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Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009

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Contents

Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009

Date introduced: 24 June 2009

House: House of Representatives

Portfolio: Health and Ageing

Commencement: Formal provisions on Royal Assent. Schedule 1, dealing with the new Medicare benefits and Pharmaceutical benefits arrangements, commences the day after Royal Assent.

Schedule 2, incorporating changes to indemnity arrangements, will commence when the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act commences (proposed for 1 July 2010).

Links: The relevant links to the Bill, Explanatory Memorandum and second reading speech can be accessed via BillsNet, which is at http://www.aph.gov.au/bills/. When Bills have been passed they can be found at ComLaw, which is at http://www.comlaw.gov.au/.

Purpose

To facilitate new arrangements:

- to expand the role of qualified, eligible nurse practitioners and midwives to allow them to request appropriate diagnostic imaging and pathology services for which Medicare benefits can be paid
- to allow qualified, eligible nurse practitioners and midwives to prescribe certain medicines on the Pharmaceutical Benefits Scheme

Background

Basis of policy commitment

Medical workforce shortages have been a cause for concern in Australia since the mid 1990s. More recently, however, it has been acknowledged that shortages also exist throughout most of the health professions. In 2005, the Productivity Commission released a groundbreaking report which argued that there was no simple solution to this problem. A multi-pronged national approach was required. Such an approach was needed to deal with structural pressures on the health system caused by a changing mix of disease burdens, rising expectations of patients, ageing of the population and the health workforce and various technological advances. The Commission suggested that one aspect of the

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approach may be to integrate new models of care and workforce practices into health planning 'to accommodate and utilise the wider range of treatment possibilities'.[1]

The Commission's report was labelled by some as 'a wake-up call' which proposed radical changes that could embrace the full scope of the health workforce, rather than focusing simply on doctors.[2] In contrast, certain critics saw the Commission's reform agenda as advocating the substitution of highly trained medical practitioners with other, lesser trained health workers.[3]

The Howard Government (1996–2007) did not respond to the Commission's recommendations advocating the exploration of alternative health workforce solutions. Throughout its term the Howard Government's strategy in addressing health workforce shortages focussed on increasing numbers of medical and nursing students and support for traditional definitions of the scope of practice for doctors and nurses.[4]

While the Labor Party also promised to increase university places for nurses, prior to the 2007 election campaign, it indicated that it was equally prepared to consider new approaches to workforce issues.[5] One such approach involved looking at alternative ways to use the expertise of nurse practitioners, mental health nurses and midwives.[6] (See box 1 for definition of these practitioners by the Australian Nursing and Midwifery Council.)

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1. Productivity Commission, *Australia's health workforce*, December 2005, viewed 14 July 2009, http://www.pc.gov.au/__data/assets/pdf_file/0003/9480/healthworkforce.pdf
2. J Lumby, 'A health system more responsive to patient's needs is a cure-all for many', *Sydney Morning Herald*, 23 January 2006, viewed 14 July 2009, http://parlinfo/parlInfo/download/media/pressclp/JQJI6/upload_binary/jqji63.pdf;fileType=application/pdf#search=%22nurse%20practitioners%22
3. Australian Medical Association (AMA) *Formal AMA response to the Productivity Commission's position paper on Australia's health workforce*, AMA, Canberra, 16 November 2005, viewed 14 July 2009, http://www.ama.com.au/node/2166
4. For example, the Coalition's 2007 election policy promised to increase the number of general practice training places to 900 training places by 2011, increase specialist training places in private settings to 300 by 2011 and increase nursing places to 10 100 also by 2011. It also committed to introduce 500 new hospital-based nursing training places, commencing in 2008. The Coalition Government, Election 2007 Policy, '*More Australia trained doctors, nurses and specialists*', viewed 17 July 2009, http://www.liberal.org.au/about/documents/AustralianTrainedDoctors.pdf
5. Australian Labor Party, *9250 extra nurses to take pressure off Australia's hospitals*, media release 17 October 2007.
6. N Dragon, 'Federal election 2007: health at the crossroads: who will lead the way?', *Australian Nursing Journal*, vol. 14, no.10, May 2007, viewed 17 July 2009, http://parlinfo/parlInfo/download/library/jrnart/Q25N6/upload_binary/q25n65.pdf;fileType%3Dapplication%2Fpdf

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Box 1: definition of nurse practitioners and midwives

Nurse practitioners

The Australian Nursing and Midwifery Council definition of a nurse practitioner is:

A nurse practitioner is a registered nurse, educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients, using nursing knowledge and skills and may include, but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations.[7]

Nurse practitioners have proven an innovative means of supplementing the services of doctors in a number of countries including the United States and New Zealand. Nurse practitioners were first introduced in New South Wales in 2000. There were 367 nurse practitioners in Australia in April 2009.[8]

Requirements to become an authorised nurse practitioner differ in each state and territory but generally, nurse practitioners are required to have completed a Masters degree and in some states, a medication module for prescribing rights.

Midwives

The Australian Nursing and Midwifery Council describes a midwife as a person who has completed a prescribed course of studies in midwifery and is registered or legally licensed to practice midwifery.

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.

7. Australian Nursing and Midwifery Council (ANMC), *Nurse practitioner competency standards*, ANMC, Canberra, 2006, viewed 17 July 2009, http://www.anmc.org.au/docs/Publications/Competency%20Standards%20for%20the%20Nurse%20Practitioner.pdf
8. Information from the Australian College of Nurse Practitioners, Australian Nursing Federation (ANF), *A snapshot of nurse practitioners*, ANF, 2009, viewed 17 July 2009, http://www.anmc.org.au/docs/Publications/Competency%20standards%20for%20the%20Midwife.pdf

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> 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 involves 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.[9]

Following Labor's election victory, the Minister for Health and Ageing, Nicola Roxon, raised the issue of the possible re-allocation of tasks between general practitioners and other health professionals in a number of instances. She considered that many routine tasks currently performed by medical practitioners could be better delivered by other health practitioners. This type of greater involvement of allied health workers in the delivery of care could particularly ease the workforce burden of general practitioners by freeing up their time and skills, which could then be more effectively used for the benefit of patients. In a September 2008 speech she argued:

> … there needs to be an incentive for doctors to eschew less complex work, and focus on the work that does require their high level skills and expertise. Or if doctors don't want to let go of [less complex work], to accept being paid less for devoting their highly skilled and heavily trained selves to less complex tasks than they might.[10]

Later in the year Minister Roxon encouraged nurse practitioners to increase their numbers. She suggested that providing them with access to the Medicare and Pharmaceutical Benefits Schedules would represent a 'positive and opportunistic' outcome for the health system.[11]

Maternity Services Review

In June 2008, the Minister directed the Commonwealth Chief Nurse and Midwifery Officer, Rosemary Bryant, to conduct a Maternity Services Review (the review). The

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9. Australian Council of Nursing and Midwifery, *National competency standards for the midwife*, Canberra, 2006, viewed 17 July 2009, http://www.anmc.org.au/docs/Publications/Competency%20standards%20for%20the%20Midwife.pdf
10. N Roxon (Minister for Health and Ageing), Annual Ben Chifley Memorial Light on the Hill Speech, *The light on the hill: history repeating*, Bathurst, 20 September 2008, viewed 17 July 2009, http://www.asmi.com.au/documents/Roxon%20Light%20on%20The%20Hill%20Speech%20Sept%2008.pdf
11. P Smith, 'Roxon pushes ahead with nurse agenda', *Australian Doctor*, 7 November 2008, viewed 17 July 2009, http://parlinfo/parlInfo/download/library/jrnart/F22S6/upload_binary/f22s61.pdf;fileType=application/pdf#search=%22nurse%20practitioners%22

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review attracted more than 900 submissions from a range of stakeholders, including health professionals, researchers, non-government organisations, representative organisations and individuals.

The review report, released in February 2009, noted that Australia is one of the safest countries in the world in which to give birth or to be born. At the same time, maternity care was seen not to be meeting the needs of all women.[12]

Issues raised in submissions to the review reflected the different perspectives of stakeholders. These included:

- consumer concern about the limited choices in models of care available
- midwives' and nurses' concerns about a lack of recognition for the services they provide and constraints on their practice caused by funding and lack of indemnity
- the medical profession's concern that changes to maternity care could result in the loss of specialist expertise. Medical practitioners expressed particular concern about the safety repercussions of home birthing as a possible endorsed maternity services option for women.

The review made a number of recommendations in what it identified as key areas:

- safety and quality
- access to a range of models of care
- inequality of outcomes and access
- information and support for women and their families
- maternity workforce and
- financing arrangements.

Expanding the role of midwives to deliver greater access to a range of models of maternity care within a collaborative multidisciplinary care environment was central to the review's recommendations. Supplementary to this fundamental recommendation were proposals that the Government consider changes to funding arrangements for midwives and support for the provision of professional indemnity insurance. The review also recommended the introduction of cross-professional guidelines, which could support collaborative care arrangements, collection of data and the monitoring of new models.

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12. Maternity Services Review, *Improving maternity services in Australia*, Commonwealth of Australia, Canberra, 2009, viewed 17 July 2009, http://www.health.gov.au/internet/main/publishing.nsf/Content/64A5ED5A5432C985CA25756000172578/$File/Improving%20Maternity%20Services%20in%20Australia%20-%20The%20Report%20of%20the%20Maternity%20Services%20Review.pdf

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While the review report argued that women needed comprehensive and reliable information about the range of antenatal, birthing and postnatal care, one omission in the area of birthing options that some consider it did not address in detail—home birthing—has become the subject of considerable debate.

Response to the Maternity Services Review was mixed, and arguably, based on preconceived perceptions of what should be a legitimate role for the nursing profession. The Royal Australian College of General Practitioners (RACGP) was tentative in its reaction. On the one hand, the college was supportive of the teamwork approach to maternity services the review recommended. However, it was concerned about possible fragmentation of care created by 'new silos of care delivery', which it believed would be created by increasing the responsibility and scope of nursing practice.[13] Similarly, while the Rural Doctors Association of Australia welcomed the review's recommendations, at the same time, it noted its belief that medical practitioners are the 'key to improving access to maternity services in rural Australia'.[14] Nursing bodies on the other hand, were enthusiastic about the review's conclusions; the Australian Nursing Federation(ANF) labelled it 'a good beginning' and the college of midwives applauded its intentions.[15]

From a consumer perspective, the Consumers Health Forum (CHF) concluded that overall, the review's recommendations would deliver a more people-centred, flexible, team-centred health system.[16] But on the negative side, CHF was disappointed that the review did not recommend professional indemnity coverage for midwives in private practice.[17] Associate Professor of Midwifery at the University of Western Sydney, Hannah Dahlen, was also generally positive about the review. But she expressed concern that more consideration was not given to creating an effective homebirth model. She warned that 'if homebirth was pushed underground and its skills lost, safety would ultimately be

13. Royal Australian College of General Practitioners (RACGP), *RACGP response to improving maternity services in Australia*, RACGP, 31 October 2008, viewed 17 July 2009, http://www.racgp.org.au/reports/28482
14. Rural Doctors Association of Australia, *Rural doctors welcome Maternity Services Review report*, media release, 21 February 2009, viewed 17 July 2009, http://www.rdaa.com.au/uploaded_documents/Maternity%20Services%20Review%20report%20--%20February%202009.pdf
15. Australian Nursing Federation, *Maternity Services Review: a good beginning*, media release, 21 February 2009, viewed 23 July 2009; Australian College of Midwives, *Maternity Services Review*, media release, no date, viewed 23 July 2009, http://www.midwives.org.au/News/CollegeMediaReleases/MaternityServicesReview/tabid/1543/Default.aspx
16. P Gibson, 'Maternity services review increases options for consumers', *Health Voices*, Issue4, March 2009, viewed 17 July 2009, http://www.chf.org.au/Docs/Downloads/hvo-2009-4-maternity-services-review.pdf
17. Gibson, *Health Voices*, op.cit.

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compromised, not improved'.[18] The homebirth issue has gathered momentum since the introduction of this legislation and the release of an exposure draft of legislation which is intended to accompany the national registration and accreditation scheme for health professionals.

The Budget and beyond

Budget announcement and response

In response to the Maternity Services Review the Government announced a $120.5 million package of maternity measures in the 2009–10 Budget. It claimed the package not only recognised the role played by midwives in the birthing experience of many Australian women, but that it also gave families a 'greater choice in the type of care they wish to receive when having a baby'.[19]

The package was to give access to Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) benefits for services provided by midwives defined as eligible under legislation:

- to provide a government-supported professional indemnity insurance scheme for eligible midwives
- to deliver more midwifery services to rural and remote communities
- to provide more scholarships for general practitioners and midwives and
- to initiate a 24 hour, seven days a week telephone helpline and information service to provide greater access to maternity information and support before and after birth.

The Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 defines the meaning of eligible midwife and nurse practitioner (see the definitions table in 'Main Provisions' below).

Nurse practitioners defined as eligible under legislation were also to gain access to the MBS and PBS through funding in the 2009–10 Budget. This achieved a goal that nursing organisations had sought since the first trials of nurse practitioners were begun in the 1990s. The ANF had often made the point, as it did in its submission to the Productivity Commission, that nurse practitioners are educationally prepared and have the clinical experience needed to deliver quality and safe health care in collaboration with other health

18. New South Wales Nurses' Association, *Maternity Services Review–'a good start'*, media release, 3 April 2009, viewed 20 July 2009,http://www.nswnurses.asn.au/news/18972.html
19. N Roxon (Minister for Health and Ageing), *Providing more choice in maternity care—access to Medicare and PBS for midwives*, media release, 12 May 2009, viewed 21 July 2009, http://parlinfo/parlInfo/download/media/pressrel/IGTT6/upload_binary/igtt60.pdf;fileType=application/pdf#search=%22maternity%20services%20review%22

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care providers.[20] However, constant and vigorous opposition by the medical profession to their gaining access to the rights to initiate diagnostic investigations, prescribe medicines and directly refer patients for specialist medical care has seriously limited their scope of practice.[21]

Response to the Budget package from most stakeholders was similar to that which greeted the Maternity Services Review. The Australian Nursing Federation considered that the proposed rebates would help 'break down the barriers that prevent Australians accessing equitable health care'.[22] It would also provide real incentives for nurses to undertake nurse practitioner training as that career pathway would be seen as a challenging and attractive option.[23]

On the other hand, the Royal Australian College of General Practitioners (RACGP) argued that, unlike funding for practice nurses, $59.7 million provided to support the expansion of the role of nurse practitioners 'does not meet the workforce needs of Australian general practice'.[24] One view of this response was that it was most likely based on the fact that unlike practice nurses, nurse practitioners work independently, and not as part of teams supervised by medical practitioners.[25]

According to some commentators, while the AMA was not happy with the Budget announcement and with the introduction of legislation to extend benefits to nurse practitioners, it acknowledged that the 'writing was on the wall'.[26] However, soon after the Budget the AMA elected a new President, Andrew Pesce, who, to date, has adopted a more conciliatory approach to dealing with government overall. As a result, when this Bill and accompanying legislation was introduced in June 2009, the AMA pledged to work with the Government 'to ensure patients benefit from the introduction of new prescribing rights'.[27] This cooperative approach could be interpreted in a number of ways. It may be that it is a first step away from the medical profession's traditional stance that it should be

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20. ANF, *Submission to the Productivity Commission on the health workforce*, ANF, September 2005, viewed 21 July 2009, http://www.anf.org.au/anf_pdf/anf_submissions/Sub_Productivity_Commission_Health_Workforce.pdf
21. ANF, Submission to the Productivity Commission, op.cit.
22. ANF, *Patients and the community are the big winners in ground breaking health reform budget*, media release, 12 May 2009, viewed 21 July 2009, http://www.anf.org.au/
23. 'Nurse practitioners: insurance status warning', *Medical Observer*, 22 May 2009, pp. 4–5.
24. Royal Australian College of General Practitioners (RACGP), *Budget lacks recognition of the role of primary care*, media release, 12 May 2009, viewed 21 July 2009, http://www.racgp.org.au/media2009/31787
25. R Jolly, 'Workforce', *Budget Review 2009–10*, Parliamentary Library, Canberra, 2009, viewed 21 July 2009, http://www.aph.gov.au/library/pubs/RP/BudgetReview2009-10/HealthAndAgeing_Workforce.htm
26. P Smith, 'Opinion', *Australian Doctor*, 3 July 2009, p.3.
27. AMA, *AMA to work with government on nurse legislation*, media release, 24 June 2009, viewed 23 July 2009, http://www.ama.com.au/node/4770

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the sole gatekeeper of health services. On the other hand, it may be that the AMA has determined a conciliatory approach which is more likely to ensure that its views continue to be heard and, more importantly, that they influence policy development to the advantage of the medical profession.

The Budget package had consequences that were probably unforeseen, in that it prompted pharmacists to demand access to the PBS, 'because of their detailed knowledge of medications and their face-to-face interaction with consumers'.[28] This reaction will no doubt raise questions about whether extending rights to one group of practitioners does indeed open a Pandora's Box. There will be some who conclude that it does. They will argue that it is better to persist with the existing model of doctor-centric health service delivery, not only to ensure patient safety, but also to limit costs to the system, which may result from multiple consultations and claims. Others will disagree. They will point to successful overseas applications of nurse and alternative practitioner prescribing, which has been proven to be effective, both in terms of cost and patient outcomes.[29] This question is likely to be posed frequently as this and other health workforce reforms are suggested, considered and either rejected and/or trialled.

Link with national accreditation scheme

In 2008, the Council of Australian Governments agreed to establish a national registration scheme for certain health professionals (see Box 2 for background on the scheme). The scheme is due to be implemented in July 2010 and is intended to provide more flexible and accountable arrangements for these health professionals.[30] The first stage of legislation to implement the scheme was passed in 2008, following extensive consultation processes, on 12 June 2009 the Australian Health Workforce Ministerial Council released an exposure draft of the second stage of legislation. The legislation will continue administrative arrangements already established under first stage legislation, but it deals also with other matters, including registration and accreditation. Under the proposed legislation, practitioners will be required to have 'suitable professional indemnity

28. Pharmaceutical Society of Australia', *Time to consider expanding prescribing rights*, media release, 24 June 2009, viewed 23 July 2009, http://www.psa.org.au/site.php?id=4325
29. See for example, D Roblin, E Becker, K Adams, D Howard and M. Roberts 'Patient satisfaction with primary care: does type of practitioner matter?' *Med Care*, 42, 2004, pp.579–590, cited by D Mittman, J Cawley and W Fenn, *Physician assistants in the United States*, Physician Assistant/Associate World website, viewed 23 July 2009, http://www.paworld.net/whatpadoes.htm
30. These are medical, nursing and midwifery, pharmacy, physiotherapy, dental (dentists, dental prosthetists, dental therapists, dental hygienists), psychology, optometry, osteopathy and chiropractic. The scheme is also to apply to podiatry (registered in every jurisdiction except the Northern Territory, where there are insufficient numbers to make registration viable).

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insurance during the period of their registration'.[31] According to Australia's home birthing movement, this requirement will effectively make home birthing illegal, as home birthing midwives will not be eligible for indemnity insurance once the national scheme is introduced.[32]

Homebirth Australia considers that the Maternity Services Review was dismissive generally of the home birth movement, and that it labelled women who choose home birth as 'a trivial minority'.[33] Homebirth Australia considers that while the review adopted this approach to home birthing it failed to explore the reasons for the current small numbers of home births. Nor did the review compare home birth statistics with other minority birthing choices, such as caesarean section on request. And it argues that 'there is certainly no consideration of banning these choices'.[34] Homebirth Australia believes the review is a response to those who wish to limit women's birthing choices. It claims this is illustrated by the review's reluctance to support a home birthing model because that model 'risks polarising the [health] professions rather than allowing the expansion of collaborative approaches to improving choice and services for Australian women and their babies'.[35]

Homebirth Australia expresses its most serious concern, however, about the review's observations about indemnity for home birthing midwives:

> For privately practising midwives, it is not currently a requirement in most jurisdictions to have professional indemnity cover in place before registration is granted. However, this situation is expected to change under the proposed new National Registration and Accreditation Scheme.[36]

This is indeed most likely to be the case when the scheme is introduced and as Homebirth Australia notes, this will mean that midwives working in private home birth practice will be working illegally. They add that this situation may force more women to opt for unattended home birthing.

Homebirth Australia concludes that the maternity services legislation package will

> … reinforce a subordinate position for midwives relative to doctors by proposing to restrict midwifery practice in line with the prejudices of less collaborative doctors.

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31. The exposure draft is available on the Health Workforce website viewed 21 July 2009 at: http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/Exposure%20draft%20of%20Health%20Practitioner%20Regulation%20National%20Law%202009%20(Bill%20B).pdf. Relevant clauses are 69, 73, 75, 80, 83, 101, and 125).
32. HomeBirth Australia, *Keep private midwifery alive! Home birth a choice not a crime*, no date, viewed 20 July 2009, http://www.homebirthaustralia.org/keep-private-midwifery-alive
33. HomeBirth, Keep private midwifery alive! op. cit.
34. HomeBirth, Keep private midwifery alive! op. cit.
35. Maternity Services Review, op.cit., p. 21.
36. Maternity Services Review, op.cit., Chapter 6.

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> This undermines the relationships [the review hopes] to enhance. The Government must make it clear that the needs, interests and autonomy of women come first.[37]

While this Bill is not the underlying legislation which will criminalise home birthing midwifery, it appears that aspects of the Bill may reinforce legislation associated with the introduction of the national registration and accreditation scheme which is currently in exposure draft form as noted above. For example this Bill includes **proposed paragraph 21A (3)(b)** of the *Health Insurance Act 1973,* which provides the Minister with a capacity to specify the types of premises at which eligible midwives can provide services. It may be that the provisions in these regulations will exclude private homes.

The issue of homebirths is covered in greater depth in the cognate Bills Digest for the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009.[38]

Box 2: National registration and accreditation scheme for health professionals

In its 2005 report on the health workforce, the Productivity Commission recommended the establishment of a single national registration board for health professionals, as well as a single national accreditation board for health professional education and training. The Commission considered this system would increase the flexibility, responsiveness, sustainability and mobility of the health workforce.[39]

In response to the Commission's recommendations, the Council of Australian Governments (COAG) decided in March 2008 to establish a national scheme covering both registration and accreditation functions which will commence operation in July 2010. Under the scheme each state and territory is to pass legislation to allow for the establishment of national boards for nine health professions. This is to have the effect of abolishing current registration boards for those professions.[40]

Queensland was given responsibility for the legislative development of the national scheme. It passed initial legislation to this end in November 2008.[41] This legislation dealt with matters such as the establishment of an agency and boards to administer the national scheme.

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37. HomeBirth, Keep private midwifery alive! op. cit.
38. P Pyburne, K Magarey and R Jolly, Bills Digest no. 12, Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009, http://www.aph.gov.au/library/pubs/bd/2009-10/10bd012.pdf viewed 10 August 2009.
39. Productivity Commission, *Australia's health workforce*, op. cit.
40. Council of Australian Governments (COAG), *Intergovernmental Agreement for a national registration and accreditation scheme for the health professions*, COAG, Canberra, 2008, viewed 21 July 2009, http://www.coag.gov.au/coag_meeting_outcomes/2008-03-26/docs/iga_health_workforce.pdf
41. *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* (QLD), viewed 21 July 2009, http://www.austlii.edu.au/au/legis/qld/consol_act/hpranla2008701/

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Subsequent legislation, which in July 2009 is in exposure draft form, and follows consultation by a group set up by Australian Health Ministers' Advisory Council, is intended to deal with matters relating to registration and accreditation arrangements, complaints, privacy and other relevant matters.[42]

The Australian Medical Association (AMA), the Committee of Presidents of Medical Colleges (CPMC) and the Royal Australian College of General Practitioners (RACGP) have expressed various concerns about the national registration scheme. They argue firstly that it may not enhance patient safety as it may result in the lowering of professional standards.[43] They argue also that the scheme may be subject to government interference in the setting of professional standards and that it is too bureaucratised.[44]

Tellingly, the AMA and the majority of Australia's specialist medical colleges also believe that the scheme 'could provide a 'vehicle' for other health professionals to take on tasks traditionally performed by doctors without consulting the medical profession'.[45]

Committee consideration

Along with two cognate Bills, the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009, this Bill has been referred to the Senate Community Affairs Committee for inquiry and was due to report by 7 August 2009. On that date the Committee issued an interim report pointing to the 1880 submissions received and suggesting that more time was necessary to give due consideration to the submissions. The new reporting date is 17 August 2009. Details of the inquiry are at http://www.aph.gov.au/Senate/committee/clac_ctte/health_leg_midwives_nurse_practitioners_09/index.htm

42. Explanatory Notes, Health Practitioner Regulation (Administrative Arrangements) National Law Bill 2008, viewed 21 July 2009, http://www.legislation.qld.gov.au/Bills/52PDF/2008/HealPracAANLB08Exp.pdf
43. H Ferguson, 'Regulation threatens CPD standards', *Australian Doctor*, 14 November 2008, viewed 21 July 2009, http://parlinfo.aph.gov.au/parlInfo/download/library/jrnart/LN3S6/upload_binary/ln3s60.pdf;fileType=application/pdf#search=%22library/jrnart/LN3S6%22
44. S Obsorn, 'Registration risks standards: RACGP', *Australian Doctor*, 19 August 08, viewed 21 July 2009, http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22library%2Fjrnart%2FS8MR6%22 and J Flannery, 'National registration flashpoint', *Australian Medicine*, 7 April 08, viewed 21 July 2009, http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22library%2Fjrnart%2FS82Q6%22
45. Ferguson, *Australian Doctor*, op.cit.

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Position of significant interest groups/press commentary

The Australian Medical Association (AMA) has consistently criticised the idea of other health professionals taking over some of the tasks traditionally undertaken by medical practitioners, derisively labelling the concept as 'task substitution'. In 2004 AMA Vice-President Mukesh Haikerwal dismissed a suggestion that provider numbers could be issued to nurses to help overcome general practice workforce shortages, arguing that if people wanted to deliver medical services, they should get a medical degree.

In 2005, the Australian Medical Association Council of General Practice (AMACGP) argued in similar terms that independent nurse practitioners could not replace the expertise of general practitioners and that attempts to do so had resulted in the delivery of 'vastly inferior services.[46] Continuing in this vein, the AMA in its response to the Productivity Commission report, primarily interpreted the Commission's proposals for reform as task substitution which it argued inevitably leads to poorer health outcomes for patients.[47] According to the AMA, task substitution produces 'a competitive regimen of overlapping clinical roles'; it calls instead for reforms to the health system 'that synergise the different skills of doctors, nurses and other health professionals'.[48] In effect, the AMA view has been that when Australians are sick, they want to see a doctor, they do not want to be directed to a 'lesser' professional.[49]

The initial response to the Maternity Services Review report from the AMA reflected an antagonistic relationship that had developed between government and the AMA during the tenure of its immediate past President, Rosanna Capolingua. Dr Capolingua saw the review as reinforcing existing practice where midwives work in collaborative teams with obstetricians and general practitioner obstetricians. She accused Minister Roxon of interpreting the review's findings in a 'gung ho' manner, and appeared to refuse to concede the collaborative approach to maternity service delivery that it had emphasised. [50]

In September 2008 a *Medical Observer* survey reported that approximately 70 per cent of general practitioners were opposed to allowing allied health workers rights to prescribe,

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46. Australian Medical Association Council of General Practice, *GP Network News*, 8 April 2005, viewed 14 July 2009, http://www.ama.com.au/web.nsf/doc/WEEN-6B89ZV
47. AMA, Response to the Productivity Commission's position paper on Australia's health workforce, AMA, Canberra, November 2005.
48. C. Yong, 'Task substitution: the view of the Australian Medical Association', *Medical Journal of Australia*, vol. 185, no.1, viewed 16 July 2009, http://www.mja.com.au/public/issues/185_01_030706/yon10552_fm.html
49. Yong, op.cit.
50. J Gordon, 'Furore over midwife report as doctors go on the attack', *Sunday Age*, 22 February 2009, p.11, viewed 16 July 2009, http://parlinfo.aph.gov.au/parlInfo/download/media/pressclp/8NUS6/upload_binary/8nus60.pdf;fileType=application%2Fpdf#search=%22maternity%20services%20review%22

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even under supervision and thought that increasing the role of allied health professionals would compromise patient safety.[51]

The AMA made it clear in its submission to the Maternity Services Review that any support for expanded funding arrangements for midwives (and by implication nurse practitioners) would be premised on the restriction that it was made available within a medically supervised model. It noted emphatically:

> Highly interventionist government agendas to advance an ideological cause are likely to create problems in the delivery of maternity services and exacerbate tensions in interprofessional relationships, not improve them. Actions by the government which favour one particular new model of care over another will generally not be in the interests of patients, will restrict real choice and will be inequitable.
>
> The Government should not introduce any publicly funded arrangement which is based on independent midwife care for mothers and babies in Australia or use public funds to encourage separate streams of midwife led maternal care on the one hand and medical maternal care on the other. This will create two separate streams of care and the gulf between these will be detrimental to good patient care. The gulf cannot be addressed through protocols and other ameliorating initiatives and will ultimately lead to less safe care for mothers and babies.[52]

In particular, as has been noted elsewhere in this digest, the AMA was strongly opposed to 'publicly funded midwife led home birth'. It cited a 1998 Australian Study published in the *British Medical Journal* which showed that in-home birthing by midwives is three times more likely to lead to perinatal mortality than conventional options, even for lowest risk pregnancies. It noted:

> … evidence for increased perinatal death rates is compelling and the difference is so substantial that the Federal Government could not reasonably nor responsibly introduce payment arrangements which encourage and sanction such activities. If the Government did sanction such practices, it is likely that independent midwives would be encouraged by this action to extend their practice into riskier patient selection areas and this could well see an escalation of an already very significant risk differential.[53]

Further information regarding this issue, with a critique of the study and analysis of other studies is available in the cognate Bills Digest for the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009. While the AMA's new President

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51. A Sheppeard, 'Crossing over: ex allied health GPs speak', *Medical Observer*, 26 September 2008, viewed 12 July 2009, http://parlinfo/parlInfo/download/library/jrnart/195S6/upload_binary/195s60.pdf;fileType=application/pdf#search=%22nurse%20practitioners%22
52. AMA, *Submission to the Maternity Services Review*, no date, viewed 23 July 2009, http://www.ama.com.au/node/4225
53. AMA, Submission to the Maternity Services Review, op.cit.

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appears to have taken a less antagonistic approach to health workforce in general, it does not appear that its stance on this particular issue has changed.[54]

It remains also that the AMA is uncomfortable with aspects of the Government's health workforce reform agenda that seek to expand the roles of other health practitioners. And while Dr Pesce does not condemn the direction outright, in a recent speech to the National Press Club, he labelled this Bill and associated legislation as 'risky' because it may lead to the fragmentation of care, increased risks of poor health outcomes and rising health costs.[55] Of particular concern to Pesce is how team care will function in the future. He argues:

> Further discussion and debate is needed around the concepts of team care as opposed to independent care as opposed to autonomous care as opposed to clinical leadership. These are all very different concepts but they are used interchangeably by the Government at different times to different audiences. More information is needed on how the proposed collaborative care models, that are supposed to be in place soon, will work. But I will make one point very clear—the AMA will continue to promote the central role of the GP in patient care
>
> …
>
> The GP-led system works. When people are sick, they want to and have a right to see a doctor. That is why the AMA must be involved in developing and implementing any changes to ensure that any new arrangements result in safe, quality outcomes, and that patient care is not fragmented. So, I am pleased to report that the Prime Minister's Office has invited the AMA to be part of the implementation process. We will be involved in consultation and providing advice in developing the regulations that will underpin the new legislation on nurse practitioners and midwives. We certainly have strong views about the safeguards that are required to protect the quality and safety of health care. And we will be making sure that these views are put clearly to the Government.[56]

In contrast to the stance generally taken by the AMA, many other organisations have been supportive of increasing the roles and responsibilities of other health professionals. The Australian Nursing Federation (ANF) has long stressed that the skills of nurses are underused. The ANF has, however, been sceptical in the past about the extent to which this type of reform can succeed, given the considerable influence on government policy it

54. L Dayton, 'Wide support for legislation', *Weekend Australian*, 4 July 2009, viewed 14 July 2009, http://parlinfo/parlInfo/download/media/pressclp/P71U6/upload_binary/p71u60.pdf;fileType%3Dapplication%2Fpdf
55. A Pesce, *Making health reform real*, Speech to the National Press Club, 22 July 2009.
56. Pesce, Making health reform real, op.cit.

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believes the medical profession has traditionally wielded.[57] In its response to the Productivity Commission report the ANF claimed:

> … government's track record is not good in confronting doctors…[it] panders to doctors as a sectional interest group rather than looking at what is best for the health sector as a whole … doctors appear to consider that, while health reform is essential, it should not apply to them.[58]

Despite its scepticism about reform, the ANF in welcoming this legislation, congratulated the Government 'for recognising the benefits that highly skilled and educated nurse practitioners and midwives bring to the health of all Australians'.[59]

The issues of home birthing and indemnity for midwives have prompted a number of media and stakeholder responses to this package of bills. One report cited a coroner's warning of disastrous consequences if midwives working outside hospitals are not covered by indemnity insurance. Anther commentator warned that 'rogue operators' will replace the qualified professionals who are unable to be registered to practice.[60]

It was predicted in the press in March 2009 that the indemnity issue could create obstacles to achieving maternity services reform. One health commentator surmised that indemnity insurance payments could cost taxpayers between $12 and $24 million annually in subsidies, as premiums for private practice could be similar to those paid by obstetricians (between $60 000 and $100 000 for individual policies).[61] One insurer suggested that even if the Government did subsidise indemnity insurance for midwives, insurance companies may be reluctant to 'fill the void for fear of alienating their own members, many of whom are at best cautious about independent midwifery'.[62]

A significant number of responses to the Maternity Services Review were from the general public and it appears the same may be the case for the Senate inquiry being conducted into the registration and accreditation scheme and the Senate review of this legislation. Public submissions to the Maternity Services Review overwhelmingly argued for increasing the

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57. Australian Nursing Federation (ANF), *Productivity Commission's reforms on shaky ground*, ANF, media release, 19 January 2006.
58. ANF, Productivity Commission's reforms on shaky ground, op.cit.
59. ANF, Historic day for health care, nurses and midwives: ANF welcomes legislation to increase access to quality health care, media release**,** 23 June 2009.
60. E Bourke, 'Home births illegal under maternity services reform', *The World Today*, Australian Broadcasting Corporation, 30 June 2009, viewed 20 July 2009, http://www.abc.net.au/worldtoday/content/2009/s2612371.htm
61. A Cresswell, 'Cost of midwife cover an obstacle', *The Australian*, 5 March 2009, p.3, viewed 21 July 2009, http://parlinfo.aph.gov.au/parlInfo/download/media/pressclp/ARXS6/upload_binary/arxs60.pdf;fileType%3Dapplication%2Fpdf
62. Cresswell, op.cit.

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number of birthing options and many criticised the intention to exclude private midwives from indemnity insurance. The tone of submissions received to date by the Senate Committee into registration and accreditation appears to indicate that similar support for private midwives will be promoted to the inquiry.[63] Once again this issue is dealt with in more detail in the cognate Bills Digest for the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009.

Political party views

There appears to have been no official comment on the Maternity Services Review and recommendations arising from the review from political parties or independent members. However, Senator Rachel Siewert noted on 31 July 2009 the Australian Greens objections to legislation that would make it illegal for midwives to attend home births. While the Greens expressed support for the Government's proposals to modernise maternity services overall they intended to move amendments 'to protect the rights of women to choose safe homebirths'.[64] They argued that preventing private midwives from providing this service

> … will be dangerous for mothers and babies. It flies in the face of international trends in maternity care and appears completely inconsistent with the Governments' stated policy of providing pregnant women with greater choice and less interventionist maternity care.[65]

The Liberal Member for Mitchell, Alex Hawke had also previously raised the issue of home birthing in the Main Committee of the House of Representatives in June. Mr Hawke expressed his support for the women who had approached him concerned that their birthing choices would be denied following the introduction of the national accreditation and registration scheme for health professionals. He noted:

> … since 1993 the UK's official policy has been that women should have more choice in the place of birth, and this is a position which the coalition supports. We certainly

63. See for example, submission from Marcia Stillwell to the Maternity Services Review, viewed 23 July 2009, http://www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesreview-013 and Submissions from Eleanor Marney and Isis Caple to Senate Community Affairs Committee, *Inquiry into National Registration and Accreditation Scheme for Doctors and Other Health Workers*, Commonwealth of Australia, Canberra, report due 6 August 2009, viewed 23 July 2009, http://www.aph.gov.au/SENATE/committee/clac_ctte/registration_accreditation_scheme/submissions/sub115.pdf and http://www.aph.gov.au/Senate/committee/clac_ctte/registration_accreditation_scheme/submissions/sub90.pdf
64. R Siewert, *Greens will move to protect women's right to choose safe homebirth*, media release, 31 July 2009, viewed 31 July 2009, http://rachel-siewert.greensmps.org.au/content/media-release/greens-will-move-protect-women%E2%80%99s-right-choose-safe-homebirth
65. Siewert, op.cit.

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> support the choice of childbirth options for women. The government has not resolved this situation despite it being noted in the maternity services review, and from listening to the experiences of these midwives and mothers within my electorate I can understand their concern…The shadow minister for health has written personally to the Minister for Health and Ageing raising these concerns and requesting that the government act and resolve this situation.[66]

Family First Senator Steve Fielding, who attended a rally outside the Health Minister's office electorate office on 4 August, also noted his opposition to this package of legislation. Senator Fielding condemned it as outrageous and inconsistent with what occurred in other health systems around the world, adding that it was another example of the Government telling people what to do. It was a woman's right to decide where and how she should give birth, according to the Senator.[67]

Task substitution debate

This legislation has reignited a long-standing debate over the issue of task substitution. The fundamental argument against task substitution has been that it inevitably compromises health outcomes, but it is further claimed that task substitution does not take into account that patients prefer and expect a doctor to provide their care.

However, considerable evidence from countries such as the United States, Britain, Canada and New Zealand amongst others, suggests the opposite is the case—alternative health practitioners can improve health outcomes by supplementing the work of medical practitioners.[68] In addition, overseas experience highlights that employing competent nursing and other professionals to deal with routine care lightens the work load of doctors. Additionally, it allows them to use their skills more effectively in treating complex conditions. This, in turn can help to increase medical practitioners' job satisfaction.[69]

But as noted earlier in this digest, it has been argued that a fundamental objection by the medical profession to task substitution is based on its desire to ensure that its position of

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66. A Hawke, Main Committee, Statements by Members, 'Maternity services', House of Representatives *Debates*, 15 June 2009, viewed 23 July 2009, http://parlinfo/parlInfo/search/display/display.w3p;adv=yes;db=;group=;holdingType=;id=;orderBy=customrank;page=0;query=Content:"maternity%20services%20review%20";querytype=;rec=2;resCount=Default
67. 'Government plan to ban homebirth an attack on "Women's Rights"', website, 4 August 2009, viewed 5 August 2009, http://www.australia.to/index.php?option=com_content&view=article&id=13203:government-plan-to-ban-homebirth-an-attack-on-qwomens-rightsq&catid=72:australian-news&Itemid=200
68. See discussion for example in R Jolly, *Health Workforce: a case for physician assistants?* Research paper no. 24, 2007–08, Parliamentary Library, Canberra, 2008, viewed 23 July 2009, http://www.aph.gov.au/library/pubs/rp/2007-08/08rp24.pdf
69. Jolly, op.cit discusses this issue.

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prominence in the health system remains intact. For this reason, sections of the profession have continually dismissed suggestions that task substitution by other practitioners adds to the quality of health care. They argue instead for workforce changes that focus on delegation/partnership outcomes, a key requirement of which is medical practitioner supervision and involvement. That is, a team work approach wherein medical practitioners are the 'natural and appropriate' leaders.[70] To paraphrase one practitioner, this approach is 'the best protection for the medical profession'.[71]

On the other hand, task substitution has been promoted as a means through which a more flexible workforce can be achieved—a mix of skills, rather than concentrating on the skill one or other type of health worker can deliver.[72] According to this argument, this flexibility is better able to deliver the right patient outcomes.

One early study in the United Kingdom for example noted that patients were more satisfied with nurse practitioner consultations than general practice consultations. This study noted also that there were few differences in clinical care and no difference in clinical outcome between nurse practitioner and general practitioner consultations. In addition, health service costs were not significantly different between nurses and general practitioners.[73] Other studies have presented similar results, finding that patients approve of, and accept task substitution. They are also happy with nurse prescribing which some commentators have found improves patient outcomes, because it promotes 'people-centredness, quality of care and accountability'.[74] Nurse prescribing has been seen to increase the competency of nurses and to foster better communications between health teams. Overall, it has been praised for fostering more timely interventions, more effective supervision of chronic conditions and a maximisation of health resources.[75]

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70. Yong, 'Task substitution', op.cit.
71. B Murphy, "Medical substitutions and delegations–overcoming the fear', *Australian Health Review*, vol. 31, Supplement 1, April 2007, p. S20.
72. S Duckett, 'Health workforce design for the 21st century', *Australian Health Review*, 29 May 2005, viewed 23 July 2009, http://www.aushealthreview.com.au/publications/articles/issues/ahr_29_2_0505/ahr_29_2_201-210.html
73. P Venning, A Durie, M Roland, C Roberts and B Leese, 'Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care', *British Medical Journal*, 15 April 2000, viewed 23 July, http://findarticles.com/p/articles/mi_m0999/is_7241_320/ai_61995030/?tag=content;col1
74. E Fernvall Markstedt, Seventh Annual Meeting of the European Forum of National Nursing and Midwifery Associations and World Health Organization, *A case history from Sweden*, quoted in Department of Health and Children, *Consultation on the extension of prescriptive authority to nurses and midwives*, Dublin, 2006, viewed 20 July 2009, http://www.whc.ie/publications/Submissions_Nurse_Prescribing.pdf
75. K Seager, 'Supplementary prescribing', Bath and North Somerset Primary Care Trust, 2003 and Fernvall Markstedt, op.cit.

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From an Australian perspective, there is some evidence which points to the value of task substitution. Ten years ago the Victorian Nurse Practitioner project concluded that granting prescribing rights to nurse practitioners had improved patient care. In addition, it fostered relationships between patients and nurses and within the health delivery team. Additionally, it had the potential to reduce health costs.[76]

This legislation may be a step towards promoting a new concept of the health 'team'; one that abandons long-standing notions that nurses are subservient to doctors, rather than cooperative professionals.[77] While nurse practitioners have previously had limited and varied prescribing rights under state and territory legislation, granting access to Medicare and the PBS challenges the medical practitioner centric focus of health care and promotes a move towards the more collaborative model to which all professionals at least pay lip service.[78] It need not devalue the doctor's role, as some medical practitioners have argued, but instead places more value on the role of nurses and midwives.

In the context of task substitution, it needs to be noted that any new spirit of team collaboration that it may foster can only be effective if there are adequate numbers of practitioners available. There have long been concerns that this may not be the case in the future, despite Government commitments to increase the numbers of doctors and nurses. It has been suggested that existing strategies will only serve to replace practitioners due to retire and compensate for changes in working practices.[79] There must be questions also about whether there will be sufficient numbers of nurses, even in the short term, to undertake the enhanced roles this legislation proposes for them.

Peak nursing organisations in Australia have expressed concern since the late 1990s that not enough has been done to address the shortages of nurses generally. Between 2001 and

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76. Department of Human Services, *Victorian nurse practitioner: final report of the taskforce*, December 1999, viewed 20 July 2009, http://www.health.vic.gov.au/__data/assets/pdf_file/0008/17639/nurse_practitioner_taskforce_report.pdf
77. L Fagin and A Garelick, 'The doctor–nurse relationship', *Advances in Psychiatric Treatment*, vol. 10, 2004, viewed 20 July 2009, http://apt.rcpsych.org/cgi/reprint/10/4/277.pdf
78. See for example, the regulations that apply to nurse practitioners in New South Wales, on the NSW Department of Health website, viewed 10 August 2009, http://www.health.nsw.gov.au/nursing/practitioner/nurse_practitioner.asp and Australian Nursing and Midwifery Council (ANMC), *National competency Standards for the Nurse Practitioner*, ANMC, 2006, viewed 10 August 2009, http://www.anmc.org.au/docs/Publications/Competency%20Standards%20for%20the%20Nurse%20Practitioner.pdf
79. The Australian Medical Workforce Advisory Committee (AMWAC) discusses this issue specifically in relation to medical practitioners, AMWAC, *The general practice workforce in Australia. Supply and requirements to 2013*, AMWAC, 2005, viewed 20 July 2009, http://www.nhwt.gov.au/documents/Publications/2005/The%20general%20practice%20workforce%20in%20Australia.pdf

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2005 a number of reports were commissioned examining the entry level and specialist nursing and midwifery workforces. Estimations were that a 120 per cent increase in nursing numbers was required to balance workforce needs by 2020.[80]

And granting access to Medicare and the PBS for a limited number of nurses does not address other fundamental issues such as the overall status of the nursing profession. Nor does it take into account the complexity of the problems in nursing workforce supply, which range from a lack of academic staff to the crucial issues of wages and conditions. A number of surveys have indicated that a lack of career path for experienced nurses, overwork, staff shortages, frustration, physical and emotional exhaustion and perceptions that their work continues to be undervalued and unappreciated and that they are not respected by doctors, may contribute more to attrition than pay.[81] At the same time, this legislation may make some progress not only towards improving the status of nursing in general but also, as noted earlier in this Digest, towards providing greater career opportunities and improved morale.

Financial implications

The Explanatory Memorandum provides detail on the financial implications of this Bill. According to the Explanatory Memorandum, MBS and PBS components of the measures that this Bill will enable through delegated legislation will cost $111.3 million over four years. Costs include administrative and Department of Health and Ageing costs as well as administrative costs allocated to Medicare Australia to introduce the necessary systems changes and to manage the program. These are set out in the table below:

2009-10 ($ million)	*2010-11 ($ million)*	*2011-12 ($ million)*	*2012-13 ($ million)*	*Total ($ million)*
14.8	**17.5**	**32.3**	**46.7**	**111.3**

80. T Karmel and J Li, *National review of nursing education: the nursing workforce—2010*, August 2002, viewed 20 July 2009, http://www.dest.gov.au/archive/highered/nursing/pubs/nursing_worfforce_2010/nursing_workforce_default.htm

81. Senate Standing Committee on Community Affairs, *Report on the Inquiry into Nursing, the patient profession. Time for action*, Commonwealth of Australia, Canberra, 2002, viewed 20 July 2009 , http://www.aph.gov.au/Senate/committee/clac_ctte/completed_inquiries/2002-04/nursing/report/

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Main provisions

Schedule 1—Amendments relating to medicare benefits and pharmaceutical benefits

Definitions and other matters

The Bill inserts various new definitions governing midwives and nurse practitioners into the *Health Insurance Act 1973* (the HIA) so that they can be regulated by the Commonwealth and incorporated in to various aspects of the Medicare system. There are three new types of definition proposed in the Bill:

Basic Criteria	**Eligible**	**Participating**
Midwife (definition introduced in **item 4**) Nurse practitioner (**item 5**)	Eligible midwife (**items 1 and 25**) Eligible nurse practitioner (**item 2**)	Participating midwife (**item 6, 21A and 21B**) Participating nurse practitioner (**item 7, 22 and 22A**)
Both definitions require the person to have satisfied the relevant State or Territory requirements.	Both definitions depend on the person meeting the basic criteria *and* requirements in the relevant regulations which may be made by the Minister (for instance particular qualifications, experience or having credentials from a particular body). The provisions governing midwives are more extensive, specifying that if there are no regulations there can be no eligible midwives. Nurse practitioners must only comply with the regulations if they exist.	Both definitions require the assent of the eligible professional to a 'common form of undertaking' if it has been promulgated by the Minister, which is effective once the Minister has accepted the undertaking. Examples of the provisions in a 'common form of undertaking' include a specification of where the practice must take place, the kinds of service offered or arrangements regarding the fees charged. In the absence of a common form of undertaking an eligible midwife or nurse practitioner is a participating midwife or nurse practitioner.

The Bill also incorporates midwives and nurse practitioners into the *National Health Act 1953* (NHA) as pharmaceutical benefits scheme (PBS) prescribers. The definitions used in the NHA are very similar to the HIA definitions, with some context specific variations. Rather than repeating the provisions a comparative table is provided:

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Basic Criteria	**Eligible**	**Authorised**
Midwife (item 67) Nurse practitioner (**item 68**)	Eligible midwife (**items 72 and 79**) Eligible nurse practitioner (**items 73 and 79**)	Authorised midwife (**item 70 and 79**) Authorised nurse practitioner (**item 71 and 79**)
These are the same as for the HIA	Similar to the HIA, however it is the Secretary rather than the Minister who allows the application (but the Minister who sets the conditions). Once again a midwife's eligibility is contingent on there being conditions established, whereas a nurse practitioner can, in the absence of conditions, be recognised as eligible.	Comparable to the participating midwife or nurse practitioner. There are criteria and conditions which must be met by an eligible midwife or nurse practitioner who applies to become authorised. It is allocated to 'the Secretary' to make these decisions, although the Ministerial legislative instrument establishing the conditions and criteria will be disallowable.

Another definition provided in the Bill with respect to the HIA is that of a 'relevant' midwife or nurse practitioner. This is a midwife or nurse practitioner who has in some way breached the HIA's provisions and has had a determination made against them which has either partially or fully disqualified them (or who the Minister believes is liable to receive such a determination). It is proposed in the Bill that the Minister should not accept an undertaking from an eligible midwife or nurse practitioner who would take over the practice or business of a relevant midwife or nurse practitioner if it would mean the financial consequences of such a determination is undermined (**items 21B and 22A**). The Minister would not accept an undertaking from a relevant midwife or nurse practitioner, in part because they would not have been able to meet the criteria for an eligible midwife.

Both the HIA and the NHA make provisions for recognitions given under the Acts to be withdrawn, either by revocation or suspension. These actions, along with a refusal to extend recognition (either as an eligible, participating or authorised midwife or nurse practitioner) can be challenged under the arrangements contained in the *Administrative Appeals Tribunal Act 1975*.

Item 25 sets out the process under the HIA and provides for review of the initial decision to refuse to accept an undertaking, and also the processes that occur if the Minister revokes or suspends the acceptance of the undertaking (**proposed sections 21B and 21C** (midwives) **and 22A and 22B** (nurse practitioners)). Administrative appeal rights are available at various stages.

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For the NHA **item 79** sets out the grounds on which suspension or revocation may occur and also the conditions which must be observed before giving notice (for instance an intention to suspend or revoke must be in writing, give reasons and invite a written response, (**proposed sections 84AAG and 84AAK**) and after giving notice (for instance notice must be given of the right to appeal). If someone has been charged but not convicted of an offence they are subject to suspension of their rights, but once convicted a revocation can apply (**items 98 and 99**). There are various administrative protections put into place for those refused recognition or whose recognition is suspended or revoked. These apply to both professions, and reflect the protections already in the Act.

It is proposed that the Bill's regulatory framework for midwives and nurse practitioners will be used to extend pre-existing arrangements covering other health professionals. So, for example, an extended definition of 'medical entrepreneur' is given in the HIA which will cover midwives and nurse practitioners. A medical entrepreneur is someone who employs, controls, is landlord to or is 'in charge of'[82] a practitioner or participating midwife or nurse practitioner (**items 3 and 9**). This definition is used in the HIA to allow pathology specimens to be collected by other employees of a medical entrepreneur (section 16A, 'Medicare benefits in relation to pathology services') and to ensure a broader operation of the prohibition on bribery in private hospitals (section 129AA).

The Bill also proposes an amendment which would include participating nurses and midwives in the assumption that professional attendances subsequent on post-operative treatment in which professional services were rendered are assumed to be covered by the particular item in the general medical services table (**item 8**).

There is an array of Medicare covered services that participating midwives and nurse practitioners will also be able to offer:

- Medicare benefits may be payable for pathology services when a participating midwife or nurse practitioner has ordered them for their patient (and they have been listed in the regulations), or when they offer the service themselves (**item 10**, **12, 13 and 14**)
- Medicare benefits may be payable for R-type diagnostic imaging services when a participating midwife or nurse practitioner has ordered them for their patient (and they have been listed in the regulations) (**items 16, 17, 19 & 20**)
- A participating midwife or nurse practitioner will be able to write 'medicare effective'[83] referrals to a consultant physician or a specialist (**item 23**). The drafting technique to broaden the field of who is allowed to make such referrals is quite broad.

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82. The technical terminology is 'receives or obtains any property, benefit or advantage from the rendering of a [relevant] service … by a [relevant] person.'
83. Used colloquially here to mean a referral which can be used to ensure Medicare benefits are payable at the higher specialist rate (see section 133 of the HIA and the general medical service table).

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The Bill proposes to delete the reference to a practitioner so that the section simply says that 'a person' can make such a referral.

The Bill specifies that pathology and diagnostic imaging services will only attract Medicare benefits 'on or after 1 November 2010' and a participating midwife or nurse practitioner's capacity to write referrals to specialists and consultant physicians will also only be effective at that time (**items 11, 15, 21 & 24**).[84]

A series of amendments incorporate the participating midwife or nurse practitioner into the pre-existing regulatory framework for the making of pathology and diagnostic imaging requests and the bureaucratic arrangements contained therein (for instance record keeping requirements and lost form arrangements) (**items 26-41**).

There is a broad range of administrative arrangements in place in the HIA which include bodies designed to oversee the professions. The Bill incorporates midwives and nurse practitioners into these arrangements. Thus the Professional Services Review Scheme will include midwifery and the practice of a nurse practitioner into its definitions of professions, practitioners and service (**items 42-44**); the Determining Authority will be expanded from 8 to 10 to accept an additional member who is a midwife and a nurse practitioner (**items 49 & 50**) and the Medicare Participation Review Committee will recognise the two professions and incorporate a member of each onto a Committee when it is convened in relation to a member of their profession (**items 51 and 52**).

There is also a wide range of penalties and prohibitions in the HIA and **items 54-57** incorporate midwives and nurse practitioners into the prohibition in section 128C against charging fees for the provision of a service to a public patient at a public hospital. **Items 58-61** incorporate midwives and nurse practitioners into section 129AA which prohibits bribery in public hospitals (the section addresses issues that could arise, for instance, if a reward was offered to obtain a place for a patient, or a practitioner could be tempted to order unnecessary services for a reward).

Item 62 seeks to provide a protection for evidence given to a Medicare officer by a midwife or nurse practitioner (inter alia). This evidence cannot be led in proceedings unless contradictory evidence is first led by the individual being scrutinised or they have agreed to the evidence being used.

The Bill preserves the State and Territory's roles not only in providing for the registration of midwives and nurse practitioners but also taking disciplinary action when necessary, with **item 63-66** providing for regulated information sharing between Commonwealth officers acting under this Act (and others, such as the *Medicare Australia Act 1973* or the *Dental Benefits Act 2008*) and the relevant State/Territory authority with disciplinary power over the relevant professionals and/or those responsible for the administration of

84. Similarly the provisions incorporating midwives and nurse practitioners into the PBS will only come into operation on or after 1 November 2010 (**items 84, 91, 93, 95**).

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laws providing for their registration. Similarly in the NHA **items 108-111** which deal with the need for secrecy when issues are investigated under that Act but recognises that such secrecy need not apply between the Commonwealth officials and the State and Territory authorities charged with regulating the registration of midwives or nurse practitioners and taking the necessary disciplinary action.

National Health Act 1953

Item 75 takes the central step of recognising authorised midwives and nurse practitioners as PBS prescribers under section 84 of the NHA, thereby incorporating them into the complex systems in place regulating prescribers, while **item 84** gives them the authority under section 88 of the Act to actually write prescriptions for drugs that have been determined by the Minister through a legislative instrument. **Item 85** amends subsection 88(3) so that the prescription power is limited to drugs required within the parameters of the relevant treatment.

Once incorporated into the framework around prescribing rights, midwives and nurse practitioners have a variety of right and obligations. So, for instance the regulations governing the amounts prescribed, what form the prescription takes and when it is possible to prescribe a more significant amount of a drug than a standard issue are dealt with (**item 81, 84, 86**) and authorised midwives and nurse practitioners are incorporated into arrangements which allow a prescriber to authorise drugs being carried or sent out of the country (when it is for personal use), (**items 91, 92, 95 and 96**).

If a midwife or nurse practitioner has their authority to prescribe revoked then their scripts cannot be filled (**proposed paragraph 134(1)(c), item 103**) and they are required to return the drugs they currently have on hand (**proposed subsection 134(1), item 105**).

Schedule 2

The amendments in this Schedule are consequential changes made as a result of the coming into operation of the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 and the Midwife Professional Indemnity (Run-off Covrer Support Payment) Bill 2009. These changes to the Acts[85], while important, are technical and are matters of drafting. They are adequately covered in the Explanatory Memorandum.

Concluding comments

The Bill's extension of the MBS and PBS to more health professionals represents a significant change in a society which has been very focussed on the delivery of medical care through doctors. This may not be universally seen as a good thing, but it is likely to

85. Health Insurance Act 1973; Medical Indemnity Act 2002; Medicare Australia Act 1973; National Health Act 1953.

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improve a range of choices. Giving midwives and nurse practitioners an independent standing within these frameworks is likely to have interesting flow on effects. Concerns regarding the future of homebirths have tended to overshadow the significance of these changes, but in another context they might be recognised as more significant.

It can be seen from the definitional tables above that the regulatory framework leaves many issues to be resolved in the form of regulations or the 'common form undertakings' (which will be legislative instruments, and therefore disallowable by the Parliament according to the procedures in the *Legislative Instruments Act 2003*). Those who have been concerned about the effect of this legislation on midwives' availability might contemplate the cliché that while the devil may be in the detail, in this case the detail is not in the Bill.

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