meetings between the midwife and the complainant in search of a resolution. On occasion, the Health Care complaints Commissioner contracts the New Zealand College of Midwives to mediate on their behalf. Professional Colleges in Australia could have a similar role.

Q15: At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?
An adverse finding and associated intervention should only be removed when a sufficient time line indicates that the practitioner has been rehabilitated. It may be appropriate to indicate on completion of a disciplinary hearing at what point the intervention recorded would be removed.

**Public protection – protected practice, advertising, cosmetic procedures and a national code of conduct**

**Q16: Are the legislative provisions on advertising working effectively or do they require change?**

The current provisions on advertising have not taken into account the recent trends in the use of social media. The current guidelines are still grey on the issue of social media in terms of advertising and different health practitioners have differing standards under the same National Law.

The issue remains particularly with testimonials on social media where the practitioner has no control over the posting of such comments – either positive or negative. In the guidelines there remains a blurred distinction between compliments and solicited testimonials.

For the profession represented by the ACM, midwifery, the discussion around social media becomes extremely complex as many women now use social media to announce the birth, including often the name of their midwife and even do so repeatedly on subsequent birthdays. This could become a significant issue for the midwife depending on the depth of storytelling by the woman.

It is strongly recommended that compliments are not considered as testimonials and that the ban on testimonials only refers to those that are solicited.

**Q17: How should the National Scheme respond to differences in States and Territories in protected practices?**

A number of high profile cases in relation to midwifery and homebirth, especially in South Australia, have highlighted deficiencies in the current protected practice provisions. The ACM fully supports protected practice however the SA restricted Birthing Practices legislation does not go far enough to protect women from unsafe practices. In South Australia, the new legislation has been passed to protect the practice of midwifery only during labour and birth under state legislation. The SA legislation (Health Practitioner Regulation National Law (South Australia) (Restricted Birthing Practices) Amendment Bill 2013) renders it an offence for a person to engage in the practice of midwifery only during labour and birth in South Australia without being a midwife or a medical practitioner registered under the Health Practitioner Regulation National Law.

This legislation concentrates on labour and birth without consideration of the antecedents that occur during pregnancy. These require care from an appropriately qualified and regulated health provider.

We recommend that this Review carefully consider this new legislation in SA and the impact on the National Law. The ACM prefers that there is national consistency in these matters and unilateral action creates potential risk to a national system.

Q18: In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?

There may be a range of mechanisms which may assist to protect the public from demonstrated harm. In the cases of professions which are currently regulated, a notation on the register to indicate any previous or pending complaints needs to occur when the practitioner’s registration has lapsed and/or they have been removed from the register.

In the case of professions which are not currently regulated through AHPRA, a National Code of Conduct would be essential.

**Mandatory Notifications**

The Consultation Paper states that nursing and medicine made up 79% of the mandatory notifications received by April 2014. Midwifery is invisible in these data again highlighting the problems with a combined nursing and midwifery board where midwifery issues are subsumed into nursing. This is not beneficial for protection of the public where there are specific midwifery issues especially in relation to the long-term ramifications as a result of birth. Data suggests that midwifery notifications make up 5% of the nursing and midwifery notifications from 2011 - 2013.

Q19: Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?

The exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment who did not pose a risk to the public were implemented in order to ensure that practitioners did not avoid treatment for fear of being reported.

The ACM agrees that national consistency on this matter is important and that any system that ensures that practitioners do not avoid treatment for fear of being reported is advantageous.

However – some practitioners will not seek treatment until notified and even then there are challenges across health sectors and jurisdictions. Recent disturbing cases, for example, the case of Neurosurgeon Dr Suresh Nair, jailed over cocaine-related deaths in Sydney, needs to be closely examined to ensure that exemptions did not allow this case to be repeated.

**Workforce Reform and Access**

Q20: To what extent are National Boards and Accrediting Authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery?
The Consultation Paper highlights the increasing demand for health services from an ageing population with significant growth in chronic disease (page 35). There is also a need to ensure that there is a healthy start to life as issues in pregnancy, labour, birth and the first weeks of life can have significant long-term health implications. This demonstrates the importance of effective maternity services.

More than three dozen reports over the past 20 years have recommended that significant reform is required in the provision of maternity services to meet the needs of women and babies in Australia (Australian Health Ministers’ Advisory Council 2011; Commonwealth of Australia 2009; Hirst 2005; Mills & Roberts 1997; NSW Health 2000, 2003a, 2003b; NSW Health Department 1989, 1996; Senate Community Affairs References Committee 1999; Victorian Department of Health 1990; Victorian Health 2004; WA Health Department 2007). These reports have addressed the need to increase access to community-based services, midwifery models of care and flexible services for all women, especially those in rural and remote settings. These reports are supported by a considerable body of national and international evidence again highlighting the need for reform and the unique role of midwives as the key provider of maternity services.

The current regulation systems do not facilitate or enable workforce reform and continue to promote barriers for women’s access to evidence-based maternity services.

As described in the preamble, in Australia, midwives are educated to the full scope of practice as a midwife (ICM 2008) which means they are able to work in a highly flexible manner providing care from pre-pregnancy to 6 weeks after the baby is born. A characteristic of midwifery is their capacity to cross the primary, secondary, tertiary care sectors extending care into the community and linking into other services (Renfrew et al. 2014). If this role were fully utilised, the workforce reforms and improved health outcomes would be significant.

The current regulation system with the NMBA means that there is a lack of clinical governance as many nursing leaders do not understand contemporary midwifery models of care and the importance of enabling midwives to work to the full scope of practice. This lack of understanding of the options and opportunities is hampering the development of a flexible, responsive and sustainable workforce. This is particularly felt in rural and remote Australia.

The ACM has heard many examples from members where midwives who are also registered as nurses have been made to work as general nurses, especially in rural areas. This is despite their desire to work as midwives and if the models of care were re-developed, there would be adequate work for them to function just as midwives, working to the full scope of practice. However, what seems to happen is that these midwives leave the workforce and either move to larger centres or leave midwifery completely. This puts rural women at higher risk as the midwifery workforce is no longer available to provide care and contributes to the closure of services that has frequently happened in the last decade with serious consequences becoming evident.
Alternatively, the ACM has also heard from midwives who are not registered as nurses being required to work as nurses if the health facility requires this. The advice from the NMBA is unclear about the midwife’s accountability and responsibility in this instance. Again, this lack of clarity in regulation places the safety of the public at risk. A lack of timeliness and consistency in addressing registration issues has also meant that midwives are unable to re-enter the workforce after a period on non-registration. The example below highlights a common story from a person seeking to re-register as a midwife after a period of more than 5 years of maternity or child care leave.

**Example 5**
Midwife P allowed her registration to lapse when she was on maternity leave and caring for four children. When she tried to return to practice, she contacted AHPRA a number of times and was given inconsistent information in relation to the number of supervised hours required (ranging from 40 to 450 hours). She was required to undertake a Refresher course (which does not exist in her state). AHPRA requested that she develop her case based on addressing the competency standards for the midwife which she submitted but heard nothing for more than 4 months.

Midwife P reported that she received incorrect and inconsistent advice and had to deal with staff who seemed to have very little knowledge of the working aspects of the profession they are overseeing. There is a significant lack of timeliness with her case taking more than 4 months to even be considered despite being initially told it would take 6 weeks.

Midwife P is very keen to work on a part-time basis in her local hospital (she lives in a rural area that needs midwives). However, this process is long and expensive and she doubts that this will ever be possible.

**Q21: Should a reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?**

As described earlier (Q1), ACM does not agree that a reconstituted AHWAC should carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps unless they are a truly independent council.

**Q22: To what extent are Accrediting Authorities accommodating multidisciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs?**

Accreditation authorities are cognisant of the imperative to accommodate multidisciplinary education and training to address changes in technology, models of care and the changing health needs. To achieve this, the Health Professions Accreditation Council’s Forum\(^6\) was established to address commonalities and opportunities for multidisciplinary education and training.

The purpose of the Forum is:

to work together on issues of national importance to the regulated health professions;
- to identify areas of common interest and concern in relation to the regulated health professions;
- to work toward a position of consensus on identified issues and concerns;
- to take joint action in areas of importance to the regulated health professions;
- to develop joint position statements which provide recommended policy directions for governments and other relevant stakeholders.

Through this Forum, accreditation authorities are modifying their processes to ensure that the important issues of multidisciplinary education is included. For example, the Australian Nursing and Midwifery Accreditation Council has revised their accreditation standards to ensure that multidisciplinary learning is measured and assessed.

Q23: What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

For nursing and midwifery, the Australian Nursing and Midwifery Accreditation Council (ANMAC) is responsible for protecting the health and safety of the Australian community by ensuring a high standard of nursing and midwifery education. Quality education assures the community that the nurses and midwives who complete education programs accredited by ANMAC can register with the Nursing and Midwifery Board of Australia (NMBA) to practice and care for people in a safe and competent manner. To perform this role, ANMAC operate under our National Accreditation Guidelines to:

- Develop accreditation standards for nursing and midwifery programs
- Accredit Australian providers of nursing and midwifery education, and nursing and midwifery programs leading to registration and endorsement

Midwifery programs are assessed by a Midwifery Accreditation Committee made up of contemporary practising midwives, midwifery educators, researchers and managers. This ensures strong midwifery involvement in the development of accreditation standards for midwifery programs and in the assessment of midwifery education. This committee is an excellent model that could be used to improve the current NMBA (see Option 3 above).

Currently there seems to be an appropriate link between the ANMAC and the NMBA. However, the current Board of the ANMAC also needs to better reflect both nursing and midwifery professions.

Assessment of Overseas Trained Practitioners

How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?

The assessment of overseas trained midwives is currently highly challenging across the country. We hear that the state and territory jurisdictions frequently provide inconsistent information to applicants and these are often overly punitive. We provide two examples in the boxes below that highlight the problems in the current system.

**Example 6**

An overseas educated midwife moved to Australia December 2012 and submitted an application in January 2013. In October, she received a letter from the national board stating:

Under section 80(1)(d) of the nation law, the board resolved, in this instance to refer you to a board approved bridging course which includes an assessment of competence as an internationally qualified midwife. The reason for an assessment is that your education in midwifery was not based on similar competencies to a Board approved course, and you are required to demonstrate knowledge and safe practice and the ability to meet the National Competency Standards for the Midwife in the Australian context by successfully completing a Board approved bridging/assessment of competence course prior to registration being granted. Please note however that there are currently no Board approved bridging programs for midwifery offered by education providers in Australia.... As an alternative to completion a bridging program, you may choose to apply to a university in Australia that conducts an NMBA approved Bachelor of Midwifery course and seek credit for prior studies you have undertaken.

When she questioned what was missing from her education they were unable to tell her any particular points or anything in general that was missing. She understood if she would need to study some specific subjects correlating to Australian midwifery practice, but to be advised to do her bachelor’s degree again seemed a bit drastic. She cannot understand why they didn’t inform her from the beginning that she needed to be a registered nurse first in order to have a chance at being registered as a midwife, same as in Finland! There has been such poor information from AHPRA and it has taken them so long to get back to her in the first place.

She spoke to XXXX at AHPRA, and the officer gave her the possibility to map the competencies from Finland against the Australian standards, but this work seems to be a huge effort with no real promise of a positive outcome, everyone she spoke to from AHPRA have commented that she can always take it to the tribunal when this doesn’t work. She feels that it is very unfair that AHPRA puts this work onto her, to be written and paid by her. She cannot understand how they can say that Australia needs midwives.

The individual has reported to the ACM:

“As I got pregnant I decided to put this whole mess aside for a while, but now I have to start pushing this again. I am so tired of the whole process.

I am registered midwife in Finland since December 2005 with a combined bachelor’s degree in midwifery and nursing. The education took 4.5 years, 3 years of basic nursing studies and 1.5 years midwifery studies.

I have worked full time since January 2006 until November 2012 when I moved to Australia. I have worked in postnatal, prenatal, gynae and labour ward and I am a IBCLC [lactation consultant] since 2011.”
Example 7

Overseas qualified midwife Z graduated from a Bachelor program in the UK in 2013 and applied for registration here in January 2014. She was notified that her application had been received. Then 2 months later when she followed up – AHPRA claimed they did not have her documents. She had to pay a Justice of the Peace for another set of copies to send in but again heard nothing for a further 2 months. When she phoned them she was told that they had almost completed her application but the payment had not gone through (they did not notify her at the time).

She gave them the same bank details and the money was withdrawn, then she was advised they would begin processing her application. Another 6 weeks passed so she phoned again to be told that she needed to provide evidence of her continuity of care follow through experience. She explained that this was not required for her UK application as it was included in her transcripts.

Midwife Z felt AHPRA did not keep any record of their conversations with her, were unable to provide any information about the progress of her application, or in relation to the payment being declined, and were unhelpful and unsupportive.

Overseas qualified midwife Z is currently working as a nanny and not hopeful that she will be able to practice midwifery in the short term.

There is also complexity in relation to the role of the NMBA and ANMAC. ANMAC is the assessing authority for the Australian Government’s Department of Immigration and Border Protection (DIBP). ANMAC assesses the skills of nurses and midwives who want to migrate to Australia under the General Skilled Migration category and determine if they are suitable for permanent migration. To perform this role ANMAC:

- Undertakes skills assessments of internationally qualified nurses and midwives who want to migrate to Australia
- Develops, reviews and provides policy advice on accreditation and skilled migration of nurses and midwives

The NMBA however is responsible for the assessment of the registration of individuals which, as we have heighted in our examples, is often poorly done and inconsistent. This means that the assessment of overseas educated midwives is a two-stage process which is unnecessarily burdensome and complex.

The Consultation paper highlights the invisibility of midwifery in this area (page 37). The paper states that

There are two bodies that provide assessment for internationally qualified nurses:

- the Nursing and Midwifery Board of Australia (NMBA) which is ultimately responsible for determining the registration status of all nurses in Australia
- the Australian Nursing and Midwifery Accreditation Council (ANMAC) which has the authority to assess nurses who are applying for a visa under the general skilled migration programme.

We assume that midwives are meant to be included in this section however their exclusion is another example of why the invisibility of midwifery as part of nursing is unhelpful and potentially, unsafe. Increasingly, midwives in Australia (and those
migrating to Australia who were educated overseas) are not nurses first and again this shows why separation from nursing is needed.

**Governance of the National Scheme**

**Q25: Should the appointment of Chairperson of a National Board be on the basis of merit?**

The appointment of Chairperson of a National Board should be on the basis of merit and should be a non-partisan process.

**Q26: Is there an effective division of roles and functions between National Boards and accrediting authorities to meet the objectives of the National Law? If not, what changes are required?**

The ACM believes that the current system where accreditation is undertaken by an independent accreditation authority who make recommendations to the National Board is effective. This separation is important.

The ACM does not support accreditation to be carried out by a sub-committee of the Board.

**Q27: Is there sufficient oversight for decisions made by accrediting authorities? If not, what changes are required?**

It is the view of ACM, that there is sufficient oversight for decisions made by accrediting authorities.

**Proposed changes to the National Scheme**

**Q28: The Review seeks comment on the proposed amendments to the National Law.**

**Protected title changes**

The protected titles need to be amended to reflect titles now in common use. The title Midwife Practitioner is not in common use and that title or role is not supported by the ACM. Since the National Law was implemented, the title of Eligible Midwife has come into usage and legislation. Therefore, ACM recommends:

- Removal of Midwife Practitioner
- Insertion of Eligible Midwife

**Reference to ‘Nursing and midwifery professions’**

Regardless of the organisation of the regulatory structures for nursing and midwifery, it has been demonstrated that midwifery has unique and particular safety and protection of the public, workforce flexibility and access to service reform and innovation that warrants the recognition of midwifery as a distinct profession in the National Law.

Amendments required are tabled in Appendix 1. Of particular note is s284 of the National Law:

S284 (5) (b) Exemption from requirement for professional indemnity insurance arrangements for midwives practicing private midwifery
(5) private midwifery means practicing the nursing and midwifery profession p253

This schedule does not have anything to do with nursing and exemplifies the danger in maintaining the status quo for the protection of the public.

Adequate representation of midwifery

The constitution of National Boards (page 40) under the National Law requires that:

.... at least half, but not more than two-thirds, of the members of a National Board must be persons appointed as practitioner members

This is not the case on the NMBA where at least half the members are not midwives and the members who do have a midwifery qualification are not practising in contemporary midwifery contexts.

As we have highlighted in this submission, the position of ACM is to have a separate Midwifery Board. We have also provided two other options that would not be our preference, however could enhance the protection of the public. These other two options would need to ensure a stronger representation of contemporary practising midwives and maternity consumers.

Nursing and midwifery are two professions from both a role and scope of practice perspective and a safety and protection of the public perspective.

The National Law and other documents from the NMBA, indicate the nursing and midwifery are one profession. Statements such as the ‘nursing and midwifery profession’ (singular) are common. For example, the website states that the function of the NMBA is to:

• develop standards, codes and guidelines for the nursing and midwifery profession

While this may seem pedantic, it is an essential element of recognizing that there are two professions – nursing and midwifery and to ensure that the public are protected through this correct nomenclature. This needs to be addressed in all documents.

Summary

The Australian College of Midwives welcomes the opportunity to contribute to this review. As we have argued, there have been considerable changes in Australian maternity services in the past two decades, mostly driven by consumer demand and by a large body of national and international evidence and this means that changes in the regulation of the profession are required. The ACM believe that maintaining the status quo is no longer in the interests of childbearing women in Australia and creates health system risks and sub-optimal protection of the public. We propose that the best option would be the establishment of a Midwifery Board – the Australian Midwifery Board.

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## Appendix 1 Legislation changes required

<table>
<thead>
<tr>
<th>Current</th>
<th>Amendment required</th>
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</thead>
<tbody>
<tr>
<td>S37 (e) Nursing and Midwifery profession p15</td>
<td>Nursing and Midwifery profession</td>
</tr>
<tr>
<td><strong>Nursing and Midwifery professions</strong></td>
<td>Nursing and Midwifery professions – plural</td>
</tr>
<tr>
<td>Part 5 – National Boards – s31(1) Establishment of National Boards pg 75</td>
<td>Nursing and Midwifery Board</td>
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<tr>
<td></td>
<td>Separate titles Nursing and Midwifery Boards</td>
</tr>
<tr>
<td>Subdivision 3- s96 Endorsement in relation to midwife Practitioner pg 110</td>
<td>The term ‘Midwife Practitioner’ not one used in midwifery</td>
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<tr>
<td></td>
<td>The one registrant in NSW should have the title protected.</td>
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<tr>
<td>s113 – Protected Titles – table on pg 120</td>
<td>Nursing and Midwifery</td>
</tr>
<tr>
<td></td>
<td>Separate these out into two separate lines Nursing one line Midwifery second line</td>
</tr>
<tr>
<td>Table – Public national registers pg 180</td>
<td>Nursing and Midwifery Board of Australia</td>
</tr>
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<td></td>
<td>Revise to reflect distinct nursing and midwifery boards</td>
</tr>
<tr>
<td>Division 8 Children and Community Services Act 2004 amended s39 (2)</td>
<td>Nursing and midwifery profession</td>
</tr>
<tr>
<td></td>
<td>Nursing and Midwifery professions – plural</td>
</tr>
<tr>
<td>Division 9 Civil Liability Act 2002 s41 (iv) s42(1) p18</td>
<td>Nursing and midwifery</td>
</tr>
<tr>
<td></td>
<td>Reflect separate professions of nursing and midwifery</td>
</tr>
<tr>
<td>s44 Nursing and Midwifery Board of Australia (8)</td>
<td>Nursing and Midwifery Board of Australia</td>
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<td>Reflect two Boards</td>
</tr>
<tr>
<td>Division 12 Corruption and Crime Commission s48 Nursing and Midwifery Profession p 22 s50 p23 S103, s112, s121, s139 (7), 153s154</td>
<td>All use nursing and midwifery profession</td>
</tr>
<tr>
<td></td>
<td>Needs to reflect both professions – by adding ‘s’ to the word profession</td>
</tr>
<tr>
<td>Division 38 - Oaths, Affidavits and Statutory Declarations Act 2005;</td>
<td>nursing and midwifery profession</td>
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<tr>
<td></td>
<td>Nursing and midwifery professions – plural</td>
</tr>
<tr>
<td>Division 16 – Criminal Investigation (2) p25</td>
<td>nursing and midwifery profession</td>
</tr>
<tr>
<td></td>
<td>Nursing and midwifery professions – plural</td>
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<tr>
<td>Division 42</td>
<td>nursing and midwifery profession</td>
</tr>
<tr>
<td></td>
<td>Nursing and midwifery professions – plural</td>
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<tr>
<td>P28 p40,43,47,57,65,253</td>
<td>All use nursing and midwifery profession</td>
</tr>
<tr>
<td></td>
<td>Change to nursing and midwifery professions – plural</td>
</tr>
<tr>
<td>Table of National registers P222 – both professions under one heading</td>
<td>Register of Nurses Register of Midwives</td>
</tr>
<tr>
<td></td>
<td>Separate headings for nursing and midwifery</td>
</tr>
<tr>
<td>S284 (5) (b) Exemption from requirement for professional indemnity insurance arrangements for midwives practicing private midwifery (5) private midwifery means practicing the nursing and midwifery profession p253</td>
<td>National Board means the Nursing and Midwifery Board of Australia; practicing the nursing and midwifery profession</td>
</tr>
<tr>
<td></td>
<td>This applies solely to midwifery - There should be no reference to nursing</td>
</tr>
</tbody>
</table>
References


Barclay, L. 2008, 'A feminist history of Australian midwifery from colonisation until the 1980s', *Women and Birth*, vol. 21, no. 1, pp. 3-8.


NSW Health 2003a, Models of Maternity Service Provision, NSW Department of Health, Sydney.


Senate Community Affairs References Committee 1999, Rocking the Cradle: A Report into Childbirth Procedures, Commonwealth of Australia, Canberra.


controlled trial. (Midwives @ New Group practice Options: M@NGO trial)', *The Lancet*, vol. 382, no. 9906, pp. 1723 - 32.

