



Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009

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Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009

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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

The Bill proposes a Commonwealth scheme whereby assistance is offered to eligible midwives in accessing indemnity for claims arising from their professional activities.

Background

Basis of policy commitment

In June 2008, the Minister for Health and Ageing, Nicola Roxon, directed the Commonwealth Chief Nurse and Midwifery Officer, Rosemary Bryant to conduct a review into the delivery of maternity services in Australia. The Maternity Services Review (the 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.¹

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

1. 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](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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- 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 were particularly concerned about the safety repercussions of home birthing.

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 for consideration of changes to funding arrangements for midwives and support for the provision of professional indemnity insurance for midwives working in a collaborative care environment. In addition, the review recommended the introduction of cross-professional guidelines which would support collaborative care arrangements, collection of data and the monitoring of new models.

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—homebirthing—has become the subject of considerable debate.

National registration and accreditation scheme for health professionals

In 2008, the Council of Australian Governments agreed to establish a national registration scheme for certain health professionals. The scheme is due to be implemented in July 2010 and is intended to provide more flexible and accountable arrangements for these health professionals.² The first stage of legislation to implement the scheme was passed in 2008, and following extensive consultation processes, on 12 June 2009 the Australian Health

2. 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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Workforce Ministerial Council released an exposure draft of the second stage of legislation. The legislation will continue administrative arrangements already established but it deals also with other matters, including registration and accreditation. Under the proposed legislation, practitioners will be required to have 'suitable professional indemnity insurance during the period of their registration'.³

There has been significant public debate over homebirthing in the context of these Bills, however none of the Bills directly impact on homebirth arrangements. They establish systems which allow distinctions to be made between midwives and nurses who will, or will not, be covered by government supported insurance arrangements and government supported access to the Medicare system or the pharmaceutical benefits system and this could be utilised to exclude midwives who attend homebirths from the benefits of these systems, however many privately practising midwives have not been able to access effective insurance for some time. The second tranche of legislation governing the registration arrangements may directly exclude homebirth midwives from practicing, but in a sense it is only Minister Roxon's comments in her second reading speech that has raised the position of homebirthing so acutely in the context of these Bills.⁴ The issue of homebirth has also arisen in responses to the review of maternity services. The issues arising are dealt with further under the 'Key Issues' section.

Interest Group Responses to the Maternity Services Review

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. It was supportive of the teamwork approach to maternity services the review recommended. But it was also concerned about possible fragmentation of care created by 'new silos of care delivery', which it believed would be created by increasing the

3. 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](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.

4. 'At this stage, the Commonwealth is not proposing to extend the new arrangements for midwives to include homebirths. Medicare benefits and PBS prescribing will not be approved for deliveries outside clinical settings, and the Commonwealth supported professional indemnity cover will not respond to claims relating to homebirths.' N Roxon, (Minister for Health and Ageing), Second reading speech: Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009, 24 June 2009, p. 7, viewed on 20 July 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F2009-06-24%2F0022%22>

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responsibility and scope of nursing practice.⁵ 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'.⁶ Nursing bodies on the other hand, were enthusiastic about the review's conclusions; the Australian Nursing Federation labelled it 'a good beginning' and the Australian College of Midwives applauded its intentions.⁷

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.⁸ But on the negative side, CHF also raised the issue of professional indemnity, expressing disappointment that the review did not recommend coverage for midwives in private practice.⁹

Associate Professor of Midwifery at the University of Western Sydney Hannah Dahlen, who was also generally positive about the review, expressed concern that more consideration was not given to discussion of an effective homebirth model. She warned that 'if homebirth was pushed underground and its skills lost, safety would ultimately be compromised, not improved'.¹⁰

Government Response to the Maternity Services Review and Subsequent Developments

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

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5. 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>
 6. 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
 7. Australian Nursing Federation (ANF), *Maternity Services Review: a good beginning*, media release, 21 February 2009, viewed 23 July 2009 and 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>
 8. P Gibson, 'Maternity services review increases options for consumers', *Health Voices*, Issue 4, March 2009, viewed 17 July 2009, <http://www.chf.org.au/Docs/Downloads/hvo-2009-4-maternity-services-review.pdf>
 9. Gibson, *Health Voices*, op. cit.
 10. 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>

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women, but that it also gave families a 'greater choice in the type of care they wish to receive when having a baby'.¹¹

The package is intended 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 government-supported professional indemnity insurance scheme for those midwives, to deliver more midwifery services to rural and remote communities and more scholarships for general practitioners and midwives as well as 24 hour, seven days a week telephone helpline and information service to provide greater access to maternity information and support before and after birth. These Bills, if passed, will implement the first two items.

Response to the Budget package from most stakeholders was similar to that which greeted the Maternity Services Review. The Australian Nursing Federation (ANF) considered that the proposed rebates would help 'break down the barriers that prevent Australians accessing equitable health care'.¹² The ANF has long stressed that the skills of nurses are underused, but at the same time it has been sceptical about the extent to which reform can succeed, given the considerable influence on government policy it believes the medical profession has traditionally wielded.¹³ Despite its scepticism about reform, the ANF has since congratulated the Government 'for recognising the benefits that highly skilled and educated nurse practitioners and midwives bring to the health of all Australians'.¹⁴

The AMA had made it clear in its submission to the Maternity Services Review that any support for expanded funding arrangements for midwives would be premised on the restriction that is was made available within a medically supervised model. It argued emphatically:

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

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11. 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
 12. 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/>
 13. ANF, *Productivity Commission's reforms on shaky ground*, (ANF), media release, 19 January 2006.
 14. ANF, *Historic day for health care, nurses and midwives: ANF welcomes legislation to increase access to quality health care*, media release, 23 June 2009.

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addressed through protocols and other ameliorating initiatives and will ultimately lead to less safe care for mothers and babies.¹⁵

The AMA considered that the Maternity Services Review Report reinforced existing practice where midwives work in collaborative teams with obstetricians and general practitioner obstetricians.¹⁶

Since the announcement of the Budget package and the introduction of this package of legislation, the issues of homebirthing and indemnity for midwives have prompted a number of media and stakeholder responses. One report cited a coroner's warning of disastrous consequences if midwives working outside the hospitals are not covered by indemnity insurance. Another commentator warned that 'rogue operators' will replace the qualified professionals who are unable to be registered to practice.¹⁷

It was predicted in the press in March 2009 that the indemnity issue could create obstacles in 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).¹⁸ An insurer suggested that even if the Government did subsidise indemnity insurance for midwives that 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'.¹⁹

The Australian Private Midwives Association (APMA) argues that the Howard Government's failure to include midwives in the government initiated measures which supported medical practitioners following the collapse of the insurance industry has led to a perception that midwives are a 'riskier' birth option than medical practitioners. In the APMA's view:

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15. AMA, *Submission to the Maternity Services Review*, no date, viewed 23 July 2009, <http://www.ama.com.au/node/4225>
 16. 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
 17. 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>
 18. 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
 19. Cresswell, op. cit.

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In a level commercial playing field this myth would be debunked. Midwives provide generally 'low risk' care. They do no major surgery, are not responsible for inductions or anaesthesia such as epidurals and they generally provide care for healthy women.²⁰

Interestingly, the AMA also supports a level indemnity cover playing field for midwives who will be deemed eligible under this legislation. Its justification for this is that such coverage will mean that it is more likely doctors will be willing to work in collaborative arrangements with midwives. In the absence of such a scheme doctors could be faced with the total burden of claims that may arise if midwives do not have sufficient indemnity cover.²¹

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 a Senate inquiry being conducted into the registration and accreditation scheme. Submissions from private citizens to the Maternity Services review overwhelmingly argued for increasing the number of birthing options available for women and many criticised the intention to exclude private midwives from indemnity insurance. The tone of submissions received to date by the Senate Inquiry into this package of Bills appears to indicate that there is similar support for overturning the intention to exclude private midwives from indemnity insurance.²²

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20. Australian Private Midwives Association, Submission to the Senate Standing Committee on Community Affairs, *Inquiry into the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills*, viewed 4 August 2009, http://www.aph.gov.au/senate/committee/clac_ctte/health_leg_midwives_nurse_practitioner_s_09/submissions/sublist.htm
 21. Australian Medical Association (AMA), Submission to the Senate Standing committee on Community Affairs, *Inquiry into the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills*, viewed 4 August 2009, http://www.aph.gov.au/Senate/committee/clac_ctte/health_leg_midwives_nurse_practitioner_s_09/submissions/sub29.pdf
 22. 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>; Submissions from Eleanor Marney and Isis Caple to the Senate Standing Committee on Community Affairs, *Inquiry into National Registration and Accreditation Scheme for Doctors and Other Health Workers*, 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. See also submissions to the Senate Standing Committee on Community Affairs, *Inquiry in to the Health Legislation amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills*, , 2009, viewed 3 August 2009, http://www.aph.gov.au/Senate/committee/clac_ctte/health_leg_midwives_nurse_practitioner_s_09/submissions/sublist.htm

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Political party views

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'.²³ 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.²⁴

The Liberal Member for Mitchell, Alex Hawke had 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 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, and we are currently developing our health policy.²⁵

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

23. 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>

24. Siewert, op. cit.

25. 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](http://parlinfo/parlInfo/search/display/display.w3p;adv=yes;db=:group=:holdingType=:id=:orderBy=customrank;page=0;query=Content:)

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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.²⁶

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

Financial implications

The Explanatory Memorandum estimates that the two Bills dealing with midwives indemnity will have a total cost of \$25.2 million over four years (including the effects of delegated legislation). This figure incorporates 'the budgeted annual costs, which include administrative and Department of Health and Ageing costs, and administrative costs for Medicare Australia to introduce the necessary systems changes and manage the program'.²⁷

2009-10 (\$ million)	2010-11 (\$ million)	2011-12 (\$ million)	2012-13 (\$ million)	Total (\$ million)
\$4.7	\$8.1	\$4.4	\$7.9	\$25.2

26. '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:governme nt-plan-to-ban-homebirth-an-attack-on-qwomens-rightsq&catid=72:australian-news&Itemid=200

27. Explanatory Memorandum, Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009, Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009, p. 3.

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Key issues

Home and free birthing

According to Australia's homebirthing movement, the requirement to be embodied in the national registration and accreditation legislation and echoed in this and related Bills, will effectively make homebirthing illegal. This is because homebirthing midwives will not be eligible for indemnity insurance once the national registration and accreditation scheme is introduced.

HomeBirth Australia considers that the Maternity Services Review was dismissive generally of the homebirth movement, and that it labelled women who choose homebirth as 'a trivial minority'.²⁸ HomeBirth considers that while the review adopted this approach to homebirthing it failed to explore the reasons for the current small numbers of home births. Nor did the review compare homebirth statistics with other minority birthing choices, such as caesarean section on request. HomeBirth points out that there is no consideration of banning other minority choices and believes the review responded in this case to the demands of those who wish to limit women's birthing choices.²⁹ It claims this is illustrated by the review's reluctance to support a homebirthing 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'.³⁰

HomeBirth in particular expresses serious concern about the review's observations concerning 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.³¹

HomeBirth 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.

28. 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>

29. HomeBirth, *Keep private midwifery alive!* op. cit.

30. Maternity Services Review, op. cit., p.21.

31. 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.³²

According to HomeBirth, the restrictions this and accompanying legislation will place on midwifery practice will force more women to opt for unattended homebirthing. Unattended homebirthing, also known as unassisted childbirth or freebirthing, involves giving birth, usually at home, without the assistance of a midwife, doctor or other medical professional.

In general freebirthing proponents argue that women have been giving birth at home, without medical assistance for thousands of years. They consider that birth should occur naturally and peacefully, without the unnecessary interventions that occur in a hospital setting. Many women who opt for freebirth have previously experienced a bad birthing experience in a hospital or other medical setting.³³ Opponents of freebirthing, however, argue that giving birth at home without the guidance of a midwife or doctor is extremely dangerous for both mother and baby. While critics of freebirthing acknowledge women have been giving birth at home unassisted for thousands of years, they add that a large percentage of women and babies died in the process.³⁴

One submission to the Senate Inquiry into the package of legislation which includes this Bill, also claims that not only is free birthing likely to ‘skyrocket’ if the restrictions on private midwifery practice are allowed to remain, but that dangers may be compounded as women turn to doulas to assist them in the birthing process.³⁵

A doula is a support person who provides physical comfort, encouragement, reassurance and information during labour.³⁶ But a doula is not required to be a trained midwife, (although some are), and a doula is not formally registered or regulated. Unlike a trained

32. HomeBirth, Keep private midwifery alive! op. cit.

33. M Carter, *What is freebirthing?* suite101.com, viewed 31 July 2009, http://birthing-options.suite101.com/article.cfm/what_is_freebirthing

34. Carter, *What is freebirthing?* op. cit.

35. Midwives in private practice, subcommittee of the ACM QLD Branch, Submission to the Senate Standing Committee on Community Affairs, *Inquiry in to the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills*, viewed 3 August 2009, http://www.aph.gov.au/Senate/committee/clac_ctte/health_leg_midwives_nurse_practitioners_09/submissions/sub07.pdf

36. S Ross, *Birth right*, Doubleday. Sydney, 2005, p.23 quoted in Midwives in private practice, Submission to the Senate Standing Committee on Community Affairs, *Inquiry into the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills*, op. cit.

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medical professional, doulas take no clinical responsibility for birth outcomes. However, it is claimed that women may see doulas as less expensive birth options if this legislation goes through. They may perceive doulas as persons who have

... *some idea* of what is happening through the birthing process. Women may mistakenly view this as 'safer' although doulas are not trained to resuscitate mothers or babies, detect complexities or treat them, or to know when there is a need for transfer. In some ways this presents a picture that is even less safe than free-birthing without a doula because women may mistakenly believe that the doula will keep them from harm.³⁷

Homebirthing: how prevalent?

Australian Institute of Health and Welfare (AIHW) figures indicate that in 2006 there were 277 436 women who gave birth, resulting in 282 169 births. Most births in Australia occur in conventional labour-ward settings. In 2006, ninety seven per cent of births were in hospitals (269 835 gave birth in a hospital). A further 5460 women gave birth in birth centres and planned homebirths and other births, such as unexpected births accounted for less than one per cent of births (2053 women).³⁸

There is no official data collected for freebirths in Australia. However, one source considers there may be around ten births annually registered in South Australia for which there is no midwife's form for a planned homebirth. This source notes that South Australia accounts for only seven per cent of the total births in Australia. It adds that if someone who has a freebirth attends hospital for antenatal or postnatal care their births may be counted as babies born before arrival. South Australia recorded 73 of these in 2006.³⁹

Homebirthing: safe or not?

The AMA is strongly opposed to 'publicly funded midwife led home birth'. In its submission to the Maternity Services Review it cited a 1998 Australian Study published in the *British Medical Journal* which showed that in-home birthing by midwives is three

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37. Midwives in private practice, Submission to the Senate Standing Committee on Community Affairs, Inquiry into the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills, op. cit.
 38. P Laws and L Hilder, *Australia's mothers and babies 2006*, Australian Institute of Health and Welfare (AIHW), viewed 3 August 2009, <http://www.aihw.gov.au/publications/per/amb06/amb06.pdf>
 39. South Australia Department of Health, *Pregnancy Outcome in South Australia 2006*, Pregnancy Outcome Unit, Epidemiology Branch, Government of South Australia, 2007 quoted in L Newman, 'Why planned attended homebirth should be more widely supported in Australia', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 458, 2008, viewed 3 August 2009, <http://www.homebirth.net.au/2008/10/homebirth-article-in-journal-of-obs-and.html>

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times more likely to lead to perinatal mortality than conventional options even with the lowest risk pregnancies noting:

... 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.⁴⁰

The same study noted however, that the death rate for homebirths in a number of other countries was lower than Australia. It added that the higher perinatal death rate in Australian homebirths was due to the inclusion in this study of predictably high risk births and prolonged asphyxia during labour.⁴¹ It concluded from this that 'home birth for low risk women can compare favourably with hospital birth' but high risk homebirth was inadvisable. It cited a number of possible reasons for the higher death rate in Australia, one of which was the low case loads of homebirth practitioners; another that many homebirth practitioners in Australia at the time did not restrict the offer of homebirth to women with a low birth risk.⁴² While this report recommends caution in concluding that homebirth is completely safe, it is not as disparaging as some would indicate.

Like the AMA, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists has also clearly stated since 1987 that it does not endorse the idea of home births.⁴³ The College also relies on the Australian study of homebirths noted above to substantiate its position and to at least one other source that is not the outright condemnation of homebirthing it suggests.⁴⁴ In opposition to these views the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG) issued a joint statement in 2007 in support of homebirth for women with uncomplicated pregnancies.⁴⁵

40. AMA, Submission to the Maternity Services Review, op. cit.

41. H Bastian, M Keirse and P Lancaster 'Perinatal death associated with planned home birth in Australia: population based study', *British Medical Journal*, vol 317, 1998, viewed 3 August 2009, <http://www.bmj.com/cgi/content/full/317/7155/384>

42. Bastian and others, op. cit.

43. Royal Australian and New Zealand College of Obstetricians and Gynaecologists, College statement June 2008, viewed 3 August 2009, <http://www.ranzcog.edu.au/publications/statements/C-obs2.pdf>

44. Bastian and others, op. cit. and E Hodnett, S Downe, N Edwards and D Walsh, *Home-like versus conventional institutional settings for birth, (Review)*, The Cochrane Library, Iss. 3, 2009, viewed 3 August 2009, http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000012/pdf_fs.html

45. Royal College of Obstetricians and Gynaecologists/Royal College of Midwives, Joint statement no. 2, April 2007, viewed 4 August 2009,

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In addition, there is a considerable body of evidence which supports the home birth option. The *British Medical Journal* for example has cited a 2005 study of planned home births in America which concluded:

Women who intended at the start of labour to have a home birth with a certified professional midwife had a low rate of intrapartum and neonatal mortality, similar to that in most studies of low risk hospital births in North America. A high degree of safety and maternal satisfaction were reported, and over 87% of mothers and neonates did not require transfer to hospital.⁴⁶

It added:

Our results for intrapartum and neonatal mortality are consistent with most other North American studies of intended births out of hospital and studies of low risk hospital birth. A meta-analysis and the latest research in Britain, Switzerland, and the Netherlands have reinforced support of home birth. Researchers reported high overall perinatal mortality in a study of home birth in Australia, qualifying that low risk home births in Australia had good outcomes but that high risk births gave rise to a high rate of avoidable death at home. Two prospective studies in North America found positive outcomes for home birth, but the studies were not of sufficient size to provide relatively stable perinatal death rates. None of this evidence, including ours, is consistent with a study in Washington State based on birth certificates. That study reported an increased risk with home birth but lacked an explicit indication of planned place of birth, creating the potential inclusion of high risk unplanned, unattended home births.⁴⁷

A recent study from The Netherlands in 2009 reached similar conclusions as have a number of others ranging over a period of more than twenty years.⁴⁸ The Netherlands study looked at perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births over seven years. It did not find increased risks of perinatal mortality and severe perinatal morbidity among low-risk women planning home births. It recommended that these women ‘should be encouraged to plan their birth at the

http://www.rcmnormalbirth.net/webfiles/Statement/Home%20Births_Joint%20Statement.pdf

46. K Johnson and B Daviss, ‘Outcomes of planned home births with certified professional midwives: large prospective study in North America’, *British Medical Journal* vol, 330, 2005, viewed 3 August 2009, <http://www.bmj.com/cgi/content/full/330/7505/1416#REF8>
47. Johnson and Daviss, op. cit.
48. A de Jonge, B van der Goes, A Ravelli, M Amelink-Verburg, B Mol, J Nijhuis, J Bennebroek Gravenhorst and S Buitendijk, ‘Perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births’, *British Journal of Obstetrics and Gynaecology*, 2009, viewed 3 August 2009, http://www.homebirthservices.com.au/files/2864672/uploaded/De_Jong_et_al_2009.pdf. See also a list of some of these studies at Home Birth Services.com.au.

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place of their preference, provided the maternity care system is well equipped to underpin women's choice'.⁴⁹

Publicly funded homebirths

One possible option to ensure that homebirthing is not forced 'underground' as a result of this legislative package and the national registration and accreditation legislation would be for the Government to provide funding to the states and territories to expand publicly funded homebirthing. Publicly funded homebirthing is currently available in Western Australia, South Australia, the Northern Territory and New South Wales. The Community Midwifery Program in Western Australia (CMWA) for example was established in 1996 in partnership with the Western Australian Department of Health through the North Metropolitan Area Health Service. It operates across the Perth metropolitan area and is available to women experiencing a low-risk pregnancy. As a result of a medical indemnity crisis in the early 2000s which was caused by rising insurance premiums and the collapse of Australia's largest medical insurance provider the Commonwealth agreed to subsidise insurance premiums for medical practitioners. It did not subsidise premiums for midwives, however, and since that time private midwives have been working without indemnity insurance. CMWA, however, was able to negotiate with the Department of Health to secure access to professional indemnity insurance for midwives working under the Community Midwife Program in that state.⁵⁰

Similar community midwifery programs are available in South Australia and the Northern Territory, but as in the Western Australia case, these are limited in geographic scope. The Northern Territory program operates only in Darwin and Alice Springs for instance, thereby ruling out a significant proportion of the Territory population from participation. In addition, as the Senate Inquiry into the nurse practitioner and midwives Bills was told, the Northern Territory program is considered by some to be 'the most vulnerable and marginalised of all maternity services in the Territory'. Its problems range from the lack of service coverage area to poor conditions and remuneration for midwives.⁵¹

The New South Wales publicly funded homebirth model was the result of several years of planning at the state and local levels. Homebirth services in that state were first established in 2005 at St George Hospital in the Sydney suburb of Kogarah and have also been

49. De Jonge and others, op. cit.

50. The Community Midwifery Western Australia website has more details on its history and services, viewed 3 August 2009, <http://www.cmwa.net.au/>

51. Darwin Home Birth Group, Submission to the Senate Standing Committee on Community Affairs, *Inquiry into the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills*, op. cit., viewed 4 August 2009, http://www.aph.gov.au/SENATE/committee/clac_ctte/health_leg_midwives_nurse_practitioners_09/submissions/sub12.pdf

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available from 2007 at Belmont and from 2008 at Shellharbour Hospitals. Indemnity issues were resolved as homebirths were attended by midwives employed by the hospitals.

Problems would need to be resolved if this model were to be expanded upon to give women more homebirth options. As a review undertaken of the St George program in late 2007 noted, midwives employed by St George Hospital were only able to provide homebirth services to women who registered with the hospital's birth centre due to workload restrictions. This meant that there were limited numbers of homebirth places available (this has been noted in Western Australia also). It was suggested by this review that contracting midwives in private practice could work in the service as an option to overcome this shortage.⁵²

Given the significant evidence that low risk homebirth attended by qualified midwives is safe, as some submissions to the Senate Inquiry into these Bills have noted, it could be argued that it would be simpler to include private midwives under the definition of those eligible for government indemnity coverage. This could satisfy both the homebirth lobby and the nursing profession. On the other hand, such a decision would most likely alienate medical practitioners who appear to consider any semblance of independent practice by other health practitioners as a threat to the traditional doctor-centric model of care that has dominated the Australian health system. The simple option would be complicated and viewed as provocative by the medical profession.

Insurance

The issue of insurance has become central to the debate around homebirth which has arisen out of Minister Roxon's comments regarding the Government's intentions not to support homebirth.⁵³ One of the fundamental questions arising is whether the community does itself a disservice by limiting its field of activities to those that can be insured. As noted above, some private midwives are currently operating without insurance. On the other hand there may be public policy reasons which oblige the government to impose requirements for insurance in various situations or, in its absence, to ban the uninsurable activity, or finally, to provide support from the public sector for forms of insurance which have become unavailable within the private insurance market.

Relying on the provision of insurance through the insurance industry as a way of determining what is, or is not a permissible behaviour can be difficult. Thus the

52. C Homer, *Evaluation of the publicly-funded homebirth program in South East Sydney Illawarra Area Health Service*, Homebirth Steering Committee, September 2007, viewed 4 August 2009, <http://www.nmh.uts.edu.au/cmcfh/research/stgeorge-homebirth.pdf>

53. 'At this stage, the Commonwealth is not proposing to extend the new arrangements for midwives to include homebirths. ... Commonwealth supported professional indemnity cover will not respond to claims relating to homebirths.' N Roxon, *op. cit.*

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‘insurance indemnity crisis’ of 2001⁵⁴ would have seen doctors going out of practice if it were not for the government decision to support the insurance of doctors in 2003.⁵⁵ The insurance market does not make its decisions of how and what to ensure in a manner that is focussed on public policy concerns⁵⁶ (indeed one insurer has suggested that the failure of the private sector to insure midwives may be to do with a desire to please its pre-existing clients rather than actuarial concerns⁵⁷).

The consensus is that childbirth is a potentially dangerous time for both mother and baby, however at the moment both midwives and pregnant women are choosing to birth at home with limited or no access to insurance. The government is faced not only with the question of whether it should allow these choices taken by women but also whether it should step in on behalf of the unborn child and try to force a situation where the birthing process will be to some extent insured. Either option has the potential to restrict the freedom of pregnant or birthing women.

The role of Medical Indemnity has been a vexed one. After the start of the ‘indemnity crisis’ there was a Medical Indemnity Policy Review Panel in 2003 which resulted in the Government offering significant support for doctors’ insurance arrangements.⁵⁸ The Consumer submission to the Panel argued that ‘[s]hort term strategies such as Government support for an ailing private sector medical indemnity organisation’ are inappropriate and unsustainable.⁵⁹ More generally they argued that ‘most of the reforms to date [have been]

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54. Rachel Callinan, ‘*Medical Negligence and Professional Indemnity Insurance*’, Parliament of New South Wales, Background Paper No. 02/2001, <http://www.parliament.nsw.gov.au/prod/parlment/publications.nsf/key/ResearchBp20012> viewed 8 August 2009.
 55. See generally AAP, Fed: *Factbox on medical indemnity insurance crisis*, <http://www.encyclopedia.com/doc/1P1-52703745.html>, viewed on 8 August 2009.
 56. Peter Cashman, ‘Tort Reform and the Medical Indemnity ‘Crisis’’ - University of New South Wales Law Journal, vol. 25 no. 3, 2002, p. 57, viewed 8 August 2009, <http://www.austlii.edu.au/au/journals/UNSWLJ/2002/57.html>
 57. 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
 58. See generally the joint media release by the then Ministers Abbott and Coonan, T Abbott (Minister for Health and Ageing) and H Coonan (Minister for Revenue) ‘Government Medical Indemnity Arrangements, media release, 17 December 2003, viewed 8 August 2009, <http://www.ama.com.au/node/3830>
 59. Submission to the Medical Indemnity Policy Review Panel on behalf of the Australian Consumers’ Association (ACA), Health Issues Centre (HIC) and Consumers’ Health Forum of Australia (CHF), December 2003, viewed 8 August 2009, http://www.chf.org.au/Docs/Downloads/311_med_indemnity_review.pdf

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superficial and directed at industry support rather than focusing on fairness to patients'. They were in favour of a no-fault system of tort law reform because

For consumers, the tort system means that we have to sue for damages to right wrongs that have been done to us. This path is costly (even in a no-win, no-fee case), extraordinarily slow and time consuming. The legal process is often traumatic and is vulnerable to being driven by lawyers' interests. Perhaps most importantly, it leaves many consumers who are severely harmed in health care with no compensation. ... [We strongly support] the development of a no-fault care cost scheme to address the most obvious shortcomings with current arrangements around the provision of high quality long term care and community support for those who need it.

There were and are other voices who argue along similar lines, however Australia does not seem immediately likely to follow in New Zealand's footsteps and abandon our fault based tort system.⁶⁰ While the no-fault system may be a longer term solution the discussions around the issue point to the fact that reliance on the insurance industry to determine what behaviours are legal or illegal may be unwise. Allowing health care arrangements to be determined by the vicissitudes of the insurance industry may have unfortunate consequences (as the government recognised when it stepped in to support insurance arrangements for doctors). Indeed a Queensland subcommittee of the Australian College of Midwives has argued that insurance arrangements should be used to promote the provision of good regulation and safety in homebirths:

The exclusion of homebirth from indemnity has been suggested to be a mechanism of "tightening up" homebirth and "bringing it in to state based services". The legislation as it is proposed will have entirely the opposite effect. Provision of indemnity insurance could be attached to a model of homebirth which enables quality and safety mechanisms to be built in. Exclusion of homebirth and the deregistration of midwives providing homebirth care excludes any potential quality and safety processes around homebirth care.⁶¹

In the end these issues may be resolved by the government in a non-parliamentary setting by use of their rule making powers.

60. For more information on New Zealand's system see generally, K Oliphant, 'Beyond Misadventure: Compensation for Medical Injuries in New Zealand', *Medical Law Review*, vol. 15, Autumn 2007, pp. 357–391, viewed 10 August 2009, <http://medlaw.oxfordjournals.org/cgi/reprint/15/3/357>

61. Midwives in Private Practice Subcommittee of the Australian College of Midwives Qld Branch, Submission to the Senate Standing Committee on Community Affairs, *Inquiry into the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills*, viewed 10 August 2009, http://www.aph.gov.au/Senate/committee/clac_ctte/health_leg_midwives_nurse_practitioner_s_09/submissions/sub07.pdf

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Main provisions

The content of the Bill is set out in four chapters.

Chapter 1—Introductory matters

Clause 3 sets out the objects of the proposed Act and its companion, the *Midwife Professional Indemnity (Run-off Cover Support Payment) Act 2009*. The Bill aims to contribute towards the availability of professional midwife services in Australia by providing Commonwealth assistance to support access by ‘*eligible midwives*’ to a scheme to provide indemnity for claims arising from their professional activities.

The term ‘*eligible midwife*’ is defined in **clause 5** as a person who:

- is licensed, registered or authorised to practice midwifery by or under a law of the Commonwealth, a State or a Territory and
- meets such other requirements (if any) as are specified in the Rules for the purposes of this paragraph,⁶² and
- is not included in a class of persons specified in the Rules for the purposes of this paragraph.

An intention to exclude the class of persons who are involved in homebirths under the Rules is apparent in the second reading speech by the Minister for Health and Ageing in relation to the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 in which she stated:

At this stage, the Commonwealth is not proposing to extend the new arrangements for midwives to include homebirths. Medicare benefits and PBS prescribing will not be approved for deliveries outside clinical settings, and the Commonwealth supported professional indemnity cover will not respond to claims relating to homebirths.⁶³

While this has excited some comment, no mention is given to the exclusion of homebirths in either the second reading speech for this Bill, or the Bill itself. On the contrary, in the second reading speech for this Bill, Ms Roxon stated:

62. Rules made under this Act will be legislative instruments in accordance with the *Legislative Instruments Act 2003* and will be subject to disallowance.

63. N Roxon, (Minister for Health and Ageing), ‘Second reading speech: Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009’, House of Representatives, *Debates*, 24 June 2009, p. 7, viewed on 20 July 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F2009-06-24%2F0022%22>

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For the purposes of this bill, an eligible midwife is one who is licensed, registered or authorised to practise midwifery under a state or territory law and who meets any other requirements specified in the rules...

Overall, this bill contributes to a new era for midwifery services in this country, by addressing a longstanding impediment that has limited the availability of a wider choice for women.⁶⁴

According to **subclause 3(2)** this will be achieved in three ways:

- the Commonwealth will pay part of the costs of large settlements or awards paid by eligible insurers that indemnify eligible midwives
- the Commonwealth will pay that part of a settlement or award which exceeds an insurance contract limits, in certain circumstances, and
- the Commonwealth will pay certain claims against eligible midwives who are no longer in private practice.

Chapter 2—Midwife Professional Indemnity Commonwealth Contributions

Clause 10 sets the relevant claim thresholds being:

- Level 1: \$100 000 or another amount set by the Rules and
- Level 2: \$2 million or another amount set by the Rules.

Level 1 and 2 are distinguished by the levels of coverage, who can make a claim and the criteria that must be met (as discussed below).

Need for a qualifying claim certificate

After a claim is made against a midwife by a person, a Level 1 or Level 2 Commonwealth contribution will not be payable unless there is a *'qualifying claim certificate'* in force in relation to the claim: **subclauses 16(1)** and **18(1)**.

The *'common requirements'* for obtaining a qualifying claim certificate, as listed in **subclause 11(3)**, must be met. These include:

- a claim is made against a midwife in relation to an incident that occurred in the course of, or in connection with, the midwife's practices as an *'eligible midwife'*:⁶⁵ **paragraphs 11(3)(a)–(b)**

64. N Roxon (Minister for Health and Ageing), 'Second reading speech: Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009', House of Representatives, *Debates*, 24 June 2009, p. 9, viewed on 20 July 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansard%2F2009-06-24%2F0026%22>

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- there is a contract of insurance held by an eligible insurer which provides midwife professional indemnity cover in relation to the claim: **paragraph 11(3)(c)**
- an incident has occurred in Australia or an external territory: **paragraph 11(3)(d)**
- the claim does not relate to an incident that occurred in the course of treatment of a public patient of a hospital or to an incident for which the eligible midwife would otherwise be indemnified: **paragraphs 11(3)(e)–(g)**
- the incident must have occurred on or after 1 July 2010, and on or before the relevant termination date:⁶⁶ **paragraphs 11(3)(h)–(i)**
- the claim is not an aggregate of two or more claims against the midwife: **paragraph 11(3)(j)**, and
- the claim is not one about which specific Rules have been made: **paragraphs 11(3)(k)–(m)**.

There are additional requirements for a Level 2 qualifying claim certificate. These include that there is a contract of insurance entered into by an eligible insurer which provides midwife professional indemnity cover in relation to the claim, and the limit of the eligible insurer's liability under the contract in relation to that claim equals or exceeds the Level 2 claim threshold.⁶⁷ **subclause 11(4)**.

An application for a Level 1 qualifying claim certificate may be made by an eligible insurer: **subclause 12(1)**. An application for a Level 2 qualifying claim certificate may be made by an eligible insurer, the person against whom the claim is made (the midwife) or a person acting on behalf of that person's behalf: **subclause 12(2)**. The application must be made to the Medicare Australia CEO in the manner and form set out in **subclause 12(3)**.

The Medicare Australia CEO is to make a decision about whether to issue the qualifying claim certificate within 21 days of the date of receipt of the application unless further information in respect of the application is requested. In that case, the Medicare Australia CEO must make a decision about whether to issue the qualifying claim certificate within 21 days of the date of receipt of the further information: **clause 13**. Where the Medicare Australia CEO makes a decision to refuse to issue a qualifying claim certificate, the decision may be reviewed by the Administrative Appeals Tribunal: **subclause 11(7)**.

65. The term '*eligible midwife*' is defined in **clause 5** as meaning a person who is licensed, registered and authorised to practice midwifery by or under a law of the Commonwealth, a State or a Territory and who meets the requirements of any of the Rules.

66. According to **clause 7**, the relevant termination date for Level 1, Level 2 and run-off cover may be set by Rules.

67. **Clause 10(2)** provides that the Level 2 claim threshold is \$2 million or another amount set by the Rules.

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Revocation or variation of qualifying claims certificate

Importantly, **clause 15** empowers the Medicare Australia CEO to revoke a qualifying claim certificate in circumstances where the terms of subclauses 11(1) and (2) are no longer satisfied. That is, the claim does not meet the *'common requirements'* set out in clause 11(3) and, for a Level 2 claim, does not meet the additional requirements in clause 11(4).

Comments about the power to revoke or vary qualifying claim certificates

Of concern is **subclause 15(2)** which allows the Medicare Australia CEO, in making the decision to revoke a qualifying claim certificate, to consider Rules under paragraphs 11(3)(k)–(m) and paragraph 11(4)(b) which have been made **after** the original decision to issue the certificate. Whilst the Minister has a broad power to make Rules which exclude a class of claim, or to make Rules which exclude claims in relation to a kind of incident, the effect of **subclause 15(2)** is that Rules made **after** claims of that type have been given a qualifying claim certificate, may operate so that the certificate can be revoked—in which case neither a Level 1 nor a Level 2 Commonwealth contribution would be payable. There is no explanation of the rationale behind this provision in the Explanatory Memorandum which contains a précis of the bill. According to **subclause 15(4)** any Commonwealth contribution which already had been paid in that circumstance would be overpaid, and therefore, recoverable.

Subclause 15(3) empowers the Medicare Australia CEO to vary a qualifying claim certificate in circumstances where a matter is not correctly identified or specified. Decisions to revoke or vary a qualifying claim certificate are subject to review by the Administrative Appeals Tribunal: **subclause 15(6)**.

Level 1 payability

Before the Medicare Australia CEO can determine that a Level 1 Commonwealth contribution is payable to an eligible insurer on a claim against a midwife, the eligible insurer must have lodged a claim,⁶⁸ a qualifying claim certificate must be in force, and the following further requirements must be satisfied:

- where there is a person, other than the midwife, against whom a claim has been made or is likely to be made in relation to the incident,⁶⁹ either:
 - an apportionment certificate is in force,⁷⁰ or

68. **Clause 58** requires an application by an eligible insurer to be made in writing, on an approved form and to be accompanied by documents and other information as required.

69. For example, a doctor who provided treatment in respect of the subject birth, in a private hospital, but not a public hospital.

70. See **clauses 51–57**.

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- there is a judgment or order of a court which apportions liability: **paragraph 16(1)(c)**
- the eligible insurer has a ‘*qualifying payment*’ which exceeds the Level 1 claim threshold: **paragraphs 16(1)(d)–(e)**
- any requirements under the Rules have been met: **paragraphs 16(1)(g)–(h)**.

The eligible insurer has a ‘*qualifying payment*’ if the insurer pays, or becomes liable to pay an amount:

- in relation to a claim against a midwife, whether under a written agreement or under a court order or judgment which is not stayed or the subject of an appeal: **paragraph 16(3)(a)**
- payable under an insurance contract with the midwife in the ordinary course of the insurer’s business: **paragraph 16(3)(b)–(c)** and
- in accordance with the proportion of the overall liability which has been specified in the apportionment certificate: **paragraph 16(3)(d)**.

Clause 17 sets the amount of the Level 1 Commonwealth contribution as 80 percent (or another percentage specified in the Rules) of the amount by which the eligible insurer’s qualifying payment exceeds the Level 1 claim threshold but does not exceed the Level 2 claim threshold.

How does it work?

For illustrative purposes, suppose a claim against a midwife is for the amount of \$140 000. This is above the Level 1 threshold of \$100 000 and below the Level 2 threshold of \$2 million, set out in clause 10. The eligible insurer is liable for the first \$100 000, plus 20 percent of \$40 000, being the amount of \$8 000. The Commonwealth contribution is 80 percent of \$40 000, being the amount of \$32 000, which is paid directly to the eligible insurer.

Level 2 payability

The Medicare Australia CEO may decide that a Level 2 Commonwealth contribution is payable in relation to the liability of the midwife where a claim against a midwife has been made, a Level 2 qualifying claim certificate is in force and, where appropriate, an apportionment certificate has been issued by the Medicare Australia CEO. In addition, the liability of the midwife must be a ‘*qualifying liability*’ under **clause 19** which requires that:

- the liability arises from a judgment or order of a court which is not stayed or the subject of an appeal in relation to the claim, settlement of the claim by way of written agreement, or some other kind of liability arising from the claim such as legal costs

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- the defence of the midwife was conducted appropriately⁷¹
- a legal practitioner has given a statutory declaration certifying that the amount of liability is reasonable and
- the amount payable in relation to the claim is in accordance with the proportion specified in the apportionment certificate.

Finally, the Medicare Australia CEO must also ensure that each of the following requirements is satisfied:

- the contract of insurance between the eligible insurer and the midwife does not cover, or does not fully cover, the amount of the liability:⁷² **paragraph 18(1)(e)**
- the amount that the eligible insurer would have been liable to pay if the contract of insurance had fully covered the liability, exceeds the amount that the eligible insurer is liable to pay under the actual contract of insurance: **paragraph 18(1)(f)**, and
- the total of the amounts the insurer has paid, (or is liable to pay) under the actual contract of insurance and the other amounts that the insurer has become liable to pay in respect of the claim, equals or exceeds the Level 2 claim threshold: **paragraph 18(1)(g)**.

The effect of **clause 20** is that, in calculating the amount that the eligible insurer is liable to pay under the actual contract of insurance, no account should be taken of any Level 1 or run-off cover Commonwealth contribution that may be payable to the eligible insurer. This means that for a claim which exceeds the \$2 million Level 2 threshold, a Level 1 or run-off cover Commonwealth contribution may also be payable to an eligible insurer.

A Level 2 Commonwealth contribution is made to the person who applies for it: **subclause 18(2)**, that is, the eligible insurer, the midwife or a person acting on behalf of the midwife. The decision of the Medicare Australia CEO to refuse an application for Level 2 Commonwealth contribution is subject to review by the Administrative Appeals Tribunal: **subclause 18(4)**.

Where the Level 2 Commonwealth contribution is paid to the midwife or a person acting on behalf of the midwife (referred to as *the recipient*) **clause 22** requires the Medicare Australia CEO to send a notice to the recipient advising how the Level 2 Commonwealth contribution is to be dealt with:

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71. **Subclause 19(2)** provides that a defence is conducted appropriately where it is conducted by an insurer or a legal practitioner engaged by the insurer to a standard consistent with the insurer's usual standard for the conduct of the defence of claims.
 72. Note that under **clause 11(4)** it is a requirement for a Level 2 qualifying claim certificate that the limit of the eligible insurer's liability under the contract in relation to a claim equals or exceeds the Level 2 claim threshold. This means that even if the contract of insurance does not fully cover the amount of the liability, the cover will be for at least \$2 million.

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- if the amount is less than or equal to the undischarged amount of the liability, the recipient must apply the whole of the contribution to discharge the liability: **subclause 22(3)**
- if the amount is greater than the undischarged amount of the liability the recipient must
 - discharge the liability: **paragraph 22(4)(a)** and
 - if the recipient is not the midwife, deal with the balance in accordance with the directions of the midwife: **paragraph 22(4)(b)**.

If the recipient does not comply with the terms of the notice the amount of the contribution becomes a debt due to the Commonwealth: **subclause 22(6)**.

Where an amount of Level 2 Commonwealth contribution has been paid in respect of a claim against a midwife, and the person who applied for the contribution becomes aware that another amount has been paid in respect of the same incident, the applicant must notify the Medicare Australia CEO that the other amount has been paid:⁷³ **clause 26**. A failure to notify is an offence of strict liability⁷⁴ and is subject to a maximum penalty of 30 penalty units.⁷⁵

Where the appropriate notification is made, **clause 25** provides that the amount of Level 2 Commonwealth contribution is to be recalculated. The effect is to reduce the Level 2 Commonwealth contribution in respect of the claim. The difference between the amount of Commonwealth contribution actually paid and the reduced amount is a debt due to the Commonwealth which may be recovered by the Medicare Australia CEO. Where an overpayment arises under clause 25, the Medicare Australia CEO may give notice to the **liable person** of the amount of the overpayment and the day on which the repayment of the amount is due, being at least 28 days from the date of the notice: **clause 27**.

Importantly, **clause 23** sets out who is the **liable person** in relation to an overpayment of Level 2 Commonwealth contribution as follows:

- if the contribution has not yet been dealt with in the manner set out in the notice given by the Medicare Australia CEO under clause 22(2)—the person to whom the Level 2 Commonwealth contribution was paid
- if the contribution has been dealt with in the manner set out in the notice given by the Medicare Australia CEO under clause 22(2)—the midwife.

73. This should be a rare occurrence as the question of whether another person is liable for the same incident would generally be canvassed in the application for an apportionment certificate.

74. **Clause 67** sets out the offence arising from a failure to notify the Medicare Australia CEO of a matter under clauses 14, 26, 38, 45, 46 or 55.

75. Section 4AA of the *Crimes Act 1914* provides that a '**penalty unit**' is \$110. This means that the amount of the penalty under clause 67 is \$3 300.

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Any part of the debt which is unpaid on the due date is subject to a late payment penalty which is calculated at a rate specified in the Rules: **subclauses 28(1)–(2)**. The Medicare Australia CEO may remit the whole or a part of a late payment penalty if there are good reasons for doing so: **subclause 28(3)**. A decision not to remit, or to only partially remit, a late payment penalty is reviewable by the Administrative Appeals Tribunal: **subclause 28(4)**.

How does it work?

For illustrative purposes, suppose a claim against a midwife is for the amount of \$2.4 million which is above the Level 1 and the Level 2 threshold amounts. The eligible insurer applies for Level 1 Commonwealth contribution and the midwife applies for Level 2 Commonwealth contribution. The claim is paid as follows:

- the eligible insurer is liable for the first \$100 000, that is, the amount below the Level 1 threshold plus 20 percent of \$1 900 000,⁷⁶ being \$380 000
- the Level 1 Commonwealth contribution, payable to the eligible insurer, is 80 percent of \$1 900 000 being \$1 520 000
- the Level 2 Commonwealth contribution, payable directly to the midwife, but to be applied in accordance with a notice from the Medicare Australia CEO, is \$400 000 being the amount in excess of the Level 2 threshold.

Eligible run-off claims

An *‘eligible run-off claim’* relates to an incident that occurred on or after 1 July 2010 and on or before the *‘run-off cover termination date’* in connection with a person’s practice as an eligible midwife:⁷⁷ **paragraph 31(1)(b)**. If a *‘run-off cover termination date’* has been specified in the Rules, **paragraph 31(1)(c)** operates so that a person already eligible under the scheme will continue to have their claims covered by the terminated scheme until they cease to be eligible.

A claim is an *‘eligible run-off claim’* if the person against whom the claim is made has midwife professional indemnity run-off cover that indemnifies the person in relation to the claim: **paragraph 31(1)(d)**.

An *‘eligible run-off claim’* may be brought in respect of the following:

76. This covers the payments under the Level 2 threshold amount of \$2 million.

77. The *run-off cover termination date* is specified in the Rules in accordance with subclause 7(3). It is the date that the run-off cover scheme which is the outlined in this Bill and the Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009, ends.

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- a person aged 65 years or over who has permanently retired from private practice as an eligible midwife, or regardless of age, has not practiced as an eligible midwife during the preceding three years: **paragraphs 31(2)(a)–(b)**
- a person who has ceased practice as an eligible midwife due to maternity or a permanent disability: **paragraphs 31(2)(c)–(d)**
- a person who is the legal personal representative of a deceased person who had been an eligible midwife: **paragraph 31(2)(e)**, and
- a person who is included in a class of persons specified in the Rules: **paragraph 31(2)(f)**.

Run-off cover payability

According to **subclause 32(1)** run-off cover Commonwealth contributions are payable to an eligible insurer if, amongst other things, an eligible run-off claim is made, an apportionment certificate is in force if appropriate, the eligible insurer is liable to make a payment in relation to the claim under a contract of insurance in the normal course of business, and the eligible insurer applies to the Medicare Australia CEO for a contribution.

The amount of run-off cover Commonwealth contribution is the amount payable in accordance with the apportionment certificate: **paragraph 32(1)(g)**.

Where a run-off cover Commonwealth contribution has been calculated without having regard to any other payments made in respect of the claim, the amount of the contribution is to be recalculated and reduced: **clause 36**. The same applies where an amount is paid to a midwife, eligible insurer or other person after the run-off cover Commonwealth contribution has been paid: **clause 37**. The difference between the amount of contribution that has been paid, and the amount that should have been paid, is an overpayment which is recoverable by the Medicare Australia CEO: **subclauses 37(2) and (4)**.

The Medicare Australia CEO must notify the eligible insurer in writing of the amount overpaid, and the date by which it must be paid, being no less than 28 days from the date on which the notice is given: **clause 39**. Where the debt remains wholly or partly unpaid after the due date, it is subject to a late payment penalty at a rate specified in the Rules: **clause 40**.

How does it work?

The manner in which run-off cover works is slightly confusing for the following reasons:

- The Bill distinguishes between those claims for which a Level 1 or Level 2 Commonwealth contribution, and those for which a run-off cover Commonwealth contribution, are paid. Level 1 or Level 2 Commonwealth contributions are payable where there is a qualifying claim certificate. One of the common requirements for a qualifying claim certificate is that there is a contract of insurance entered into by an

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eligible insurer that provides midwife professional indemnity cover in relation to the claim.⁷⁸

- In comparison, a claim for a run-off cover Commonwealth contribution is payable without the requirement of a qualifying claim certificate, and only in respect of contract of insurance entered into by an eligible insurer that provides midwife professional indemnity run-off cover.⁷⁹
- **Clause 5** defines the terms '*midwife professional indemnity cover*' and '*midwife professional indemnity run-off cover*' as being two separate types of insurance cover which are provided to two separate classes of persons.
- The contradiction arises in **subclause 35(2)** which provides that an amount of run-off cover Commonwealth contribution is reduced by the amount of any Level 1 or Level 2 Commonwealth contributions which have been paid. Given that there are different requirements for payment it is difficult to see how all three types of contribution could be paid in respect of one claim. It does appear from the drafting of the Bill that the contributions are intended to be different, as Level 1 and Level 2 Commonwealth contributions are covered by Part 2 of Chapter 2 of the Bill, whereas run-off cover Commonwealth contributions are covered by Part 3 of Chapter 2 of the Bill.
- Adding to the confusion is the reference in **paragraphs 16(1)(a)** and **18(1)(a)** in Part 2 of Chapter 2 to the '*current claim*' and the reference in **paragraph 32(1)(a)** in Part 3 of Chapter to the '*current claim*'. The term in Part 2 refers to a claim in relation to which a Level 1 or Level 2 qualifying claim certificate is in force⁸⁰ and the term in Part 3 means an eligible run-off claim. This runs contrary to 'the expectation that where a word is used consistently in legislation it should be given the same meaning consistently'.⁸¹

If it was intended that all types of Commonwealth contribution could be payable in respect of a run-off cover claim, this should be clarified.

Where a run-off cover termination date is set

Once a *run-off cover termination date* has been set the amount of Commonwealth contribution (paid out of the Consolidated Revenue Fund) is to be calculated in accordance with **clauses 41–44**.

Clause 42 introduces the term '*affected eligible midwife*'. An eligible midwife is an '*affected eligible midwife*' if:

78. **Paragraph 11(3)(c)**.

79. **Subclause 32(2)**.

80. See **paragraphs 16(1)(b)** and **18(1)(b)** respectively.

81. D C Pearce and R S Geddes, *Statutory Interpretation in Australia*, sixth edition, LexisNexis Butterworths, Australia, 2006, p. 117.

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- a run-off cover termination date has been set
- before that date, premiums have been paid by the midwife in respect of midwife professional indemnity cover in relation to one or more periods totalling 12 months and
- immediately before the run-off cover termination date the eligible midwife was not a person in respect of whom an eligible run-off claim could be made, that is, the eligible midwife did not satisfy any of the conditions of clause 31(2).

The Commonwealth is to make payments in respect of an affected eligible midwife to the person nominated as the provider of the midwife's professional indemnity cover, as part of the premium payable in respect of that insurance cover, within 12 months of the run-off cover termination date. The total of the payments must not exceed the eligible midwife's **'total run-off cover credit'**: **clause 43**. The method for calculating total run-off cover credits is set out in **clause 44**.

Apportionment certificates

Before a decision can be made about the amount of the Commonwealth contribution, it is necessary to determine whether an **'apportionment certificate'** is to be issued. **Clause 53** requires an eligible insurer of a midwife to apply for an apportionment certificate in relation to a claim, if the insurer considers that there is another person against whom a claim has been, or is reasonably likely to be made in relation to the incident which is the subject of the claim. In that case, the eligible insurer must apply for the apportionment certificate in the manner and form required by the Medicare Australia CEO: **subclause 53(2)**. The time limits for making the decision are the same as those set out in clause 13 above: **clause 54**.

Under **clause 51** the Medicare Australia CEO may issue an apportionment certificate in relation to a claim against a midwife where a qualifying claim certificate has been issued and a claim for the apportionment certificate has been made in accordance with clause 53. The apportionment certificate specifies the proportion of overall liability which is to be attributed to the midwife and any other person or persons against whom a claim has been made or is likely to be made in respect of the incident: **subclause 51(2)**. In making the decision about the proportional liability of each party, the Medicare Australia CEO may have regard to the information provided in the application and any other information that is considered to be appropriate: **subclause 51(6)** but is not required to have regard to any information beyond that which was included in the application: **subclause 51(7)**.

Payment of Commonwealth contributions

The Medicare Australia CEO must pay a Level 1 Commonwealth contribution or a run-off cover contribution to an eligible insurer before the end of the month which follows the month in which the application for contribution is made: **subclause 59(1)**. For example, if

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an eligible insurer applies for Level 1 Commonwealth contribution on 11 May of a year, the payment must be made by 30 June of the same year.

The exceptions to this are:

- where the Medicare Australia CEO requests further information in relation to the claim and that information is not provided within the above time frame, the payment must be made before the end of the month which follows the month in which the information is provided: **subclause 59(2)**. For example, an eligible insurer applies for contribution on 11 May of a year. Further information is requested but not received until 3 July of that year. In that case payment must be made no later than 31 August of the same year.
- where the Medicare Australia CEO has received both an application for a qualifying claim certificate and an application for Level 1 Commonwealth contribution, the former is to be determined before any time limits apply to the payment of the latter: **subclause 59(3)**.

An application for payment of Level 2 Commonwealth contribution cannot be made more than 28 days after the date of a judgment or court order in relation to liability and is no longer subject to appeal or an action to stay; or the date that a settlement agreement was entered into: **subclause 60(3)**. The Medicare Australia CEO may accept a late application where there are good reasons for doing so: **subclause 60(4)**. A decision not to accept a late application is subject to review by the Administrative Appeals Tribunal: **subclause 60(5)**.

The Medicare Australia CEO must decide an application for Level 2 Commonwealth contribution on or before the 21st day after the day on which the application is received: **subclause 61(1)**. Where a decision is made to grant the application, payment of the contribution must be made as soon as practicable after making that decision: **subclause 61(4)**.

Information gathering and record keeping

The Medicare Australia CEO is empowered to require information from a person if there are reasonable grounds for believing that the person is capable of giving information which is relevant to, amongst other things, whether a Commonwealth contribution is payable, the amount of the contribution and any future liability to Commonwealth contributions of a particular kind: **subclause 62(1)**. The information may be required from an insurer, an eligible midwife or person who was formerly an eligible midwife, a person acting for an eligible midwife or former eligible midwife, or the legal personal representative of a person who was formerly an eligible midwife: **subclause 62(2)**. Requests for information must be in writing, state the information required and allow for at least 28 days in which the information is to be given: **subclause 62(5)**.

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Persons who apply for a Commonwealth contribution and/or a qualifying claim certificate are obliged to keep the records set out in **clause 63**. Those records must be kept for a period of five years, or another period specified in the Rules, starting on the later of, the day on which the records were created or the day on which this Act commenced.

Overpayment of contributions

Clause 64 provides that an amount of Commonwealth contribution which is overpaid is a debt due to the Commonwealth by the *liable person*. In the case of a Level 1 Commonwealth contribution the liable person is the eligible insurer. The liable person for a Level 2 or run-off cover Commonwealth contribution may be the eligible insurer, the midwife or a person acting on behalf of the midwife. Under **subclause 64(4)** the amount overpaid may be recoverable by an action by the Medicare Australia CEO in a court of competent jurisdiction, by deduction from a Commonwealth contribution payable to the liable person or by garnishee.

Offences

Four offences are created under the Act being:

- failure to give information in response to a formal request from the Medicare Australia CEO: **clause 66**
- failure to notify a matter to the Medicare Australia CEO: **clause 67**
- failure to keep and retain records: **clause 68**
- failure to include the required information in invoices: **clause 69**.

These offences are ‘strict liability’ offences and each has a maximum penalty of 30 penalty units.

Chapter 3—Run-off cover support payments

Chapter 3 of this Bill provides for the payment and administration of ‘run-off cover support payments’ (ROCS).⁸² ROCS payments, imposed under the Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009, are a tax on the premium income of eligible insurers in respect of midwife professional indemnity insurance contracts in a contribution year. According to **clause 74** of this Bill the Rules may provide that a person is exempt from making a ROCS payment in certain circumstances or for a particular contribution year.

82. Note that these matters could not be included in the Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009 because of the constraints in section 55 of the Constitution.

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Clause 75 provides that the ROCS payments in respect of a contribution year become due and payable on 30 June of the contribution year or on another day specified in the Rules. A late payment penalty will be applied to any unpaid amount of ROCS payments at a rate which will be specified in the Rules: **subclauses 76(1) and (2)**. The Medicare Australia CEO may remit the whole or part of the late payment penalty if there are good reasons for doing so: **subclause 76(3)**. The decision of the Medicare Australia CEO is reviewable by the Administrative Appeals Tribunal: **subclause 76(4)**.

Both the ROCS payment and any late payment penalty are debts due to the Commonwealth and are recoverable by the Medicare Australia CEO in a Court of competent jurisdiction: **clause 79**. The Medicare Australia CEO has the power to recover a *'payment debt'* arising under clause 79 by garnishee action: **clause 80**. Where a third party fails to comply with a garnishee notice, so far as they are able to do so, they commit an offence. The penalty is 20 penalty units which is equivalent to \$2 200. The offence is an offence of strict liability. The explanatory memorandum does not indicate whether the *Guide to Framing Commonwealth Offences, Civil Penalties and Enforcement Powers* was considered in the course of framing the strict liability offence.

Clause 82 empowers the Medicare Australia CEO to give written notice to a person seeking information about a liability to pay a ROCS payment if there are reasonable grounds for believing that the person is capable of giving that information. A person who is given a notice which complies with the terms of clause 82 commits an offence if they fail to provide the requested information. The penalty is 30 penalty units which is equivalent to \$3 300: **clause 84**. The offence is an offence of strict liability.

Chapter 4—Miscellaneous matters

Clauses 86 and 87 make clear that the Medicare Australia CEO is to have the general administration of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2009* and the *Midwife Professional Indemnity (Run-off Cover Support Payment) Act 2009*; and will undertake functions under those acts.

Clause 90 provides that the Minister may make Rules by legislative instrument about matters required or permitted under the Act or which are necessary and convenient to give effect to the Act. **Clause 91** contains a regulation making power in similar terms.

Concluding comments

The Bill's broadening of access to insurance coverage has generally been well received, however not all the implications of the arrangements are clear. The Bill provides considerable scope for rule making. At this stage it appears that it is the intention of the Government to make a rule which will exclude those midwives who are involved in homebirths from the benefit of the insurance scheme, however the role of 'insurance' in setting the direction of health policy has not been universally embraced.

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