Introduction:

Many thanks for the opportunity to provide some input into this review, this submission will focus on some of the questions presented by the NRAS review – it also supports the Australian College of Midwives (ACM) Submission and many of the concepts of this submission are based on the ACM submissions with some of my own variations.

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

The first option, and in my view is 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). I am 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 mindful 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 judgment.
- Increased protection of the public through the nimbleness of a midwifery focused 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.

I 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 proposal is 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.

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.

**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 (Also see ACM submission)

It is 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.

☐ The costing are based on the revenue from the 2012-13 Annual report
☐ Midwifery registrants constitute 9.48% of all NMBA registrants and is used on a pro rata basis for calculations.

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.\(^2\)

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. 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. 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.

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?

\(^1\) AHPRA Annual Report 2012/13. p143
\(^2\) AHPRA Annual Report 2012/13
I am 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.

I feel 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 it is possible that you 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.

**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.*

This seems a reasonable option however 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. 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.

It is important to remember 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?

It is important 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?

It would be important 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.

Complaints and Notifications

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

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, 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. I have been made aware of many complaints from colleagues that there are long delays in processing complaints. 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.

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. This system is new and untested; only time will tell if this new system will be effective. It is better to fix the current system before introducing another 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.

Q12: Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?
Consistency is essential therefore it is agreeable 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, notifies need to be made aware of the outcome in a timely and respectful manner.

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.

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?
Yes, 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.

**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.

**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.

**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. It is very important to protect midwifery practice – that is all facets of midwifery care;

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. The other issue is that of Doulas who attend birth without a midwife or doctor present this is problematic and needs addressing.

**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.

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.

It is important for a National Law to be consistent therefore 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.

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.

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:

- [ ] 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 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.

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

As a health practitioner I welcome the opportunity to contribute to this review. Key points are that it is important to note that Nursing and Midwifery are two distinct professions therefore requiring acknowledgement of this as in recognition of two Boards. 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. I would propose that there be a separation of the professions and an establishment of an Australian Midwifery Board.

Appendix 1 Legislation changes required

Sections of the National Law that needs to be amended – referring to Nursing and Midwifery Board of Australia and or Nursing and Midwifery Profession.

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<tr>
<th>Current</th>
<th>Amendment required</th>
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<tr>
<td>S37 (e) Nursing and Midwifery profession p15</td>
<td>Nursing and Midwifery professions</td>
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<tr>
<td>Part 5 – National Boards – s31(1) Establishment of National Boards pg 75</td>
<td>Separate titles Nursing and Midwifery Boards</td>
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<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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<td>s113 – Protected Titles – table on pg 120</td>
<td>Separate these out into two separate lines Nursing one line</td>
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<td>Table – Public national registers pg 180</td>
<td>Midwifery second line</td>
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<td>Division 8 Children and Community Services Act 2004 amended s39 (2)</td>
<td>Nursing and midwifery profession</td>
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<td>Division 9 Civil Liability Act 202 s41 (iv) s42(1) p18</td>
<td>Nursing and midwifery</td>
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<td>s44 Nursing and Midwifery Board of Australia (8)</td>
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<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>
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<td>Division 38 - Oaths, Affidavits and Statutory Declarations Act 2005;</td>
<td>nursing and midwifery profession</td>
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<td>Division 16 – Criminal Investigation (2) p25</td>
<td>nursing and midwifery profession</td>
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<td>Division 42</td>
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<td>P28 p40,43,47,57,65,253</td>
<td>All use nursing and midwifery profession</td>
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<tr>
<td>Table of National registers P222 – both professions under one heading</td>
<td>Register of Nurses</td>
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<td>Register of Midwives</td>
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<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>
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<td></td>
<td>This applies solely to midwifery - There should be no reference to nursing</td>
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