



## **First Principles Review of the Indemnity Insurance Fund (IIF): Midwife Professional Indemnity Support Schemes**

**The Australian College of Midwives (ACM)** is a national, not-for-profit organisation that serves as the peak professional body for midwives in Australia. The ACM 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. We provide a unified voice for the midwifery profession, support midwives to reach their full potential and inform professional practice and education standards.

**The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)** was founded in 1997 with a primary role to represent, advocate and support Aboriginal and Torres Strait Islander nurses and midwives at a national level. Aboriginal and Torres Strait Islander health professionals play a critical role in the delivery of improved social and emotional wellbeing outcomes for all Australians. CATSINaM is committed to providing national leadership around Aboriginal and Torres Strait Islander health and health workforce policy development and implementation.

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### **Introduction**

In our work with privately practising midwives, the ACM and CATSINaM have encountered a number of challenges and barriers regarding indemnity insurance and welcome this opportunity to provide feedback on the Indemnity Insurance Fund.

The complexity of insurance policy has resulted in one option for insurance being available for private midwives, i.e. insurance available under Government contract with Medical Insurance Group of Australia (MIGA) through the *Commonwealth midwife indemnity support schemes*. In addition to meeting national registration requirements, to be eligible to access the schemes midwives are required to undertake another endorsement with the Nursing and Midwifery Board of Australia (NMBA); be self-employed and directors of their own company, and have written collaborative agreements with doctors or healthcare services that employ obstetricians. Further, midwives who wish to be insured to provide intrapartum care in healthcare facilities must have access agreements with each facility they access.

One of the points raised by Government is the low level of uptake by practitioners, which is caused by a number of factors, not least the barriers erected by the requirements of the schemes, the cost of becoming endorsed and the more expensive MIGA insurance product, the lack of an insurance product for planned homebirth, and the low level of entry into private practice.

These barriers have resulted in the loss of a number of excellent privately practising midwives from the midwifery profession. These barriers have further negatively affected the

services provided by private midwives, which has reduced the ability of women to choose their care providers and place of birth. This flies in the face of the intent of the policy at its inception.

The ACM and CATSINAM will address these barriers and the impact they have on the efficacy of the schemes, and complete this submission with recommendations for how the schemes can become more user-friendly, which in turn will improve uptake by midwives and increase choice of maternity services for women.

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## **1. Does there continue to be a need for the Commonwealth midwife indemnity support schemes?**

The *Commonwealth midwife indemnity support schemes* are essential for midwives providing Medicare rebated care. Midwives who work outside state government employment require Professional Indemnity Insurance (PII) in order to meet the conditions of their midwifery registration<sup>1</sup>. These midwives currently have no affordable commercial options for insurance available and therefore are completely reliant on the *Commonwealth midwife indemnity support schemes* in order to register and practise.

For those midwives who access the schemes, it does work reasonably well. However, the low level of uptake of the schemes are as a result of many complex elements.

Low uptake of the schemes relates to the following:

- Midwives needing to be endorsed by the NMBA before they can apply for and be accepted into the insurance schemes, and in particular, the requirement of the NMBA for midwives to have achieved the equivalent of three years full time experience before they can apply for endorsement;
- Lack of insurance across the childbirth continuum for planned birth at home;
- Low level of entry into private practice generally, associated with:
  - Cost of private practice, including insurance, especially for midwives who have small caseloads or provide locum or back-up services;
  - Bureaucratic barriers into private practice, including care plans/collaborative arrangements; and
  - Lack of visiting access arrangements meaning the midwives in all states other than Queensland have limited opportunity to provide intrapartum care.

### ***1.1 Requirement to be endorsed***

In order to be able to access the schemes, private midwives are required to be endorsed, as in the NMBA *Endorsement for scheduled medicines for midwives*<sup>2</sup> (endorsement).

Endorsement is the pathway to a Medicare provider number and access to the Pharmaceutical Benefits Schemes (PBS). In order to achieve endorsement, private midwives are required by the NMBA to:

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<sup>1</sup> <http://www.nursingmidwiferyboard.gov.au/Registration-Standards/Professional-indemnity-insurance-arrangements.aspx>

<sup>2</sup> Endorsement for scheduled medicines for midwives:

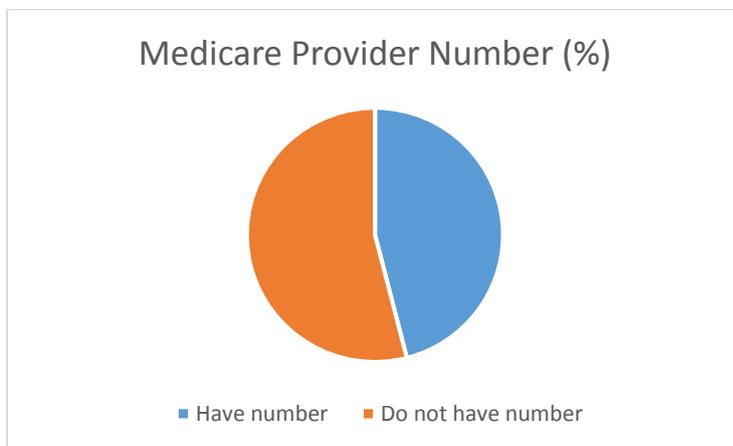
<http://www.nursingmidwiferyboard.gov.au/Registration-Standards/Endorsement-for-scheduled-medicines-for-midwives.aspx>

- Have midwifery registration in Australia
- Have the equivalent of three years' full-time clinical practice (5,000 hours) as a registered midwife
- Successfully completed an approved course of study about drugs, prescribing and diagnostics.

This requirement to be endorsed before they can access the *Commonwealth midwife indemnity support schemes*, presents a large barrier to midwives.

Griffith University is one of the universities in Australia that delivers an approved prescribing course for midwives wishing to apply for endorsement. The university surveyed the graduates of its 'Prescribing for Midwives' course in 2017. Only 19 of 41 respondents (46%) responded that they had completed the course and had applied for and obtained their Medicare provider number.

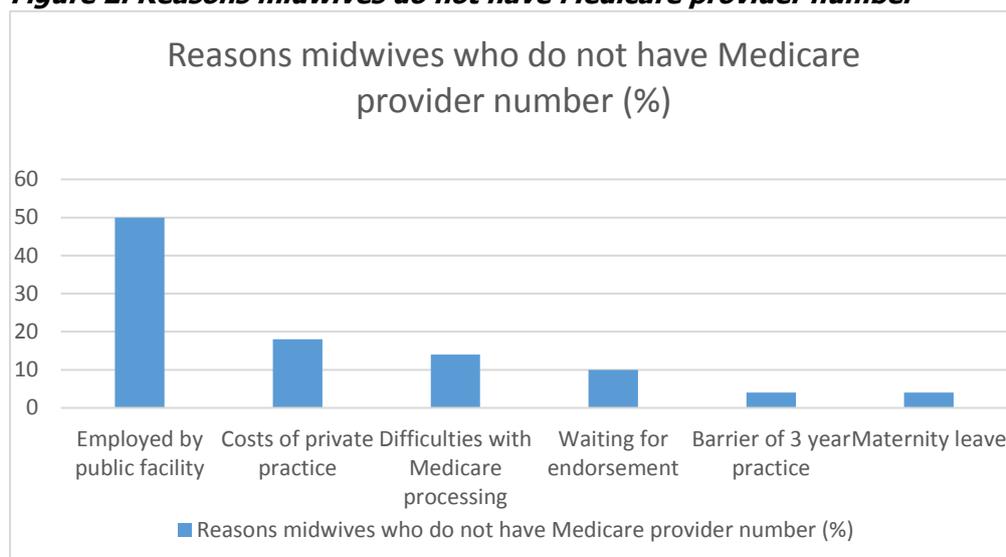
**Figure 1. Number of 'Prescribing for Midwives' course postgraduate midwives from Griffith University who have a Medicare provider number**



There were a number of reasons why the remaining 22 respondents had not applied for, or obtained their Medicare number:

- Employed by a public hospital or facility so could not prescribe because of local policies (n=11, 50%)
- Unable to afford ongoing requirements of private practice including insurance (n=4, 18%)
- Difficulties with Medicare processing application (n=3, 14%)
- Waiting for NMBA to process application for endorsement (n=2, 10%)
- Did not yet meet requirement for three year's full time equivalent practice (n=1, 4%)
- On maternity leave (n=1, 4%)

**Figure 2. Reasons midwives do not have Medicare provider number**



In particular, the requirement for midwives to have completed the equivalent of three years full time practice before they can apply for endorsement is draconian and prevents midwives accessing insurance, especially midwives new to the midwifery register, and those who work part time hours. The indemnity schemes does not provide any mechanism to support transition into being an endorsed, private practice midwife. Midwives are forced to work in the public sector until they can gained the required hours of experience. The requirement for *endorsement* has severely affected availability of midwives providing back-up, locum or second-midwife services to private midwives, especially in rural or remote areas.

The requirement for three years equivalent experience as a midwife prior to endorsement has no logical basis. The requirement for endorsement should relate to scope of practice. The scope of practice of all midwives upon registration is to exercise occupational autonomy around normal, physiological birth. The scope of practice of an Endorsed Midwife is exactly the same. The only difference between a midwife and an endorsed midwife is the additional education required to attain endorsement to prescribe scheduled medicines. This education is currently at a post-registration level related to prescribing - it is not related to midwifery practice. There is no evidence to demonstrate that a three-year post-registration period is necessary as a mandatory requirement to attain endorsement, ergo prior to obtaining insurance. This barrier is recommended to be reduced to 12 months following initial registration in keeping with the length of time it takes to complete the studies.

## **1.2 Lack of insurance across the full continuum of care for a planned homebirth**

The lack of indemnity insurance for intrapartum care at home is a barrier to midwives who provide homebirth services. Whilst the *Exemption*<sup>3</sup> may be accessed for intrapartum care, the ongoing lack of certainty around insurance for homebirth has restricted practice and resulted in private midwives discontinuing practice and thus accessing the schemes to cover antenatal and postnatal care only.

<sup>3</sup> The *Exemption* is the mechanism whereby midwives who provide intrapartum homebirth service are exempted from PII: <https://www.midwives.org.au/insurance-exemption-private-midwives>

The lack of insurance for intrapartum care at a planned homebirth has resulted in the loss of a basic human right for many women– the right to be able to choose their place of birth. This right is underpinned by the National Maternity Services Plan<sup>4</sup>, which was auspiced and supported by all Australian Governments, states that providing a range of services and options for maternity care, including homebirth “is a priority”.

The lack of access to homebirth services provided by private midwives is forcing women to choose unsafe options such as employing support people who are not midwives, or having unassisted births resulting in less than optimal clinical outcomes for both women and babies.

### **1.3 Low level of entry into private practice**

The low level of entry into private midwifery practice impacts on the uptake of the insurance schemes. This low level of entry into private midwifery practice is associated with a number of factors as discussed below.

#### **1.4 Bureaucratic barriers, including collaborative agreements**

The requirements of the Determination<sup>5</sup> are a further barrier to midwives going into private practice and accessing the insurance schemes, particularly the conditions around collaboration. Midwives are the only group of health professionals who work in private practice who are required to have collaborative arrangement with another health profession to access Medicare rebates. This is an unequal impost which is unreasonable and unfair. It is also unnecessary from a clinical practice perspective, as midwives are regulated and educated to practice to a scope and to consult and refer when indicated. Further, midwives around Australia have found it very difficult to establish collaborative arrangements with doctors or facilities for a number of reasons, not least because of other professionals wanting to maintain competitive advantage. Being at the “mercy” of another profession or business is anti-competitive and is a restriction of trade, resulting in midwives being unable to carry out their business.

##### **1.4.1 Lack of visiting access arrangements around Australia**

The lack of consistent and equitable visiting access arrangements around Australia, especially for the provision of intrapartum care, apart from Queensland, has prevented midwives entering private practice and thus accessing the schemes. It is imperative that all states and territories not only provide visiting access arrangements that meet the intent of legislation, but that they also be equitable with other private practitioners using facility services. This includes ensuring hospitals and facilities have consistent approach to acceptance of business PII for access agreements to hospitals for all practitioners. Currently, there are hospitals that accept doctors’ business insurance policies but reject the business policies of midwives. The ACM and CATSINAM understand the roles of the jurisdictions in determining this policy but the Commonwealth has significant influence that could be brought to bear.

##### **1.4.2 Cost of private practice, including insurance**

The cost of private practice, including insurance, is another factor why midwives do not enter the schemes. For midwives who have a small caseload, such as rural and remote midwives, as well as midwives who provide locum or back-up services, the cost is

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<sup>4</sup> <http://www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesplan>

<sup>5</sup> <https://www.legislation.gov.au/Details/F2013L01485>

prohibitive. The revenue they make from the small numbers of women in their care does not make private practice viable, including the cost of insurance. The ongoing cost of run-off insurance paid for three years is also problematic especially for midwives who take a career break, go onto maternity leave, retire, or are unable to work, particularly for unplanned reasons such as illness or injury.

Another example of financial burden is midwives employed in small private midwifery practices. These midwives are unable to access the schemes and rely on the insurance of their employers. Yet for small private practices, such insurance is extremely expensive and in some instances, prohibitive. There is no logical reason why insurance should be accessible to only private midwives who have an endorsement. All midwives providing services in private midwifery practice should be able to access the insurance schemes. It is worth noting that employed doctors have the ability to access a Commonwealth schemes, the Premium Support Schemes, but midwives cannot. This inequity discriminates against midwives and is unacceptable.

The endorsed midwife is eligible to apply for a Medicare provider number for the PBS and the MBS. These rebates are not available for care from employed midwives with one exception, those employed in an Aboriginal Medical Service or Aboriginal Community Controlled Health Organisations (ACCHOs). However, the insurance schemes are not available to endorsed midwives employed by ACCHOs or AIMs by virtual of the fact that they are employed. ACCHOs and AIMs have been unable to secure affordable PII to cover their employed midwives. This not only presents a barrier to employing endorsed midwives but impacts on the implementation of Birthing on Country<sup>6</sup> models of maternity care for Aboriginal and Torres Strait Islander women and babies, which is another priority of the National Maternity Services Plan.

### ***1.5 Impact on women of the low uptake of insurance and private midwifery***

The National Maternity Services Plan has clearly identified as a priority, and committed to, access for women to different models of maternity care, including private midwifery services. Continuity of midwifery care, which is usually provided in the private midwifery model, has been demonstrated to provide improved clinical outcomes and greater satisfaction than routine care, as well as being more cost-effective<sup>7</sup>. Further, the Federal Government implemented the reforms, which gave private midwives access to Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) as a strategy to support private midwifery and increase options for women. This policy enables women to access the services provided under the MBS and subsidies for certain medicines prescribed by midwives under the PBS. The insurance schemes was devised to underpin and “facilitate the sustainability of private midwifery-managed models”.

It is vital to address and remove the barriers that are preventing private midwives from accessing insurance, because these barriers are impeding national policy and preventing the full implementation of the National Maternity Services Plan. Furthermore, the low uptake of insurance and private midwifery is preventing women from accessing a range of models of

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<sup>6</sup> <https://www.midwives.org.au/birthing-country-project>

<sup>7</sup> <https://www.midwives.org.au/shop/continuity-care-handbook-hardcopy>

care, including continuity of care, which is so often women's preferred option for maternity care.

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**2. Are the current Commonwealth midwife indemnity support schemes the most appropriate way of providing professional indemnity insurance for privately practising midwives? Why?**

The current schemes is the most appropriate way due to the consistency across all jurisdictions and the level of cover it provides in an already fragile market.

At the moment there is no alternative to the Commonwealth schemes as there has been no movement in the availability of affordable PII for private midwives, and an unwillingness of the market to participate. Insurers require claims history to be reassured about their exposure or be able to quantify their potential exposure. Currently, the only yardstick insurance companies have is obstetrics and the practice of obstetricians, which is not a comparable profession to midwifery. Obstetricians, by the very nature of their work with, and responsibility for, high risk women and clinical scenarios, are more likely to be involved in adverse events than midwives, who for the most part work with low-risk women and babies.

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**3. Are there alternative models of providing indemnity insurance for privately practising midwives? If so, what are they and what barriers and/or enablers are there to implementing these models?**

There are no realistic alternatives available for privately practising midwives. No commercial insurance product is available and there appears to be insufficient numbers of midwives to develop any alternative at this stage.

In relation to homebirth, the Commonwealth could choose to self-insure midwives providing private homebirth services subject to accreditation and participation in schemes such as MidSURE developed by the ACM.

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**4. If the current midwife indemnity support schemes are retained could they be improved, and if so, how?**

Until such time that alternative commercial products are made available, it is vital that the indemnity support schemes are retained. A number of improvements both to the schemes and to the overall policy position surrounding private practice would make the schemes more suitable and enable increased uptake.

## **The ACM and CATSINAM recommend the following improvements to the midwife indemnity support schemes.**

### **Recommendation 1:**

That the requirement for midwives be endorsed be removed from the conditions of the Commonwealth supported insurance schemes.

Access to the current midwife indemnity schemes should be accessible to non-endorsed midwives who do not carry a caseload yet provide locum, back-up or second midwife services. This will not only ensure these midwives are adequately covered by insurance, but also support endorsed midwives in their practice, especially at planned birth at home. Further, this will improve women's access to appropriately trained and qualified birth attendants. This is a matter of protection of the public and enabling endorsed midwives to comply with regulatory standards and requirements.

### **Recommendation 2:**

That the requirement for midwives to have achieved three-year equivalent of full-time practice be removed from the NMBA registration standard for endorsement, and thus as a requirement to be able to access the insurance schemes.

There is no evidence-base or logical reason for this requirement. The registration standard for endorsement does not ensure ongoing competency or quality of practice; the *NMBA Safety and quality guidelines for privately practising midwives*<sup>8</sup> and yearly audit process provide a safety and quality framework to regulate midwifery practice.

### **Recommendation 3:**

That homebirth be added to the schemes.

The insurance schemes should include provision of planned homebirth by appropriately qualified midwives who are networked into local services for women in categories A and B of the ACM *Consultation and Referral Guidelines*<sup>9</sup>, and meet standards and policies such as the ACM *Birth at Home Practice Standards*<sup>10</sup> and *Transfer from Planned Birth at Home Guidelines*<sup>11</sup>.

### **Recommendation 4:**

That the requirement for midwives to be directors of their own company be removed; this is too restrictive in terms of business and growth, and prevents midwives from accessing the schemes.

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<sup>8</sup> <http://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/Endorsements-Notations.aspx#eligible>

<sup>9</sup> ACM C&R Guidelines are available here: <https://www.midwives.org.au/resources/national-midwifery-guidelines-consultation-and-referral-3rd-edition-issue-2>

<sup>10</sup> <https://www.midwives.org.au/resources/australian-college-midwives-birth-home-midwifery-practice-standards>

<sup>11</sup> <https://www.midwives.org.au/resources/australian-college-midwives-transfer-planned-birth-home-guidelines>

**Recommendation 5:**

That change be made to the legislation that currently prevents midwives who are employees of a Private Midwifery Practice (as for General Practice) to purchase insurance.

This will take the pressure off practices needing to access expensive private practice insurance products, especially small midwifery practices. The Commonwealth may wish to integrate some restrictions to ensure large corporates who can afford business insurance do not take advantage or exploit this workforce.

**Recommendation 6:**

That an appropriate level of cover be provided to protect the women and the midwives, as well as the collaborators.

Doctors and healthcare services need to be reassured as to the robustness of the policy such that it is comparable to the medical schemes.

**Recommendation 7:**

That the unequal impost on midwives as the only profession required to collaborate, be removed.

The requirements for written collaborative agreements/care plans should be relaxed, and/or removed from legislation. Midwives should be required to comply with the same regulatory, professional and facility requirements as any other private health practitioner, including private obstetricians and nurse practitioners.

**Recommendation 8:**

That the Commonwealth use its influence with the jurisdictions to ensure there is consistent and equitable visiting access arrangements for private midwives to hospitals and facilities across Australia, modelled on the successful approach that Queensland has taken.

This includes a consistent approach to acceptance of business PII for access agreements to hospitals and facilities for all practitioners.

**Recommendation 9:**

That Aboriginal Community Controlled Health Organisations and Aboriginal Medical Services employing midwives have access to the schemes to support the provision of midwifery care to Aboriginal and Torres Strait Islander women and enable to implementation of 'birthing on country' models of midwifery/maternity care.

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