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Dear Mr Humphery

**Re: Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009
Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009
Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009**

The AMA welcomes the Senate Community Affairs Committee Inquiry into the above Bills currently before the Parliament. This submission will be directed primarily at the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 (the MNP Bill), which essentially sets up the overarching framework to recognise midwives and nurse practitioners in the Medicare Benefits Schedule (MBS) and for the purposes of the Pharmaceutical Benefits Scheme (PBS).

At best, if implemented carefully the legislation may help deliver unmet community health needs where and when they occur in a safe, coordinated, cost effective system of care. If not implemented carefully, it will fragment care, increase the risks of inadvertent patient outcomes, cause duplication and increase costs.

Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009

The MNP Bill has been portrayed by some stakeholders as “historic” and the Minister for Health and Ageing in her second reading speech described it as “one of the centrepieces of the Rudd Government’s workforce and primary health care reform agenda”. The Minister went on to describe the Bill as “a landmark change for Australia’s nurses and midwives”.

The AMA agrees that it is an important bill, but not necessarily for the same reasons that others have outlined. Whether the legislation succeeds or fails depends on what is not contained in the Bill - the requirement for collaborative care models, the detail of who will be responsible for the development and implementation and monitoring of these models and a quality use of medicines framework to govern prescribing privileges. These details are too important to leave to chance.

To ensure that the concerns outlined earlier do not eventuate, the Committee needs to consider not only the overarching legislative framework that the MNP Bill will establish, but also give significant thought to the safety and quality framework that needs to be put in place once the Bill is passed. The Committee needs to examine whether or not the Bill currently has sufficient protections to ensure that a robust quality and safety framework is ultimately put in place.

While the Bill deals with two different health professional activities i.e. nurse practitioners delivering primary care services and midwives delivering maternity care services, the risks are the same and so are the underpinning solutions/recommendations. The AMA submission identifies the risks inherent in the MNP Bill and puts forward recommended solutions to these risks, as we believe it is part of our

medical duty of care to provide them. The recommendations outlined in the submission focus on collaboration and ensuring that a two-tier health system does not emerge.

Looking beyond the rhetoric

The AMA would also encourage the Committee to look beyond the rhetoric when considering the MNP Bill. This Bill is not the panacea to workforce shortages that some groups might have the Committee believe. Australia already has chronic nursing workforce shortages and it makes little sense to seek to transfer more work from doctors to nurses in such an environment.

According to the Australian Nurse Practitioners' Association, there are around 370 nurse practitioners across the country. Nurse practitioners generally work in specialised areas of practice and they are primarily employed in the public sector working in a well-supported team-based environment.

Taking Victoria as an example, there are forty-seven endorsed nurse practitioners, twenty-two of whom are endorsed to work in emergency care. The remainder are endorsed to practice in a range of specialised areas such as nephrology, palliative care, paediatrics, men's health, and young people's health. Two nurse practitioners are endorsed to work in rural and remote health.¹ The expectations in the community about the impact this Bill will have on access to primary care services have been raised by the Government's announcement strategy, but the available statistics clearly tell a much more different story. They also suggest that only a limited number of the current nurse practitioner workforce will seek to provide MBS subsidised services or prescribe PBS-listed medicines.

In contrast, there has been rapid growth in the number of practice nurses working in general practices across the country. A practice nurse is different to a nurse practitioner. Practice nurses are qualified registered or enrolled nurses who deliver primary health care in a general practice. In 2007, there were 7824 practice nurses with the total having nearly doubled since 2003.² Practice nurses improve access to primary care services because they provide support and additional services working in a team with doctors and support the general practice to see more patients, thus improving access to primary health care in the community. Improving support for practice nurses is the AMA's preferred approach to improved access to primary health care services and it is disappointing that the Government did not choose to direct further support towards a model that is clearly working well.

According to Australian Institute of Health and Welfare data, two-thirds (65.3%) of encounters at which a practice nurse performed a clinical or procedural activity did not attract a Medicare benefit³. Despite this lack of support, general practice has embraced the use of practice nurses because it is a good model of care. The international literature suggests a number of benefits that enhanced roles for nurses in general practice can bring to the patient, to the practice, to the nursing and medical professions and to the health system. This research generally suggests that most benefits occur when models of working between nurses and doctors are collaborative⁴.

Australian women also have good access to midwifery services. Sixty four percent of deliveries are public patients in public hospitals, where we largely already have shared care. Most public patient deliveries are performed by midwives if the pregnancy is normal but this occurs under the supervision

¹ Nurse Practitioner Statistics as at 25/06/2009, Nurses Board of Victoria.

² Phillips CB, Pearce CM, Dwan KM, Hall S, Porritt J, Yates R, Kljakovic M, Sibbald B, *Charting new roles for Australian general practice nurses*, Abridged report of the Australian General Practice Nurses Study. Canberra: Australian Primary Health Care Institute, 2008.

³ Britt H, Miller GC, Charles J, Henderson J, Bayram C, Harrison C, Valenti L, Fahridin S, Pan Y, O'Halloran J 2008, *General practice activity in Australia 2007-08*, General practice series no. 22. Cat. no. GEP 22. Canberra: Australian Institute of Health and Welfare.

⁴ Phillips CB, Pearce CM, Dwan KM, Hall S, Porritt J, Yates R, Kljakovic M, Sibbald B, *Charting new roles for Australian general practice nurses*, Abridged report of the Australian General Practice Nurses Study. Canberra: Australian Primary Health Care Institute, 2008.

of an obstetrician in a conventional labour ward or on referral from a birthing centre⁵. Similarly, in the private sector midwives play a key role working with obstetricians and GP obstetricians.

Will there be any savings to the health system?

It is unlikely that the substitution of nurses for doctors will save the health system any money. Studies show that, while there may be potential savings with respect to salaries, this is often offset by longer consultations, higher patient recall rates and the increased use of tests and investigations.⁶

According to Alan Maynard, Professor of Health Economics at the University of York:

*“there is a lack of good evidence to underpin doctor substitution. There are studies around but these are not good design.”*⁷

Looking at GPs as a specific example, research that is often cited as supporting the substitution of nurses for GPs suffers from a number of weaknesses. Most studies have:

- included only small numbers of nurses,
- had patient samples that have generally been too small to detect rare but potentially serious health outcomes such as missed diagnosis, and
- rigorously evaluated only a narrow range of nursing roles.

From a cost perspective, the case for reform is weak.

The devil is in the detail

Like many Bills that now come before the Parliament, the MNP Bill is what could be termed “high-level” law. It establishes an overarching legal framework but gives no insight into how the legislation will work at a practical level. This detail will only emerge once the Government releases subordinate legislation and guidelines to support the operation of the legislation.

This places the Senate Committee in a difficult position. It is required to consider a Bill with key pieces of the puzzle still missing. The MNP Bill provides insufficient guidance on key matters such as:

- the definition of an “eligible midwife”,
- the definition of an “eligible nurse practitioner”,
- the potential scope of practice of eligible midwives and eligible nurse practitioners,
- details of how collaboration will occur,
- any additional qualifications, experience etc that will be required of midwives and nurse practitioners,
- the relevant Medicare items numbers and associated rebates,
- the range of tests that an eligible midwife or eligible nurse practitioners might order,
- the range of medications an eligible midwife or eligible nurse practitioner might prescribe, and
- what processes will be put in place to settle the detail of the matters highlighted above.

In addition, while the Minister’s second reading speech and other commentary highlights that midwives and nurse practitioners will be working in collaboration with medical practitioners, the

⁵ Australian Medical Association, *Maternity Services Review Submission*, October 2008.

⁶ Sibbald B, Laurant MG, Reeves D, ‘Advanced nurse roles in UK primary care,’ *Medical Journal of Australia*, Vol 185 No 1, 3 July 2006.

⁷ Coombes R, ‘Dr Nurse will see you now’, *British Medical Journal* 2008; 337: 660-662.

words collaborate and collaboration do not appear in the Bill at all. There is no guarantee in the Bill that this will be a legislated requirement, nor any prescription as to how it should happen.

In essence, the Committee is required to trust that future processes initiated by the Government will get the above details right. However, in our view the above questions are fundamental to any determination of the merits or otherwise of the Bill and, most importantly, fundamental to ensuring that we maintain the quality and safety of healthcare.

Australia has a good primary care system

Australia has a very good primary care system. It is built on a GP led model of care that ensures the provision of comprehensive, continuous and coordinated patient centred care. A joint Australian Institute of Health and Welfare/University of Sydney report released in October 2008 revealed that general practice provides all the care needed for more than 90% of all health problems that GPs encounter.⁸

GPs champion a team-based approach to patient care, routinely utilising the skills and knowledge of colleagues in the allied health professions. More than 60% of GPs, for example, have a practice nurse. GPs also routinely refer patients to allied health professionals to provide specific specialised care for patients – particularly in relation to chronic disease.

It is widely acknowledged that Australia's GP-led model of primary health care services delivers affordable high-quality health care outcomes. The Commonwealth Government spent \$250 per Australian on general practice in 2005-06 through Medicare, non-Medicare funding, expenditure by the Department of Veterans' Affairs and other funding programs.

The AMA acknowledges that access to a GP is difficult in some areas, particularly in outer metropolitan, regional and rural Australia. However, we do not think the solution lies in the removal of the highest trained health professional from the care model and offering nurse practitioners as the solution. The AMA believes Government should focus on improving access to primary care services by:

- increasing GP training numbers in line with workforce planning recommendations,
- increasing the efficiency of general practice through better IT and other infrastructure,
- freeing up consulting time by reducing red tape such as authority prescriptions,
- supporting GPs to utilise the skills of other health professionals, such as practice nurses, in the care of patients, and
- ensuring that other health professionals working in remote areas have access to medical support and retrieval services, underpinned by robust protocols.

Australia is well positioned to increase GP numbers relatively rapidly. The number of medical graduates in Australia has grown substantially in recent years and will increase further to around 3400pa by 2012 and, given the right policy settings, many of these additional graduates will choose a career in general practice.

Australia is a very safe place to have a baby

In relation to maternity services, Australia has infant and maternal morbidity and mortality statistics that are the envy of many countries. Our mothers and neonates are safe, and our babies are given the best possible start in life. These outcomes must be the primary goal of maternity services.

⁸ Britt H, Miller GC, Charles J, Henderson J, Bayram C, Harrison C, Valenti L, Fahridin S, Pan Y, O'Halloran J 2008. General practice activity in Australia 2007–08. General practice series no. 22. Cat. no. GEP 22. Canberra: Australian Institute of Health and Welfare.

Historically, maternity services in Australia have been medically led. In assessing the public sector deliveries (around 167,000 deliveries pa), we largely already have shared care. Midwives do most deliveries if the pregnancy is normal under the supervision of an obstetrician in a conventional labour ward or on referral from a birthing centre.

The AMA is supportive of a broader role for midwives, particularly in the private sector, but this must not come at the expense of safety and quality. To support greater choice for women, while maintaining safety and quality, Australia must build on the team-based care model that already works well in practice.

Team-based care in the medical model

The AMA respects the skills that other health care professionals bring to the care of a patient. Doctors have been working effectively with other health care professionals for generations. Within a “medical model” of care, the role undertaken by other health professionals has evolved and continues to do so. Indeed, over the years many tasks that were traditionally the realm of doctors have been taken over by other health professions with particular technical skills.

This model has inherent strengths. It ensures that a patient is medically diagnosed and that their care is properly coordinated. Within this model, other health professionals may work autonomously – but they do not work independently. There are defined roles and clear lines of responsibility for a patient’s care. The medical model of care avoids duplication of effort and unnecessary tests or interventions.

The AMA does not agree with the assertions made by some groups that this model of care is disrespectful of the skills of other health care professions. It utilises the skills that different professions bring in an efficient and clinically effective and safe way. With the highest level and longest training, a medical practitioner is best placed to accurately diagnose a patient, giving considering to the patient’s needs as a whole.

This is fundamental to good patient care – not only from the perspective of ensuring the correct diagnosis but also with respect to the initiation of specific interventions and the development and implementation of an appropriate management plan.

In an era where the incidence of chronic disease is growing rapidly and over 80% of Australians aged 60 years or over have at least three chronic conditions, the importance of the medical model of care cannot be stressed enough. Multiple conditions often mean multiple medications, with the inherent risk of adverse effects from the interaction of these medicines. Dealing with such patients requires the exercise of significant judgement that goes well beyond the application of “technical skills” or predetermined single disease treatment protocols that may conflict with other treatment protocols. The required skills in these circumstances lie with the general practitioner, which are developed through many years of medical school, prevocational medical training, the GP training program and ongoing professional development activities.

The enemy of quality care is fragmentation

Despite the stated intentions of the Government, in its current form the MNP Bill has the potential to allow nurse practitioners and midwives to work in isolation of the medical profession or put in place “sham” arrangements that are designed to give the appearance of collaboration. This would provide significant potential for care to become fragmented and could also lead to confusion over who is responsible for a patient’s overall care and conflict between health care professionals.

When care becomes fragmented in this way, the consequences can include:

- the patient’s usual doctor is excluded from decisions about a patient’s care,
- increased risk of misdiagnosis and missed diagnosis,

- the patient's health record becomes increasingly fragmented with different parts being kept in different places by different health professionals (an e-health record is unlikely to properly address this issue because of a lack of clarity over who is responsible for what in relation to a patient's care),
- the increased risk of adverse outcomes from the interaction of different medications and treatments,
- communication between health professionals breaks down and professional silos re-emerge,
- medical intervention is called for at the last minute when things go wrong, and
- increased workload and cost to the health system because of extra tests being ordered, inappropriate referrals, delays in access to treatment, adverse outcomes and the like,

A new funding model can result in less choice and the loss of local services

In its submission to the Maternity Services Review, the AMA highlighted the impact of maternity services reforms in New Zealand. It is worth revisiting this material. New Zealand introduced reforms in 1995-96 providing for the concept of a Lead Maternity Carer. The scheme had the following key features:

- primary maternity care would continue to be delivered without cost to the women and baby. Specialists could continue to charge for their services,
- each woman would have a Lead Maternity Carer (LMC) to provide and/or coordinate care throughout her pregnancy. This could be a midwife, GP Obstetrician or a specialist obstetrician,
- it became compulsory for a midwife to be present at each delivery, but not for a doctor to be present ie midwives could deliver on their own but a doctor could not,
- there was a more or less standard fee arrangement for LMCs, except that a doctor LMC had to pay an extra fee to have the midwife present. The fees were considered inadequate by most GPs, and
- a set of (weak) guidelines governed handover to medical care in cases where the birth was not proceeding normally.

Some of the adverse outcomes include:

- most GPs no longer provide intra-partum care, so almost all maternity care is delivered by midwife LMCs. Services are provided via a mix of community-based independent midwives and hospital-based midwives. Patients have lost the choice to have a GP obstetrician, which has had an enormous negative impact in rural communities,
- referral by midwives for medical care tends to go to a specialist obstetrician, so there is a growing gulf between maternity care and general practice care. Once again this has significant negative impact in rural areas and the concerns about maternity services being delivered closer to home, and
- there are substantial workforce issues facing maternity services. Many women find it hard to obtain an LMC. Rural women in particular find it increasingly difficult to get access to maternity services, particularly medical care. The reform in New Zealand has reduced maternity service access to women.

Importantly under the New Zealand model, the reforms seem to have disconnected families from general practice after the birth of a baby, leading to dramatic falls in immunisation rates and sharp rises in cases of late presenting post-natal depression. These phenomena have been widely reported in New Zealand in direct correlation to the maternity services intervention.

The number of GP Obstetricians in New Zealand has dropped to less than 20 in the whole country.

Edward W Weaver et al have noted that in relation to the New Zealand reforms "...negative changes have also occurred, such as the effective loss of the option for women to have a GP involved in their maternity care, and an initial exodus of midwives out of the public hospital system."⁹

It is also important to note that other specialists play a role in high-quality maternity care such as anaesthetists and paediatricians. To maintain their skills and the viability of their practice, they depend on having a certain level of work. This is particularly important in regional and rural areas. Badly designed funding models that discriminate against models of maternity care involving medical practitioners (GP obstetricians, obstetricians, paediatricians and anaesthetists) could, as in New Zealand, result in a medical workforce "exodus" with an impact that goes well beyond maternity care.

How do we maintain quality and safety?

Notwithstanding the concerns and reservations outlined above, the Government has now announced that it has decided to expand the role of nurse practitioners and midwives. Given that this decision has been taken, the AMA has responded by offering to provide advice to Government as to how to minimise the risks to the patient safety and quality of care in the implementation of this initiative.

Patients will enjoy better health outcomes when they are treated in a model of care that provides coordinated, continuous and comprehensive patient-centred care – delivered by appropriately trained health professionals. Recognising the benefits of this, public policy in Australia has been directed largely towards support for the proven medical model of care. When new funding arrangements have been introduced to expand access to other primary health care services (eg MBS rebates for allied health services), it has been largely implemented within a framework that enshrines the role of the patient's usual general practitioner.

For all the reasons outlined in this submission, this type of approach still makes eminent sense. The legislation and supporting regulations and guidelines that will be developed following the passage of the MNP Bill need to 'hardwire' the role of a medical practitioner in the patient's care and ensure that meaningful collaboration between doctors, nurse practitioners and midwives always occurs.

The AMA uses the word "meaningful" in a very deliberate way. A framework, for example, where a nurse practitioner could simply reach an arrangement to refer patients who are difficult to treat to the local emergency department or local public hospital obstetrics unit would not be sufficient. This would not address concerns around fragmentation of care and it would inevitably lead to an increased load on the hospital.

The AMA understands that in some cases, particularly in remote areas, that local access to a doctor will not be possible. Such circumstances do not provide any justification for the medical profession to be bypassed in the care of the patient. Innovation and common sense is required and there are good examples of how this is already being done in practice.

The CARPA¹⁰ manual, for example, provides advice and support for remote health workers and includes protocols that help establish when medical support or retrieval is necessary. Combined with appropriate IT and communications equipment and clear "on the ground agreement" about which doctors will step in to assist when required, this type of approach ensures that remote health workers can deliver quality patient care in a supportive environment.

Taking the above into account, the AMA believes that there is strong case for the Bill itself to incorporate basic criteria that will guarantee effective collaboration, rather than leaving this detail to

⁹ Edward W Weaver, Kenneth F Clark and Barbara A Vernon, 'Obstetricians and midwives modus vivendi for current times', *Medical Journal of Australia*, 2005;182(9): 436-437.

¹⁰ Central Australian Rural Practitioners Association.

be determined via regulation. The AMA believes that this can be achieved through two mechanisms as follows:

1 Collaborative care agreement

The medical profession has already helped to develop well-established guidelines to support collaboration between medical practitioners and other health care professionals. The Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG), for example, has developed best practice guidelines to support multi-disciplinary maternity care¹¹.

The development of these types of protocols and guidelines should continue and involve a broader range of stakeholders and specialty areas. For example, guidelines and protocols should be developed to underpin the work of nurse practitioners in the primary care setting. These professionally-endorsed guidelines should underpin the services covered by this Bill.

To formalise collaborative care in daily practice, the MNP Bill should be amended to include an additional threshold requirement for the purposes of defining an “eligible nurse practitioner” or an “eligible midwife”. This would specify that a patient being treated by an “eligible nurse practitioner” or an “eligible midwife” must either hold a valid referral from a medical practitioner or there must be a collaborative care agreement in place between the nurse practitioner or midwife and the patient’s usual doctor, or a doctor nominated by the patient.

The form and content of a collaborative care agreement would be specified in an additional set of supporting regulations as a requirement in the Bill. The AMA envisages that a collaborative care agreement could take the form of an explicit commitment that the ‘eligible nurse practitioner’/ ‘eligible midwife’ and the patient’s usual doctor/doctor nominated by the patient will follow the collaborative care guidelines and protocols developed by the relevant professional bodies (as outlined above).

If this was not considered appropriate for the individual patient or health professional’s circumstances, the collaborative care agreement would need to set out specific details about how the care arrangements for that patient were to be handled. This should include details such as:

- patient name,
- patient address and telephone number,
- protocols, criteria, standing orders, or other method by which services are authorised,
- protocols to ensure that relevant communication takes place regarding the patient’s condition and treatment,
- the method established for the assessment of patient outcomes, if appropriate,
- protocols governing the circumstances in which a patient should be referred back to their usual or nominated doctor, or in emergency circumstances – relevant health services,
- pathology and diagnostic imaging tests that may be ordered by this particular practitioner (subject to any other limits defined in relevant legislation/regulations), and
- special arrangements to support access to care in areas where a local doctor is not available.

The importance of a “collaborative care agreement” in circumstances where the patient has not been referred by a medical practitioner cannot be overstated. It supports an environment that:

- ensures that a medical practitioner is genuinely involved in the patient’s care,
- ensures patient care is well coordinated,

¹¹ Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care, RANZCOG Guideline, March 2009.

- provides for structured reporting lines and well-defined roles within a team, and
- expands the involvement of other health care professionals in patients care, with appropriate support mechanisms in place.

A collaborative care agreement would also ensure that some flexibility is available in order to tailor arrangements to suit local needs and circumstance and patient circumstances and individual health risks. While the AMA supports the development of an overarching quality and safety framework, it is unlikely that such a framework will be able to adequately account for all situations. A collaborative care agreement would also ensure there was much greater clarity in the responsibility of different health professionals for the purposes of medical indemnity.

Where the patient has a valid referral from a medical practitioner, a collaborative care agreement would not be required. That said, the regulations should require that the doctor's referral set out the relevant scope of activity of the eligible midwife/nurse practitioner in relation to the patient's care. This should include the scope of appropriate tests that could be ordered, prescribing arrangements, and any other relevant protocols including what information the doctor expected to be kept appraised of and when the patient should be sent back to the treating doctor.

We note that the Bill already includes a requirement that a common form of undertaking be given by eligible midwives and eligible nurse practitioners, similar to requirements placed on optometrists who provide MBS funded services to patients. This has very different purpose to the collaborative agreement that the AMA has proposed above in that a common form of undertaking is an agreement made directly between the Government and the nurse practitioner or midwife that covers matters such as the bulk-billing of patients. It does not really deal with the key question of how the nurse practitioner or midwife will collaborate with a doctor in the delivery of care.

2 Consultation framework

The AMA highlighted earlier in this submission that the Bill provides for regulations to be made to clarify a range of issues that are not detailed in the Bill such as the range of tests a nurse practitioner or midwife may order. It is important that the medical profession is strongly involved in developing the regulations and guidelines that will support the operation of the MNP legislation. In this regard the AMA wants to work with other stakeholders in a cooperative way to ensure the best outcomes for patients.

The AMA recommends that the Bill should also include an additional requirement that the Minister for Health and Ageing must form an expert advisory panel to provide advice on matters relating to the development of regulations and the implementation of the Bill. This panel should include representatives of the AMA, the relevant medical colleges, the Rural Doctors Association of Australia (RDAA) and relevant nursing groups. The initial development and any future amendments to these regulations should be required to take into account advice from this expert advisory panel.

Recommendations

1. That the MNP Bill be amended to include additional threshold criteria for the purposes of defining an eligible nurse practitioner or eligible midwife specifying that a patient must either hold a valid referral from a medical practitioner or there must be a collaborative care agreement in place between the nurse practitioner or midwife and the patient's usual doctor, or a doctor nominated by the patient (who agrees to accept responsibility, not simply the emergency department consultant or public hospital obstetrics consultation), and
2. The Senate Committee recommend that the Minister for Health and Ageing establish an expert advisory panel (the Care Collaboration Advisory Panel) with broad terms of reference to provide advice on any matters relating to the development and future amendment of regulations and the implementation of the Bill.

Skills and training

The definitions of an eligible nurse practitioner and an eligible midwife in the Bill differ significantly:

- an eligible nurse practitioner is essentially a person who has the appropriate registration/authorisation under state/territory law. The Bill provides that additional requirements can be specified under regulation but, in the absence of such regulation, registration/authorisation will be relied upon for definitional purposes. (Schedule 1, amendment 2 – Subsection 3(1)), and
- an eligible midwife is a person that has the appropriate registration/authorisation under state/territory law and who meets additional requirements specified under regulation. In the absence of such regulation, it is not possible to meet the definition of an eligible midwife. (Schedule 1, amendment 25 – Section 21).

It is fundamental to the delivery of high quality health care that practitioners are appropriately qualified. The AMA understands that the qualifications required to practice as a midwife or a nurse practitioner can vary. In midwifery, a number of qualifications are recognised:

- Bachelor of Midwifery,
- a degree in nursing and a postgraduate qualification in midwifery, and
- an undergraduate double degree in midwifery and nursing.

There will clearly be differences in the skill set of a midwife with a direct entry Bachelor of Midwifery degree and a midwife with a nursing degree and postgraduate midwifery qualifications. By requiring a midwife to meet additional requirements set out in regulation, the MNP Bill appears to acknowledge that there is variation in the skills and experience of midwives and that the Government wants to establish a more consistent and appropriate benchmark.

Similarly, not all nurse practitioners have had the same level and type of training. For example, a registered nurse may apply for recognition as a nurse practitioner if they hold an approved masters degree and meet other relevant criteria. Alternatively, if they do not hold an approved masters degree they can seek recognition on the basis of other post registration education, professional development activities and experience - sufficient to demonstrate 'equivalence'.

The AMA believes that the MNP Bill should also seek to ensure greater consistency in the qualifications and skills of nurse practitioners. To that extent, the AMA proposes that the definition of an eligible nurse practitioner should be strengthened so that it follows the same format as the definition that is used for eligible midwives.

The additional skills requirements for both midwives and nurse practitioners would be established based on the advice of the expert advisory panel that the AMA proposes earlier in this submission.

Recommendations

3. That the definition of an eligible nurse practitioner (Schedule 1, amendment 2 – Subsection 3(1)) be amended so that both of the conditions below must be satisfied:
 - hold the appropriate registration/authorisation under state/territory law, and
 - meet additional requirements specified under regulation.
4. That the Bill include an additional provision requiring that, where regulations are not in place specifying such additional requirements, the nurse practitioner cannot be an eligible nurse practitioner for the purposes of the legislation.

Prescribing

The AMA is a strong advocate for the quality use of medicines framework (QUM) to achieve better health outcomes for all Australians. All medications have side effects and need to be prescribed with caution. The risk of adverse events increases when more than one medication is taken at the same time. Any changes to medication prescribing arrangements must ensure medicines continue to be used safely, judiciously, appropriately, and efficaciously. This represents a good national medicines policy framework and the appropriate standards must be developed up front, and not in an ad hoc or piecemeal manner such as happened recently in respect of the extension of prescribing rights for some medications for optometrists.

While the AMA has outlined consultative processes above that are intended to provide advice to the Minister for Health and Ageing, particularly in relation to how medical practitioners, nurse practitioners and midwives can work together, we think an additional new process is required to provide advice on any proposals to allow nurse practitioners and midwives to prescribe pharmaceuticals.

At the moment there is an ad hoc process of allowing particular professionals to prescribe particular medications with the process and outcome varying from state to state. The Government has recognised that there needs to be better coordination and consistency and this is also an opportunity to ensure that such decisions are made based on the best possible advice.

The AMA has previously made public its concerns about policy initiatives to expand prescribing rights to other health professions because of the health risks that could result to patients. Any proposal to extend prescribing rights to another health profession group in respect of an individual medicine must not be made without comprehensive advice from an expert advisory group of medical practitioners who have detailed pharmacological knowledge.

To facilitate this process a new expert committee (the Health Profession Prescribing Committee) should be established to evaluate and advise the government on any proposal to allow nurse practitioners and/midwives, or indeed any health professional group other than medical practitioners, to prescribe pharmaceuticals. This will establish best practice standards of prescribing for non-medical health professionals. The AMA notes that there is currently a disparity across states and territories in respect of the medicines that can be prescribed by non-medical health professionals. As well as providing advice to the Federal Government about medications for PBS-funding, there would be scope for the advice of this new expert committee to inform state based decisions about prescribing rights (endorsements) for other health professionals which would introduce much greater uniformity both across states and between Commonwealth and State prescribing arrangements.

For these advisory arrangements to be acceptable to the medical profession, the committee would need to be comprised of expert medical practitioners. Representatives from the relevant health profession group and their training and education sector could be invited to present their proposal to the committee in respect of an individual medication and the relevant professional skills and training that are undertaken by members of the particular health profession.

The committee's deliberations and final advice would need to take into account a range of factors including: the training and expertise of the particular profession group; the skills required to diagnose, assess and monitor a patient requiring the specific medication under consideration; any risks inherent in inappropriate prescribing of the specific medication; potential medication interactions; necessary clinical guidelines and patient management protocols for a patient being prescribed the specific medication by someone other than a medical practitioner.

This new committee would complement the Pharmaceutical Benefits Advisory Committee (PBAC) assessment process for listing medicines on the PBS but would be a more appropriate forum than the PBAC to make recommendations to the government on the extension of pharmaceutical prescribing

rights beyond the medical profession. The PBAC has a different focus in its work and is particularly concerned with looking at the cost/benefits of medicines for the purposes of PBS listing, rather than the skill set and training required to determine who should prescribe them.

The AMA believes this process would ensure that the quality use of medicines framework continues to be applied to all prescribing decisions. Further, it would protect PBS expenditure. And most importantly, it would ensure patient safety and quality of care is maintained.

Recommendation

5. That the Committee recommend the establishment of an expert committee (the Health Profession Prescribing Committee) to evaluate and advise government on any proposal to allow nurse practitioners and/or midwives to prescribe medications.

Indemnity insurance

In relation to the other two Bills, the AMA recognises that it is very important for health professionals to carry appropriate indemnity insurance that reflects their scope of professional practice.

These Bills seek to establish a framework that allows midwives to access affordable indemnity insurance and the AMA accepts that this is necessary legislation that serves to protect the interests of patients and their families and ensure that funding for compensable injury is available. We have strongly supported a requirement in the proposed new legislation for the National Registration and Accreditation Scheme that all registered health professionals are required to hold appropriate indemnity insurance as a registration requirement and are pleased to see this reflected in the exposure draft of Bill B under the National Registration and Accreditation Scheme.

The AMA understands that the Department of Health and Ageing intends to work with indemnity insurers to develop appropriate indemnity insurance products for midwives. In this regard, it is very important to ensure that the overall level of cover offered to midwives is comparable to obstetricians and GP obstetricians. The Government's own Maternity Services Review Report touched on this issue when it stated that:

“It is clear that other health professionals are concerned about the potential transfer of risk to them, should an adverse event occur in a collaborative team model. In such circumstances, legal claims may be more likely to be brought against the health professional who has the means of settling any successful claim.”

A level “indemnity” playing field is required to address the concern that patients could potentially “shop around” and take legal action against the person with the most generous insurance policy. It is also required to support meaningful collaboration between doctors and midwives. Doctors will be reluctant to enter into collaborative arrangements if they face extra risks because midwives do not carry appropriate indemnity cover.

The AMA notes that the Bills relating to indemnity insurance do not seek to define what is an eligible midwife for the purposes of accessing Government support. This highlights the issue raised earlier in this submission about the problems the Committee faces when it must consider Bills that only contain “high level” provisions. In the absence of key details about who exactly is eligible for cover, it is clear that insurers will face significant difficulty in attempting to assess the risk profile of midwives and tendering to provide this cover.

Recommendation

6. Indemnity cover for midwives must be comparable to obstetricians and GP obstetricians.

Evaluating the impact of reforms

The AMA believes that it is critical for the impact of the MNP Bill to be properly evaluated over time. This submission highlights that there is a lack of evidence to support the substitution of doctors with other health professionals and that there are inherent risks in doing so. It is also important to closely monitor how the legislation works in practice to check that any such risks are minimised.

In this context, the Bill should be amended to include a formal requirement for the Minister for Health and Ageing to commission an independent evaluation of the patient outcomes in terms of access, mortality and morbidity and the effects on the cost of care provision resulting from these new arrangements and provide this evaluation to Parliament on the operation of the legislation no later than four years from its date of commencement. This evaluation should cover all matters related to the operation of the legislation including the impact on health system costs, the quality and safety of care, access to care, workforce impacts and operational issues.

Once this evaluation is provided, Parliament will be in a better position to assess the merits of this legislation and determine whether or not this initiative has resulted in any deleterious outcomes. The AMA therefore proposes that a five-year sunset clause also be included in the MNP Bill. This would ensure that any decision to continue these arrangements beyond this period was fully considered again by Parliament in light of the available evidence at the time.

Recommendations

7. The Bill should be amended to include a formal requirement for the Minister for Health and Ageing to provide a report to Parliament on the operation of the legislation.
8. The Bill should be amended to include a five-year sunset clause.

This submission has focused largely on the MNP Bill and proposes a number of amendments to that Bill. The AMA envisages that the changes proposed to the definition of an eligible nurse practitioner or eligible midwife would need to flow on to the other two Bills being considered by the Committee as well as the proposed evaluation arrangements and sunset clause.

Conclusion

Providing commentary on these Bills is not an easy task for the AMA. While the AMA has the utmost respect for the work of other health professions, these Bills challenge many of our fundamental beliefs about the right framework to deliver high-quality health care. This submission attempts to provide constructive input that will help the Committee in its consideration of these Bills and to make positive recommendations about changes to the Bills to ensure that appropriate support mechanisms are put in place to minimise any risks to the quality and safety of patient care.

Yours sincerely



Dr Andrew Pesce
President

SUMMARY OF AMA RECOMMENDATIONS

1. That the MNP Bill be amended to include additional threshold criteria for the purposes of defining an eligible nurse practitioner or eligible midwife, specifying that a patient must either hold a valid referral from a medical practitioner or there must be a collaborative care agreement in place between the nurse practitioner or midwife and the patient's usual doctor, or a doctor nominated by the patient (who agrees to accept responsibility, not simply the emergency department consultant or public hospital obstetrics consultation).
2. The Senate Committee recommend that the Minister for Health and Ageing establish an expert advisory panel (the Care Collaboration Advisory Panel) with broad terms of reference to provide advice on any matters relating to the development and future amendment of regulations and the implementation of the MNP Bill.
3. That MNP Bill definition of an eligible nurse practitioner (Schedule 1, amendment 2 – Subsection 3(1)) be amended so that both of the conditions below must be satisfied:
 - they hold the appropriate registration/authorisation under state/territory law; and
 - they meet additional requirements specified under regulation.
4. That the MNP Bill include an additional provision requiring that, where regulations are not in place specifying such additional requirements, the nurse practitioner cannot be an eligible nurse practitioner for the purposes of the legislation.
5. The Committee recommend the establishment of an expert committee (the Health Profession Prescribing Committee) to evaluate and advise government on any proposal to allow nurse practitioners and/or midwives to prescribe medications.
6. Indemnity cover for midwives must be comparable to obstetricians and GP obstetricians.
7. The three Bills should be amended to include a formal requirement for the Minister for Health and Ageing to provide an independent report to Parliament on the operation of the legislation.
8. The three Bills should be amended to include a five-year sunset clause.