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# *Professional indemnity insurance for midwives research*

*Nursing and Midwifery Board of Australia*

*30 July 2013*

Nursing and Midwifery Board of Australia

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Mary Chiarella
Chair of Policy Committee
Nursing and Midwifery Board of Australia
Level 7, 111 Bourke Street
Melbourne, VIC 3000

30 July 2013

Dear Mary

***Re: Professional indemnity insurance for midwives research***

Please find attached our report on the research completed on professional indemnity insurance (PII) for privately practising midwives (PPMs) in Australia.

Historically, PPMs have had difficulty in obtaining PII. This has led to the current exemption under the Health Practitioner Regulation National Law for PPMs to hold PII for intrapartum care. In seeking a resolution to ongoing exemptions, this research report was commissioned by the Australian Health Practitioner Regulation Agency on behalf of the Nursing and Midwifery Board of Australia. The report:

- outlines the Australian PII market and the relevant factors relating to PII products for PPMs
- identifies and outlines the practice of PPMs and how the context in which PPMs practice as well as implicit risks have impacted upon PII product offerings, both nationally and internationally
- details the extent of claims and tribunal cases that have been raised nationally and internationally, and their impact on the development of insurance products.

To strengthen this report, we have in turn looked to equivalent PPM practice internationally to determine insights into PII offerings in these jurisdictions and associated claims raised, and to outline any transferable lessons for Australia.

This report has been informed by consultations with key stakeholders both nationally and internationally, in the areas of health regulation and administration, health service provision, midwifery and PPMs, as well as with representatives from tribunals and insurers. We have also analysed recent literature on PPM practice, and quantitative data where available.

Informed by the base of evidence we have assembled, we have sought to provide you with key insights and considerations that we hope will assist in future discussions relating to the future provision of PII for PPMs.

Kind regards,

James van Smeerdijk
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# Abbreviations

The following abbreviations have been used within this report.

| | |
|---|---|
| **ABS** | Australian Bureau of Statistics |
| **ACC** | Accident Compensation Corporation (NZ) |
| **ACCC** | Australian Competition and Consumer Commission |
| **ACCO** | Aboriginal Community Controlled Organisations |
| **ACM** | Australian College of Midwives |
| **ACM Guidelines** | *National Midwifery Guidelines for Consultation & Referral (2nd edition)* |
| **AIHW** | Australian Institute of Health and Welfare |
| **AHPRA** | Australian Health Practitioner Regulation Agency |
| **AOM** | Association of Ontario Midwives |
| **ANF** | Australian Nursing Federation |
| **ANMAC** | Australian Nursing and Midwifery Accreditation Council |
| **AWBZ** | Exceptional Medical Expenses Act (the Netherlands) |
| **CAD** | Canadian dollars |
| **CMO** | College of Midwifery Ontario |
| **CNST** | Clinical Negligence Scheme for Trusts |
| **CPD** | Continuing professional development |
| **CQC** | Care Quality Commission |
| **Departments** | UK Health Departments (England, Wales, Scotland and Northern Ireland) |
| **DHS** | Department of Human Services (Commonwealth) |
| **Directive** | The European Union Directive (2011/24/EU) |
| **DoHA** | Department of Health and Ageing (Commonwealth) |
| **EU** | European Union |
| **Guidelines** | Consultation and Referral Guidelines (NZ) |
| **HIROC** | Health Insurance Reciprocal of Canada |
| **IBNR** | Incurred but not raised |
| **ICM** | International Confederation of Midwives |

| | |
|---|---|
| **IM** | Independent Midwife |
| **IMGA** | Insurance Marketing Group of Australia |
| **IRCM** | The Interim Regulatory Council on Midwifery (Canada) |
| **LMC** | Lead maternity caregiver |
| **the Manual** | The Obstetric and Midwifery Manual (the Netherlands) |
| **MDO** | Medical Defence Organisation |
| **MDU** | Medical Defence Union |
| **MDT** | Multi-disciplinary team |
| **Medicare** | Medicare Australia |
| **MIGA** | Medical Insurance Group Australia |
| **MOU** | Memoranda of Understanding |
| **National Law** | Health Practitioner Regulation National Law |
| **National scheme** | National Registration and Accreditation Scheme |
| **NFP** | Not-for-profit |
| **NHMRC** | National Health and Medical Research Council |
| **NHS** | National Health Service (UK) |
| **NHSLA** | National Health Service Litigation Authority |
| **NICE** | National Institute for Health and Clinical Excellence (UK) |
| **NMBA** | Nursing and Midwifery Board of Australia |
| **NMC-UK** | Nursing and Midwifery Council, UK |
| **NPESU** | AIHW National Perinatal Epidemiology and Statistics Unit |
| **NSW** | New South Wales |
| **NZD** | New Zealand dollar |
| **NZCOM** | New Zealand College of Midwives |
| **OMA** | Ontario Medical Association |
| **PC** | Policy Committee of the NMBA |
| **PHI** | Private health insurance |
| **PII** | Professional indemnity insurance |
| **PPH** | Postpartum haemorrhage |

| | |
|---|---|
| **PPM** | Privately practising midwife |
| **PwC** | PricewaterhouseCoopers |
| **RCM** | Royal College of Midwives |
| **RK Harris** | RK Harris Insurance Services Limited |
| **SA** | South Australia |
| **Scott review** | The Finlay Scott Review (United Kingdom) |
| **TMFs** | Treasury Managed Funds |
| **UK** | United Kingdom |
| **WA** | Western Australia |

# Disclaimer

This report has been prepared by PricewaterhouseCoopers Australia (PwC) at the request of the Australian Health Practitioner Regulation Agency (AHPRA) on behalf of the Nursing Board of Midwifery (NMBA), in our capacity as advisors in accordance with the Terms of Reference.

This report is objective, aimed at a discussion based on research and evidence in accordance with the Terms of Reference. It is to provide an evidence base on potential barriers to the provision of a professional indemnity insurance product for privately practicing midwives providing intrapartum care in the home. Based on the evidence found, including the provision of equivalent insurance arrangements for similar midwives internationally, it seeks only to provide a range of actions that the NMBA could consider further to support the provision of professional indemnity insurance for these midwives going forward.

Accordingly, PwC accepts no responsibility for the use of this report by any other persons or for any other purpose. This document is not intended to be utilised or relied upon by any other persons other than from the NMBA, or to be used for any purpose other than that stipulated within the contract.

The information, statements, statistics and commentary (together the 'information') contained in this report have been prepared by PwC from publicly available material, as well as consultations held with key stakeholders identified by the NMBA and from material provided by specific stakeholders including AHPRA and the NMBA.

PwC has not sought any independent confirmation of the reliability, accuracy or completeness of this information. It should not be construed that PwC has carried out any form of audit of the information that has been relied upon. Accordingly, while the statements made in this report are given in good faith, PwC accepts no responsibility for any errors in the information provided by AHPRA or the NMBA, publicly, or by any other parties in this report, nor the effect of any such error on our analysis, considerations put forward or reported.

# Summary

## The desire of women to be able to choose and access a range of safe, high quality maternity services is clear

In late 2012 PricewaterhouseCoopers (PwC) was commissioned by the Australian Health Practitioner Regulation Agency (AHPRA) on behalf of the Nursing and Midwifery Board of Australia (NMBA) to research professional indemnity insurance (PII) for privately practising midwives (PPMs). This was in response to the lack of availability of PII products for intrapartum care provided by PPMs in homes, as well as the consequent exemption for PPMs from the *Health Practitioner Regulation National Law* (National Law) registration requirement to hold such PII. The National Law requires all other health professionals intending to practise to hold PII as a part of the conditions of registration.

In order to provide an evidence base on the lack of availability of PII products for PPMs providing intrapartum care in the home, the NMBA commissioned PwC to gather data and consult widely. An extensive amount of literature was reviewed and data collected both nationally and within a select number of international jurisdictions. This provided insight as to the current factors precluding a viable national insurance product for PPMs, and what transferable lessons could be available from other jurisdictions to assist in determining a way forward for Australia.

In the Commonwealth Government's *Report of the Maternity Services Review*, the concern about the level of current access to homebirth services in Australia was resounding,[1] with over 60% of the submissions from consumers wanting to improve access to homebirth options.[2] While the report identified that these women represented a small proportion of the total, it did note that "maternity care in Australia is not meeting the needs of all Australian women".[3] Consultations held nationally and internationally with a wide range of stakeholders representing regulators, professional associations, Colleges, insurers and consumers confirmed the desire that women should have a broad choice of maternity services and have access to safe, high quality and appropriate care.

It was therefore established that women ought to have a range of birthing options for the settings of birthing services, including giving a birth within their home and community, when it is assessed by a registered health professional as safe and appropriate. Further, the attending health professional should have the ability to have that birth covered by appropriate professional indemnity insurance. This report aims to provide the evidence that moves discussion on PII for PPMs to a constructive debate on how expectant mothers can be provided with a range of safe maternity services, which provide common protections and avenues for reparation should things go wrong in the case of adverse events. This report is not a discussion on the 'rights' or 'wrongs' of homebirth.

1 Commonwealth of Australia, 2008a.

2 Dahlen H, Jackson M, Schmied V, Tracy S & Priddis H 2011.

3 Ibid, p.3.

## *Professional indemnity insurance is available for all other maternity service providers – its absence for PPMs affects access and workforce*

One of the most critical issues identified in the literature and by those consulted is the availability of, and access to professional indemnity insurance products. Since 2001 PPMs have been unable to obtain PII for intrapartum care as a result of the collapse or exit from the market of a number of commercial insurers, and through inadequate policy or subsidised support (relative to other maternity service providers). From 2010, two PII products have become available for PPMs but only for antenatal and postnatal care, one being Government underwritten.

There have been multiple impacts from the absence of a PII product for PPMs providing intrapartum care in the home. It has created significant challenges for women who want to give birth at home,[4, 5] and consultations reflected that in part, it has the reduced the number of midwives who work in private practice. This translates to limited access to safe and appropriate homebirth for Australian women. At present it is estimated that there are no more than 200 PPMs in practice (at least 57 were confirmed through a survey undertaken with this report). For those that have continued to practise, they do so at their own financial risk and should an adverse outcome occur or a legal claim arise, the usual sources of compensation or recourse for service users are not available.[6]

This issue is compounded through the National Law requirement for compulsory PII as a condition for registration for those who intend to practise. Without commercial PII products available, the National Law has created a situation where PPMs who wished to provide homebirths were at risk of being legally unable to practise privately as a registered midwife. At present there is an exemption from holding PII until July 2015 for PPMs. This exemption, although assisting PPMs in the short term, is not a long term solution.

## *Australia compares poorly to other international jurisdictions in access, data and consistency of practice*

Australia has a relatively low proportion of homebirths compared to other international jurisdictions reviewed for this report (see Figure 1). The reasons behind the variations between the jurisdictions are complex and have been explored only partly through this report. However, for all jurisdictions reviewed, except Australia, a PII product for PPMs providing intrapartum care at home has been developed.[7]

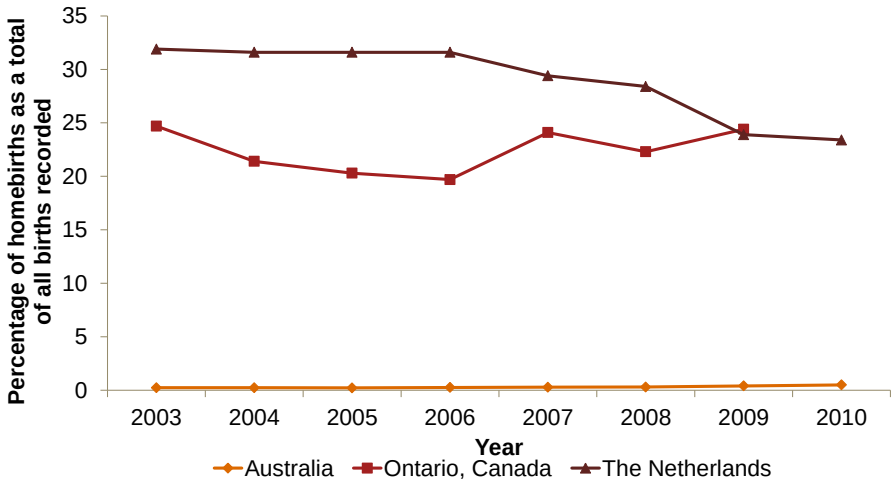
4 Homer C 2011.

5 Catling-Paull C, Foureur MJ & Homer CS 2012.

6 Commonwealth of Australia, 2008a.

7 Although it should be noted that the product available in England is only available for a legal entity in which a group of midwives practise.

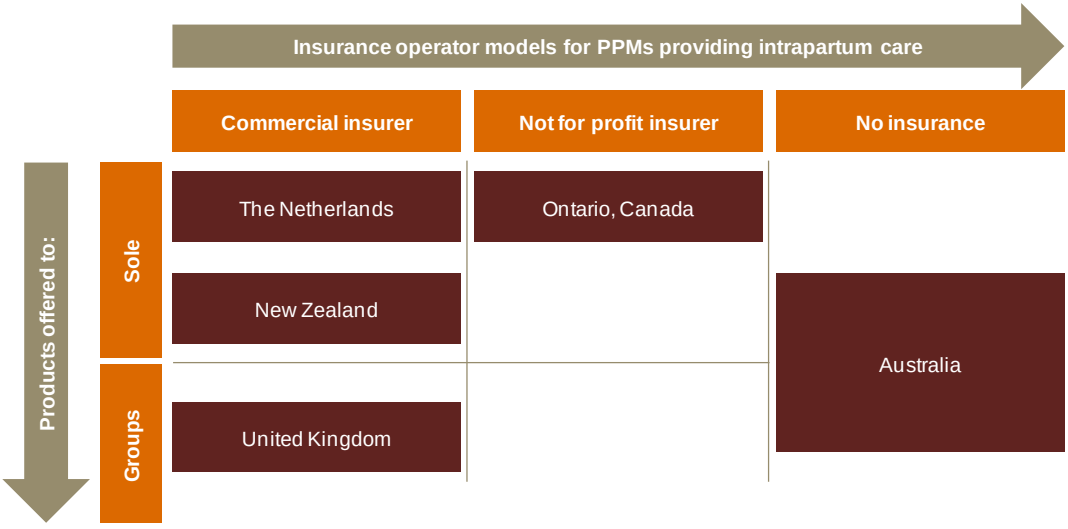
**Figure 1: Comparison of homebirths as a percentage of a total of births per jurisdiction (Australia, province of Ontario and the Netherlands)**




**Note:** Information on the percentage of homebirths as a total of all births recorded was not publicly available for England and New Zealand and therefore has been excluded from the table above.
**Source:** Australian Institute of Health and Welfare 2004b- 2013; Commonwealth of Australia 2008b; Statistics Netherlands 2013; Statistics Canada 2009, 2013.

Each of the international jurisdictions analysed (England, province of Ontario, the Netherlands and New Zealand) are able, through different insurance operator models, to provide PII products for either sole or group midwifery practices. The operator models and the products offered are outlined in Figure 2.

**Figure 2: Midwifery insurance operator models for different practice by jurisdiction**




The features of each jurisdiction's PII model were found to be a product of both the history of PPM practice and the environment in which midwifery practice occurs in that jurisdiction. For example, in England, the financial impact for insurers of the relatively small number of independent midwives was overcome through insuring a group practice, support mechanisms for independent midwives, and a

strong and cooperative relationship between health professions and insurers.[8] Alternatively, for the province of Ontario, the midwifery market that insurers operate within is relatively larger than the markets within the other jurisdictions, as all midwives are deemed independent and must hold insurance. Registration requirements in the province of Ontario also include the completion of a certain number of homebirths and access arrangements with appropriate health services. Further, there is a strong relationship between the professional association and insurers, and significant government support.

None of the models adopted in each of the jurisdictions were found to be the same, nor were the factors or enablers supporting the development of the particular model applied. While no model could be applied directly to the Australian environment, we believe that each model provides findings and lessons that are relevant for PPMs in Australia.

## *The key findings centre on issues with the communication of PPM practice and the inherent risks of maternity services*

The project focused on understanding what factors within the current Australian market preclude PII being provided. Within the predominant 'for profit' insurance market in Australia, product providers generally assess the insured market's **scale**, **probability** of a claim (its likelihood and timing), and the **quantum** of the claim and any other payout.

From the research undertaken, two key areas were identified from which six findings were grouped. The importance of identifying the areas that preclude PII for intrapartum care for PPMs providing care within the home is not to dissuade the practice of PPMs. Instead, it seeks to provide the available evidence on practice and provide a number of considerations for future action that can be taken.

### *Communication of practice and available data*

International literature demonstrates that for low-risk women and babies, the outcomes for women having a homebirth are usually the same as those experienced in other health settings. Some women assessed as high-risk appear to have poorer outcomes. However, overall, there are limitations in available data and the literature is generally inconclusive. As a result, the field is open to claim and counter claim, with attention drawn to the outcomes of these studies, rather than to their inadequacies or lack of data. This appears to have impacted on the confidence or certainty of the insurance market on the real risk of PPM practice within the home.

It is evident that at present there are data limitations that affect the ability for insurers in Australia to sufficiently assess the risk profile of Australian PPMs. The evidence is complex given that there are real and perceived variations in practice and risk management frameworks, combined with insufficient availability of quality data relating to PPM practice, and an evidence base of the causal factors in outcome or claims. The three specific findings are:

8 Note that this may be changing with the advent of The European Directive (2011/24/EU).

### 1 *Practice of PPMs*

Through the research completed, insurers appear unclear on who would be insured, how they would practise, and what services would be provided. This is the result of an absence of, or unclear definitions relating to PPM practice as well as variation in the level of support and supervision provided to PPMs. Further variation between both practice models (such as group or sole practitioner), as well as national, state and territory quality and safety frameworks exists. This means that any insurance product developed at present would need to accommodate not only individual PPMs practising with different scopes of practice that may have different risk profiles, but also those practising within different states and territories.

### 2 *Data quality supporting PPMs practising*

The availability and quality of data are currently insufficient to confidently understand the extent of PPM practice and the associated risk. Data are important to provide an evidence base for insurers to set premiums, particularly in establishing the scale, probability and quantum of a claim. The availability and reporting of key data should include:

- the number of PPMs **(scale)**
- the number and likelihood of incidences **(probability)** – the number of homebirths, adverse outcomes and situational factors (eg risk profile of women, geography, transfers from home to health services)
- the number and quantum of claims **(quantum)**.

From what data are available it can be established that there is a relatively small PPM workforce supporting births within the home, which make up only 0.3% of all births.[9] Consultations linked the difficulties of practising not only to obtaining insurance, but also in establishing collaborative partnerships with other health professionals and services.

Claims data was difficult to obtain in Australia as a result of it being no longer recorded or held, it being commercially sensitive, or insurers being unable or unwilling to disclose. Data available from an international jurisdiction demonstrated a relatively low number of claims in relation to homebirth: in the province of Ontario between 2003 and 2010, only two out of 15,119 homebirths resulted in a claim.

### 3 *Data relationships*

Similarly, the relationship between incidence and claims does not appear to be well understood. Available data substitutes such as tribunal and court information are insufficient to provide a true picture of the risk associated with PPM practice.

## *Inherent risks with the provision of maternity services*

It is well evidenced that there are relatively higher inherent risks of an adverse outcome within maternity services (including obstetric and midwifery care) than for most other health professions. As a maternity service provider, PPMs deliver services that have some expected risk. However, given a reduced range of practice and scope, their risk profile is accepted to be lower than other providers, such as obstetricians. Despite this, often the risk profiles of each of these maternity service providers are not well separated and/or conflated.

The combination of inherent risk and a small PPM workforce appears to limit the market and results in limitations to insurance offerings. In line with the drivers of a premium for a PII product (scale, probability and quantum), this challenge was grouped, again, into three findings:

9 Australian Institute of Health and Welfare, 2013.

### *4 Scale of practice*

The scale of practice has been mentioned in other reviews and in consultations for this report. The number and volume of PPMs practising is not likely, in the short to medium term, to alone, be sufficient for commercial insurers to provide a financially viable product.

### *5 Inherent risks associated with PPMs as maternity service providers*

As maternity service providers, PPMs (as do obstetricians) have a relatively higher inherent risk of an adverse outcome, compared to other health service providers. In Australia this is a barrier in the development of a PII product for intrapartum care, when insurers are assessing the potential of a claim arising. Building on this, the challenge is that, due to the absence of data, PPMs have often been coupled with other maternity service providers, such as obstetricians, who have a higher risk profile due to their greater and more clinically complex scope of practice.

To overcome this inherent risk, other health professionals in Australia providing maternity services have had government assistance. For example, obstetricians in Australia have Commonwealth Government support to make risk premiums affordable and accessible. The provision of this for PPMs has, at present, been limited.

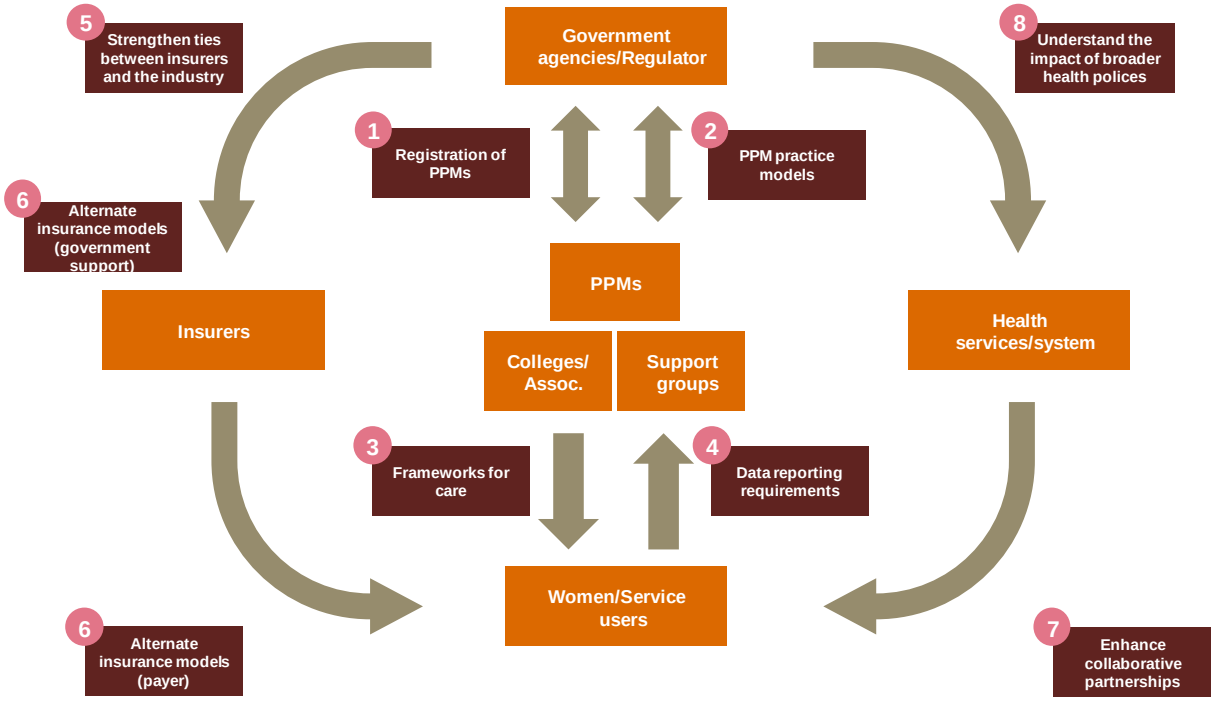
### *6 High expected value of claims from adverse outcomes*

Claims raised for maternity services can be relatively significant as they relate to critical life events and potential long term disability. The quantum is considered to be relatively high for intrapartum care provided by PPMs as a result of the large claims for the life of the baby, the long lag time between an incident and the claim arising, the legal and associated costs and some precedents set in relatively recent times. Again, in the absence of substantive PPM data, information often is linked to obstetric cases such as *Simpson v Diamond* in which a significant claim for both damages and long term care occurred.

## *Considerations for the future provision of PII for PPMs*

Based on the evidence, in Australia and internationally, eight actions were identified that could assist in an insurance product being developed and these actions should be the subject of further consideration. These actions address the key findings identified in literature relating to uncertainty in practice and the inherent limitations, which were identified. As Figure 3 shows, each of these involves not only PPMs, but other key stakeholders including government agencies, insurers, health services, as well as colleges, associations and support groups. It is therefore evident that support and commitment is required from the maternity services sector more broadly.

**Figure 3: Interrelationship of options for consideration**




## 1 *Specific registration of PPMs*

Consideration could be made of the requirement for PPMs providing homebirth to be registered as a separate sub-class of midwives, or alternatively either as an eligible midwife, or is required to practise in a professionally networked supportive model of practice in order to access PII. This may assist in some of the definitional, support and supervision frameworks and risk assessments issues identified with current PPM practice.

## 2 *PPM practice models*

Consideration should be given to different options for private midwifery practice, such as partnership or group legal entities. This may assist in overcoming the scale of practice as well as the risk profile of practice through supportive arrangements.

## 3 *Frameworks for care*

The development of consistent national safety and quality (including risk assessment) frameworks for homebirth should be considered, as well as support models for PPMs that address compliance, complaints and the capability to meet the framework requirements. This would have the intent of providing not only clarification over practice but improve the supportive arrangements for PPMs.

## 4 *Data reporting requirements*

At the centre of this issue of PII for PPMs appears to be the clarity, quality and understanding of data on PPM practice. Improvements to data quality and collection including an increased level of specific PPM and homebirth data that are collected consistently should be considered. So to should the feasibility and cost-benefit of doing so, given the size and impact of the cohort. The role of alternative or substitutable data should also be considered along with an understanding of its limitations.

## 5 *Strengthen ties between insurers and the industry*

A key factor identified in each international jurisdiction was the importance of relationships between insurers and the industry. While relationships exist, particularly with one insurer, consideration should be given to encouraging stronger relationships between not only insurers, but also the NMBA, midwifery and medical practitioner representatives. This is seen to be beneficial not only for moving

PII for PPM forward, but also to encourage optimal maternity service provision more sustainably into the future.

### *6 Alternate insurance models*

As other international jurisdictions highlighted, there are a number of insurance models that exist. Part of the challenge in Australia at present is that the model adopted is focused on profit and yet it is available for a very small number of providers. This appears to make it commercially unviable. Support through a government subsidy, not-for-profit (NFP) or alternate models along with enabling factors seen internationally for the provision of PII, may assist in the development of a solution.

### *7 Enhance collaborative partnerships*

Collaborative partnerships have been consistently identified in consultations and literature as important to assist in achieving the best outcomes for women and babies. There should be a focus on identifying factors that prohibit effective collaboration between PPMs and health services. Improving access to health services so that there are effective pathways for consultation, referral and collaboration and support for PPMs to provide safe care, could reduce the risk profile of PPMs for insurance purposes.

### *8 Impact of broader health policies*

Consideration should be given to the impact of policies, particularly enablers that will support the provision of PII for PPMs. These include for example, the impact of the DisabilityCare Australia, a cap on claims, the role of Medicare Locals and the potential for co-payment models.

## *Looking to the future*

These findings are interrelated, are linked to various components of the broader context of PPM practice and involve multiple stakeholders. In developing these considerations, it was noted that, in some form, each consideration has been identified in previous reviews and reports.

As a result, a recommendation is that a number of health professionals, appropriate authorities and consumers need to be better engaged and committed to resolving these matters in the interests of safety and choice.

In its role, the NMBA could be instrumental in assisting the development of a partnership in which key stakeholders are engaged to collectively work together to develop the best model in the Australian context for PPM practice. From international review completed, commitment by each group including government agencies, professional associations, Colleges, insurance bodies and regulators was found to be the most effective way in which indemnity insurance could be developed for PPMs to support choice for those women who wish to give birth at home.

# Contents

# 1 Introduction

## 1.1 Background

Privately practising midwives (PPMs) are defined by the Nursing and Midwifery Board of Australia (NMBA) as health professionals who practise within the midwifery profession in the capacity of a sole practitioner, within a partnership or collective, or employed by a company owned solely by the midwife or practising midwives.[10]

As private or self-employed health practitioners, PPMs are not covered by vicarious liability, a common avenue of indemnity cover that is available to employees of health services. Under vicarious liability an employer is made liable for a tort, or civil wrong, including any negligent act committed by an employee in the course of their employment.[11]

From 1 July 2010, under section 129 of the *Health Practitioner Regulation National Law* (National Law), all health professionals are required to hold professional indemnity insurance (PII) prior to practising in their respective profession. For the majority of health professionals who are employed by a health service, this requirement is met through the insurance arrangement their employer holds. For all other health practitioners who practise independently (including PPMs), individual PII products are required to be purchased.

PII is a form of liability insurance necessary to indemnify health practitioners for financial loss arising from claims brought against them.[12] At the time of this report, two commercial PII products exist in the insurance market for PPMs. Importantly, as both products do not provide indemnity cover for PPMs providing intrapartum care (the birthing stage of pregnancy) PPMs are unable to meet the National Law requirements while undertaking intrapartum care. Without a resolution to this issue, an exemption from the National Law has been applied to PPMs until July 2015.

> ***"No adequate and reliable data is available to develop an accurate risk profile for privately practising midwives who provide birthing services"***
>
> *(Commonwealth of Australia, 2008a)*

Commonwealth Government reviews[13] and other subsequent publications, including the recent NMBA public submission into PPM quantum of cover, have all sought resolution of the problems arising from the lack of PII for PPMs providing intrapartum care.

## 1.2 Scope of the report

PricewaterhouseCoopers (PwC) was commissioned by NMBA, through the Australian Health Practitioner Regulation Agency (AHPRA), to undertake research into the provision of professional indemnity insurance for privately practising midwives in Australia and to complete a national and selective international review of PII arrangements and claims.

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10 Nursing Board of Australia, 2012.

11 NSW Nurses and Midwives' Association, 2009.

12 Commonwealth of Australia, 2009.

13 Commonwealth of Australia, 2008a.

The project scope was to outline the current context in which PPMs operate nationally and internationally in terms of the:

- environment in which PPMs practise
- insurance market, including the products and quantum of cover available
- claims and tribunal cases brought against PPMs
- outcomes for women and babies through homebirths.

To complete the scope, a number of documents have been produced including:

- **Data report:** contains information on insurance products and quantum of cover of existing products as well as national and international claims, tribunal and court data
- **Medicare report:** contains information on Medicare Australia items that have been accessed by eligible midwives including an identification of key trends
- **Final report:** this report, the intent of which is to provide an understanding of the environment in which PPMs practice that precludes the development of PII for PPMs for intrapartum care. This includes findings on outcomes from homebirths by PPMs as well as findings from international PII arrangements.

In analysing the various issues described above, key findings and transferable lessons relating to the provision of PII products for PPMs were identified. The intent of this Report is to describe the role of PPMs, as well as gaps in risk or policy, and highlight areas of opportunity and considerations for the NMBA to assist the NMBA with future decision-making in relation to the exemption of PPMs from the National Law.

## 1.3 Methodology

This final report and its finding are based on a collection of evidence-based research made available either through public sources, or provided by stakeholders both nationally and internationally.

### Stakeholder engagement

To obtain evidence for this report, wide consultations were conducted under the direction of the Policy Committee (PC) of the NMBA. Stakeholders consulted included both national and international representatives from government agencies, professional associations, Colleges, academic institutions, consumer groups, regulators, insurers and practitioners. PwC would like to acknowledge and thank the organisations and individuals consulted (see Appendix C) for their valuable time and information.

### Data collection and literature scan

Where there were gaps in data, information was collected and supplemented with independent data requests and primary data collection from a variety of sources including PPMs, insurers and tribunals. The data collected include:

- **Claims:** data were requested from insurers that were known to have either offered or currently provide PII products for PPMs in Australia and within the four selected international jurisdictions. Further consultations were held with representatives from insurance companies contacted to clarify findings
- **Tribunals:** data were requested from representatives within state-based AHPRA offices, and relevant tribunals within the four selected international jurisdictions. Information was

subsequently collated and analysed by PwC. Where necessary, further consultations were held to clarify findings

- **Courts:** data were obtained through completing legal database searches

- **Other information:** additional information was collected to support the key findings presented within this report. Examples of sources from where data were obtained include the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW) and the AIHW National Perinatal Epidemiology and Statistics Unit (NPESU).

In some cases public data were not available, or were not sufficient for the purposes of this report. In these cases either primary data collection was performed by PwC (eg through a survey), or other data sources (eg insurers, tribunals) were provided with requests for information.

### *Literature scan*

The report seeks to provide evidence through publicly available information where possible. Our findings from this literature that relate to PII, and more specifically the outcomes from homebirth as requested in the scope of the project, have been specifically presented in the discussion in Chapter 3 and Appendix J. While PwC has not performed a comprehensive or academic-level review on the quality or reputation of the articles, authors or organisations that contributed to the scanned literature, the intent is that this evidence adds to the discussion, particularly to the issue of data quality, assisting in highlighting relevant considerations for assessing the risk profile of PPMs.

## *1.4 Structure of this report*

This report is structured to provide the following information:

- **Chapter 2: PII for PPM:** This chapter provides the history and context of the PII industry broadly and as it specifically relates to PPMs with reference to significant events that have shaped the current state of the market. The history of PII for PPMs is also discussed, with an outline and comparison of current product offerings

- **Chapter 3: Impact of the PPM practice on PII product offerings:** This chapter discusses the interrelationship between PII and PPMs. It outlines findings on the current factors within PPM practice and their operating environment that precludes a PII product by outlining:

  – the 'premium equation' and the requirements of commercial insurers to develop a profitable product that is affordable to PPMs

  – six key findings relating to two key areas – the communication of practice and available data, and the inherent limitations in PPM practice that to varying degrees impact at present upon PII for PPMs' intrapartum care

- **Chapter 4: Practice of homebirths internationally and transferable lessons:** This chapter outlines the practice of PPM and PII arrangements with a selection of international case studies, England in the United Kingdom, the province of Ontario in Canada, the Netherlands and New Zealand, highlighting lessons that are transferable to Australia

- **Chapter 5: Considerations and next steps:** Based on our findings, this chapter provides the NMBA with considerations for resolving the issue of PII for PPMs

- **Appendices:** A range of appendices provide further detail and information relating to the body of the report.

# 2 Professional indemnity insurance for PPMs

The following section describes the historical factors that have affected the insurance market for privately practising midwives in Australia. Professional indemnity insurance products were withdrawn from the market for independently practising maternity service providers. When PII products were reintroduced, these excluded intrapartum care for PPMs. At the same time the Commonwealth Government PII scheme for obstetricians was not offered to midwives in private practice.

## 2.1 Professional indemnity insurance defined

Professional indemnity insurance is a form of liability insurance necessary to indemnify health practitioners or institutions for financial loss arising from actions brought against them as a result of the performance of their professional duties.[14] Negligence is an example of an action (or lack of action) where a duty of care is believed to have been breached, directly resulting in adverse outcomes. As a result, those affected may seek payments for damages and losses suffered due to a problem with a service, if it could have been reasonably foreseen. Compensation is designed to reinstate the person/s affected to their position should the adverse event not have arisen.

Under the National Law, all health professionals are required to hold PII prior to practising. Individuals employed by health services may not be required to purchase separate PII cover. This is because the insurance products held by health services generally cover negligent actions of the institution and of its employees (through vicarious liability). This cover is obtained either through commercial insurers, or in the case of public State and Territory services, through self-insurance arrangements including Treasury Managed Funds (TMFs).

In contrast, those health professionals that are not covered by, or do not have employers, need to purchase individual PII products from commercial insurers to meet National Law requirements. As PPMs fall into this cohort, the focus of this report is on those insurance products and the regulatory system in which they function.

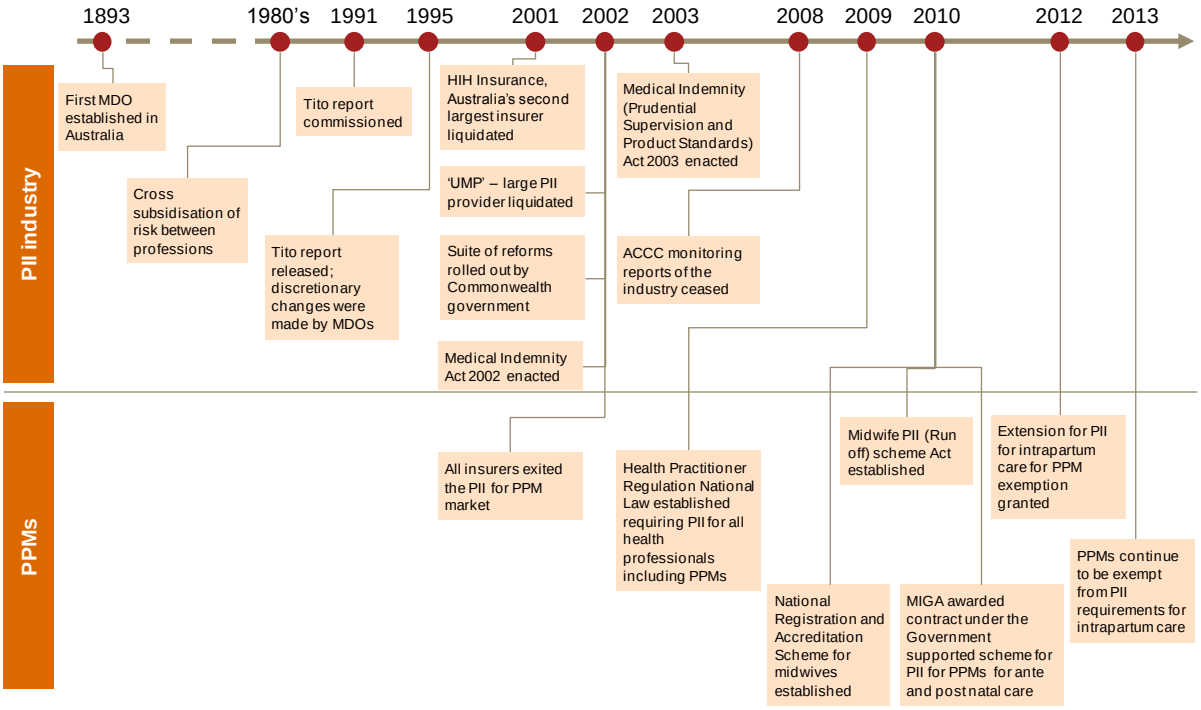
## 2.2 History of professional indemnity insurance

The history of current PII products on offer to PPMs provides important context for understanding the evidence upon which previous reforms were based and points to potential areas for future changes. Inherent deficiencies identified in the structure and operations of past indemnity providers and the subsequent collapse of the market in 2001 have been identified by stakeholders as pivotal in shaping the current industry.

In short, the industry has transitioned from an unregulated market with discretionary-based product fees and benefits, to one with a relatively stronger regulatory framework. As a result, the market became better managed providing greater certainty and protections for the public and their ability to have claims paid out. Conversely, it also appears that this has led to companies being more conscious of risk and potential market opportunities. This appears to have led to a greater emphasis being placed on commercial decisions having a direct impact on access of PII for PPMs for intrapartum care. An outline of the key events shaping this history is provided in Figure 4.

14 Commonwealth of Australia, 2009.

**Figure 4: Key events in the PII industry within Australia**




## *Early years: Medical Defence Organisations – unregulated and unstable*

The industry has evolved from when the first Medical Defence Organisation (MDO) was established in 1893.[15] As the increasing incidence and size of claims made in Australia shifted over time, weaknesses in the market were exposed particularly in MDO operations and their products. While from research undertaken it is apparent that MDOs did not provide PPMs with PII products, the impact of MDO operations influenced and shaped the PII market, and its subsequent collapse affected the offering of PII for PPMs.

### *Regulation*

Initially, by providing discretionary products, MDOs were not classified as insurance companies and therefore were not required to adhere to the requirements of regulatory prudential bodies or legislation including the *Insurance Act 1973*.[16] Without regulation, there was no oversight of the financial management of the organisations or the adequacy of the products offered, and government bodies at the time had limited power to influence their practises.

### *Products*

Without insurance in its more commercial form, there was little protection for members against premium rises or calls (in which additional subscriptions were charged) by MDOs for additional funds. This occurred consistently in the early 2000s. In terms of payments, health professionals had no contractual right to be indemnified by MDOs meaning that MDOs retained discretion over any payments made.[17]

15 Callinan R 2001.

16 The cost of insurance products, and the benefits paid out were discretionary.

17 Commonwealth of Australia, 2009.

Uncertainty about the sufficiency of funds collected by MDOs was exacerbated by cross-subsidisation and claims-incurred[18] products. Until the mid 1980s, cross-subsidisation between professions occurred, as all members in an MDO paid the same subscription regardless of their risk or profession.[19] Provisioning for future payments, where the timing and extent of the payments to be made was unknown, meant that current members subsidised previous members for potential claims. The result was that in 1994, it was believed that the industry had unfunded liabilities of approximately $240 million.[20]

## *The 'claims crisis' and legislative reforms*

In 1991 the Commonwealth Government commissioned a review into indemnity arrangements. This was driven by multiple factors including:

- increased scrutiny over MDOs and the adequacy of their products and financial management
- the funding of liabilities from claims-incurred cover products
- perceived lack of transparency of the industry
- a 'claims crisis' in which it was perceived that there was an increasing number of claims.

### *The Tito report*

Released in November 1995, *The Review of the Professional Indemnity Arrangements for Health Care Professionals*, or the 'Tito report', was the first key investigation into the indemnity industry.

While some MDOs followed recommendations within the report (for example, moved to claims-made[21] cover in 1997), the majority continued to increase premiums or require members to pay additional levies. This was to improve their funds pool that had been depleted from sluggish global market conditions and a perceived "explosion of medical negligence litigation" during the late 1990s and 2000s.[22]

While many recommendations were subsequently employed through legislative reforms following the 2001 insurance market 'collapse', several remain outstanding today. An example of relevant key recommendations or commentary to the current issue of PII for PPM is outlined in Table 1.

***"I don't think the medical community or the political groups involved at the time could see far enough ahead to realise that Fiona [Tito] was trying to provide answers to a problem that was bigger than we all realised at that time... the medical litigation crisis that we're facing now [in 2002] would be a lot different if a number of the recommendations that she'd made earlier in the piece had been taken more seriously."***

*Prof Bruce Barraclough, Previous Chair, Australian Council for Safety and Quality in Health Care (Australian Doctor, 2002)*

18 Claims incurred products allow claims to be made for prior incidents subsequent to the period in which cover was held.

19 Callinan R 2001.

20 Ibid.

21 Claims-made cover provided health professionals cover only when they had paid the premium for the year in which the claim was made.

22 Callinan R. 2001, p.i.

**Table 1: Recommendations from the Tito Report of relevance to this report**

| Number | Description |
|---|---|
| 128, 133 | Adequate PII required for all health professionals |
| 130 | Contractual as opposed to discretionary PII required |
| 136 | All health professional and health care business indemnity cover be uncapped |
| 137 | PII cover be on a claims-incurred basis[23] |
| 150 | The concept of a mutual insurance mechanism to a health care sector (including individual health professional groups) that consider commercial insurance too costly, and self-insurance too risky |

**Source:** Commonwealth of Australia, 1995.

## *The perfect storm – the collapse of an unregulated market*

The perfect storm arose in 2001 with the liquidation of HIH Insurance, Australia's second largest insurance company. As the major reinsurer of United Medical Protection Ltd (UMP), one of the largest PII insurers in Australia (with 60% coverage at its height), the liquidation of HIH Insurance led to a $30 million write off for UMP. This, coupled with an estimated $455 million of incurred but not raised (IBNR) [24] claims, led to UMP's own liquidation in April 2002. The liquidation highlighted the system as being "unsustainable" due to insufficient premium collections required to meet rising claims.[25]

The Commonwealth Government responded in 2002 by implementing a suite of reforms. Reforms with specific impact for PII for PPMs were the passing of the *Medical Indemnity Act 2002* and the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* which were important steps towards:

- **establishing a prudential structure** to the PII industry including requiring insurers to hold minimum capital requirements and sufficient resources to pay claims
- **requiring authorised general insurers** under the Insurance Act 1973
- **increasing regulation** of indemnity products
- **establishing contractual arrangements** between the insurer and product holder.[26]

23 There is variation in the use of the claims-incurred and claims-made cover definitions. The definition of claims-incurred cover used in the Tito Report is in line with the definition applied to claims-made cover in this report.

24 IBNR (Incurred but not raised) liabilities result from claims where an incident has already occurred but the claim has not yet been reported to the risk carrier

25 Centre for Health Economics, 2005.

26 Note that not all reforms were well received. The 'IBNR levy' where members of UMP were to fund existing IBNR was met with hostility and the resignation of 100 practitioners (Centre for Health Economics, Research and Evaluation, 2005).

## 2.3 Professional indemnity insurance for privately practising midwives

Obtaining specific information on the history of PII for PPMs has been challenging. This is due to a range of factors:

- There has been limited research and literature completed on the topic of PII for PPMs in Australia, possibly because the industry is relatively small compared with other health professionals
- The collection of meaningful data at the level of the PPM is limited because the numbers are small and not recorded separately on the NMBA register of midwives
- Insurance agencies and brokers have changed ownership, names and structure (eg merged, liquidated) over time or do not currently exist. As a result, identifying and consulting with agencies has been challenging
- Insurers have been unable and/or unwilling to share product and claims information due to the commercial nature of the information.

### History of professional indemnity insurance for PPMs

#### Products offered pre-2001

From the available literature and consultations with insurance agencies and brokers, it appears that PII was available to PPMs up until 2001 through brokers acting for professional nursing and midwifery associations. While the full number of insurers could not be ascertained, those insurance agencies thought to be providing products included:[27]

- **St Paul Insurance:** Provided to members of the Victorian and Tasmanian Branches of the Australian Nursing Federation (ANF)
- **Guild Insurance:** Provided to the Australian College of Midwives (ACM) members.[28]

There were a number of insurance brokers that also facilitated insurance including:

- **Sawtell & Salisbury:** A Queensland-based broker[29]
- **Marshall Brokers:** A Victoria-based broker[30]
- **Hope Island Insurance Brokers:** A Queensland-based broker.[31]

The cover available at the time appears to have been financially affordable to PPMs. As an example, the product offered through Hope Island Insurance Brokers provided cover from $1 million to $5 million for $450–850 per year on a claims-made basis (with a $500 excess/claim).[32]

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27 Canil M 2008.

28 Cover provided by Guild Insurance for PPMs could not be verified.

29 Personal communication, March 2013.

30 Ibid.

31 Commonwealth of Australia, 1995.

### *Insurers leaving the market – Assessing midwifery as maternity services*

In 2001 Guild Insurance and St Paul's Insurance exited the market. By March 2002, no commercial PII product was available for PPMs, resulting in an exit of PPMs from the profession.[33]

The decline in the availability of insurance products has been linked to a perception of the high-risk profile of PPM practice.[34] This can be attributed in part to midwifery services being bundled together with other high claim maternity services such as obstetrics (see box below).

**Simpson v Diamond & Anor**

Colander Simpson sought damages from the obstetrician (Diamond) who delivered her in July 1979, and the private hospital in which she was born. Ms Simpson, who has cerebral palsy, claimed that a competent doctor would have been able to deliver her without complications and uninjured by forceps. It was claimed that the cerebral palsy resulted from the methods Diamond used during the deliver that led to hypoxia and injury to her brain.

In November 2001, the NSW Supreme Court awarded Ms Simpson $13 million (which was reduced to $11 million on appeal). The amount awarded was determined by:

- **Future attendant care**: Fees to "put the plaintiff in the same position as if she had not been injured by the defendant's negligence" (Whealy J), based on her life expectancy
- **Damages**: with interest from birth to judgment due to Simpson being unable to "enjoy life to the full as normal able bodied people do" (Whealy J).

While relating to obstetrics as opposed to midwifery, this case had implications across the maternity services sector. The material damages awarded and length of elapsed time between event and claim became a concern for insurers.

**Source:** Allens, 2001.

### *PPM practice in indemnity crisis*

Professional associations, including the ACM and ANF branches, were unsuccessful in securing insurance for PPMs following the exit of Guild Insurance and St Paul Insurance. Insurers either declined to insure midwives or offered premiums that were not financially viable for PPMs.[35] For example, some agencies managed to secure insurance through a Lloyds of London underwriter, where in at least one case the premium was inflated to at least five times that of the original policy.[36]

In 2010, the National Law was instituted which led to compulsory PII as a condition for registration. Without commercial PII products available, the National Law held PPMs at risk of being legally unable to practise privately as registered midwifes.

## *Current product offering – MIGA and IMGA insurance*

Prior to the National Law, the issue of PII for PPMs was identified in 2008 within the Commonwealth Government Maternity Services Review. The review recommended that:

> *"consideration be given to Commonwealth support to ensure that suitable professional indemnity insurance is available for appropriately qualified and skilled midwives."*[37]

Subsequently, the Commonwealth issued a tender for PII (excluding intrapartum care), which was awarded to the insurer MIGA.[38] Following this, another commercial insurer, IMGA, entered the market. While both provide PII for PPMs, the products differ, as outlined in Table 2.

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32 Ibid.

33 Canil M 2008.

34 Ibid.

35 Ibid.

36 Ibid.

37 Commonwealth of Australia, 1995.

**Table 2: Insurance products in Australia**

| Insurer | MIGA | | IMGA |
|---|---|---|---|
| **Product type:** | • Federal government underwritten. | | • Commercial product. |
| **Insurer's product name:** | Category A<br>(if provide intrapartum care) | Category B<br>(if provide no intrapartum care) | Category A<br>(The provision of antenatal and postnatal and education services) |
| **Annual premium** | • $7,500 | • $3,400 | • $1,405 – $2,315 |
| **Calculation of premium** | • Caseload* | • Caseload* | • Level of indemnity required<br>• Membership in the ACM |
| **Run off cover** | • Yes | • Yes | • No<br>• "claims-made and notified" |
| **Excess** | • No | • No | • Yes<br>• $2,500 |
| **Quantum of cover** | • Unlimited | • Unlimited | • $1,000,000 – $5,000,000 |
| **Not included in cover** | • Homebirth | • Birthing activities | • Birthing activities<br>• Court/Industry investigations |

**Note*:** Caseload is to the number attended per year.

**Source:** MIGA 2012, IMGA 2012.

The common feature of both products is that they do not provide PII for homebirth or birthing services during the provision of intrapartum care. The key differences between the products include:

- **Eligible midwives/practice:** MIGA requires holders to either be an eligible midwife, or become one
- **Excess:** while the MIGA product is higher cost than the IMGA product, it has no excess attached
- **Premium:** the premium varies between products and companies. The driver of variation was not provided, but could be linked to actuarial computation of the premium equation (see Chapter 3)
- **Quantum of cover:** MIGA has no limitation to the cover provided unlike the IMGA product
- **Run-off cover:** as a government-underwritten cover, MIGA offers run-off cover through the Midwifery Professional Indemnity Scheme. This is free PII cover whereby the Commonwealth will make payments to reimburse claims that are raised subsequent to a PPM ceasing practise.

Consultations have identified that the inability to obtain insurance for intrapartum care has reduced the number of PPMs in practice. This could present difficulties in meeting access needs of women over their choice of birthing models. Alternatively as the *Report of the Maternity Services Review* from the

38 Note that this tender is in contrast to other maternity service providers, including obstetricians, in which a scheme including intrapartum care was put forward.

Commonwealth Government identified, where PPMs have decided to continue to provide services, the result is concerning for both the PPM and the woman. Those that continue to provide intrapartum care do so at their own financial risk.[39] Depending on the financial circumstances of the midwife, the risk may transfer to a woman and/or baby if no financial recourse is available.

39 Commonwealth of Australia, 2009.

# 3 Key findings

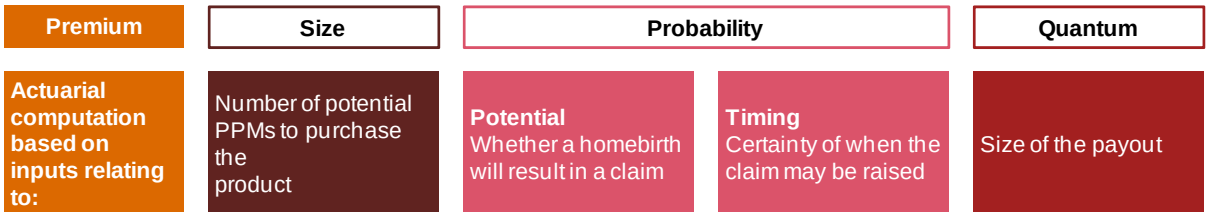
## 3.1 Profitability drivers for insurers

In order to explain the findings below, a short summary of the drivers of insurance product development has been provided.

In the current Australian commercial insurance market, a professional indemnity insurance product for privately practising midwives will likely need to be assessed as profitable, in the absence of a government subsidy or alternate insurance schemes. This is in contrast to other jurisdictions internationally such as Canada, where reciprocal and non-profit arrangements exist (see Chapter 4).

For any commercial insurer to determine a premium for a product, there are several considerations that need to be taken in to account. From relevant research, three key components were identified from the 'premium equation' concept as outlined in Figure 5.

**Figure 5: equation for insurance premium development**




As the Flaxman report from the United Kingdom (UK) notes (see box below), the current challenge of insuring privately or independently practising midwives relates to the apparent limitations in assessing each of these components. Either an absence of sufficient data on each of these components, or the inherent limitation in the current practice and/or environment in which PPMs provide services, has meant that developing a product is either:

- unprofitable for the insurer
- profitable at a price that is unaffordable for those to be insured.

**The Flaxman report**

In 2001, the Flaxman report (named after the author Flaxman Partners) was commissioned by the Royal College of Midwives and the Nursing & Midwifery Council. It discussed the feasibility and insurability of independent midwifery in England. England historically experienced similar issues to Australia in providing indemnity insurance for independent midwives. The report identified 7 **principle** reasons why the commercial market rejected insurance provision (Section 8.2):

- Perceived high-risks associated with the intrapartum process
- Extreme vulnerability of midwives to allegations of negligence... seeking to apportion blame to a midwife
- Legal complexities and costs of defending midwives against allegations of negligence
- Amount of damages/awards typically associated
- Absence of a legal entity to employ and control the operational and performance of Independent Midwifery services
- Absence of uniform standards for Independent Midwifery
- Insufficient numbers of independent midwives to charge a sufficient but affordable premium.

These principles were also identified to varying degrees in the Australian research and fall within six findings which are explained later in further detail in this chapter.

While there are differences between the Australian and English indemnity market and midwifery sector (See Chapter 4), the challenges relating to insuring seem consistent.

**Source:** Flaxman Partners, 2001.

## 3.2 Overarching findings

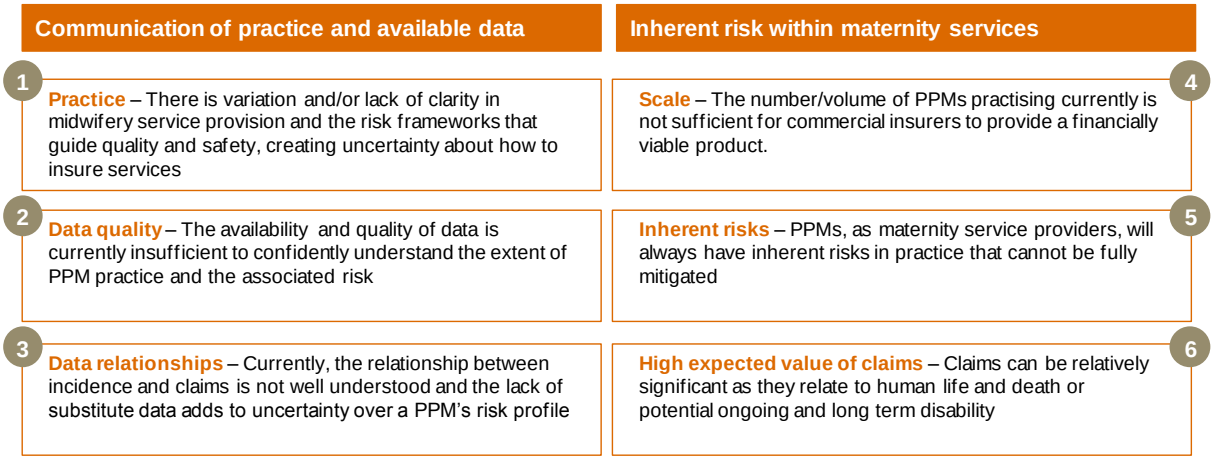
Two key areas were identified through consultation and literature which appear to inhibit the current commercial PII market for PPMs requiring intrapartum cover care in Australia:

- The lack of available or consistent data has resulted in poor evidence on PPM practice and homebirth outcomes. This appears to have led to risk assessments being influenced by the various claim and counter claims and the communication of the practice within the maternity sector. Ultimately, this appears to have driven a lack of confidence and certainty within the insurance market on PPM practice

- Inherent risks within maternity service provision, combined with a small PPM market, result in limitations to insurance product offerings. This is exacerbated where the risks of obstetric care are conflated with maternity services.

These areas and the associated findings are outlined in Figure 6 and explored further below.

**Figure 6: Key areas and associated findings**




The evidence available has not supported a determination of the relative importance of these key areas in decision-making about the offering of particular insurance products. For example, it cannot be proven that if communication of outcomes and data quality improved, a commercial product would be developed. Neither can it be proven, despite some success in other jurisdictions (see Chapter 4), whether inherent risks in PPM practice within the current Australian health context relating to the size and risk profile can be mitigated sufficiently to provide a PII product in a commercial market.

The importance, however, of identifying profitability as the ultimate driver of commercial insurers, is that each finding in Figure 6 can be seen to have an impact on one or more of the components in the premium equation. This is outlined in Table 3.

**Table 3: Impact of Findings on premium equation components**

| Premium equation items: | Finding 1: Practice | Finding 2: Data quality | Finding 3: Data relationships | Finding 4: Scale | Finding 5: Inherent risks | Finding 6: Value of claims |
|---|---|---|---|---|---|---|
| **Size** | | ✓ | | ✓ | | |
| **Probability** | ✓ | ✓ | ✓ | | ✓ | ✓ |
| **Quantum** | | ✓ | ✓ | | ✓ | |

In outlining the six findings in Figure 6 throughout this chapter, the impact of each finding on the three premium equation items is presented. Assessing this impact can lead to considerations for how a market for professional indemnity insurance for PPMs can be created. It may be that a commercial market will not be viable, and that government intervention (eg subsidy similar to other professions) or other models (eg co-payment, NFP) may be required (see Chapter 5). Alternatively, it may be that by understanding these findings better, the market may become more attractive to the existing commercial insurers.

The point to make is that it is important for women to have a choice in whether they have a homebirth, and that PII can be one element in supporting safe homebirth care. PII for antenatal, intrapartum and postnatal care is available for midwives practising within a similar scope in other jurisdictions (see Chapter 4), and is necessary to support women's choice and the PPM homebirth model in Australia.

These findings in light of internationally established models (see Chapter 4) should provide guidance as to what the next steps should be. In Chapter 5 we have outlined considerations and potential actions or options to address the findings presented.

## 3.3 Communication of practice and available data

Literature and stakeholder consultations identified that the communication on what women should expect from a safe, high quality privately practising midwife, the context in which they operate, and the outcomes seen from their care can be improved. Underpinning this communication would be standard frameworks developed by appropriate authorities to allow consumers to make more informed choices about their care options.

Where evidence is available around the practice of PPM, often the intra-professional dialogue was found to cloud the capacity of the insurance industry to draw clear conclusions on this practice. In addition, sometimes the evidence is inconclusive or lacks clarity. Our review and consultations identified several supporting findings as outlined in Table 4.

Each of the findings (whether they relate to the environment in which PPMs practise, or the practice of PPM itself), may have prevented a PII product being developed (includes cover for intrapartum care). It is likely that any resolution to the issue of PII for PPMs will need to address these findings, in part or as a whole.

**Table 4: Key findings precluding the development of a commercial PII product for PPMs for antenatal, intrapartum and postnatal care services**

| Number | Topic | Finding |
|---|---|---|
| 1 | Service provision and frameworks | *There is variation and/or lack of clarity in midwifery service provision and the risk frameworks that guide quality and safety, creating uncertainty about how to insure services.* |
| 2 | Data quality and availability | *The availability and quality of data is currently insufficient to confidently understand the extent of PPM practice and the associated risk.* |
| 3 | Data relationships | *Currently, the relationship between incidence and claims is not well understood, and a lack of substitute data adds to uncertainty over a PPM's risk profile, causing uncertainty over a PPMs risk profile.* |

These findings do not suggest that a PII product for PPMs that includes intrapartum care can only be developed if these data are made available. Some stakeholders consulted highlighted that other maternity service providers have been able to obtain PII for antenatal, intrapartum and postnatal care

without, for example, quality and safety frameworks.[40] Instead, these data were identified by insurers and literature as necessary to support and assist in the PII development, particularly if the PII market for PPMs continues to be serviced by commercial insurers.

## *Finding 1: Service provision and frameworks*

**Variation and/or lack of clarity in midwifery service provision and risk frameworks that guide quality and safety, creating uncertainty about how to insure services.**

Without clear definitions and frameworks, an understanding of the probability of a potential incident arising may not be sufficiently known. This appears to increase the perception of uncertainty of practice and subsequent risk to insurers in developing a product. In the case of PPMs, necessary definitions for insurers may include:

- who PPMs are, their qualifications, skills and experience
- how PPMs deliver services, their operating model and interrelationships with others
- what services are being insured and the scope of PPM practice including regulation and quality controls.

### *Who PPMs are*

Definitions are important for insurers as they establish who can obtain or is eligible for cover. They also can assist in determining the risk profile of those being insured. Currently, the NMBA Register of Midwives does not identify who is a PPM, and there are no national data on the number of PPMs in Australia or the number of PPMs who are currently providing homebirth services. While registering as a midwife provides insurers with a suitable indicator for understanding eligibility as a PPM, it may not provide suitable guidance to an insurer on the range of practice environments seen, and therefore an individual PPM's risk profile.

To practice, PPMs are required to register as a midwife with the same skill set as midwives practicing in other settings. This is supported by the International Confederation of Midwives (ICM) definition of a midwife (see Appendix D.1):[41]

*"that a midwife should have the same set of skills and level of competency in practice, regardless of the setting of the birth"*.

However, the definition of a PPM does not provide insurers with information to develop a risk profile for an independent midwife providing maternity services, as it only relates to the operating model in which PPMs provide care and not the skill, competency or practice of a PPM (see Appendix D). It also does not distinguish between a midwife, a PPM and a PPM providing services in the home. It is the latter group that insurers need to understand the risk profile of.

'Eligible midwives' are a more regulated sub-class of midwives under NMBA. Developed in 2010, registration as an eligible midwife grants a midwife access to the Medicare Benefits and the Pharmaceutical Benefits Schemes.[42] It is necessary to demonstrate registration (or the intent to

40 Personal communication, June 2013.

41 International Confederation of Midwives, 2012.

42 Nursing and Midwifery Board of Australia, 2010.

register) as an eligible midwife to purchase the MIGA insurance product[43], unlike IMGA which only requires a midwife to be registered with the NMBA to purchase its product.[44]

The eligible midwife classification provides an example of how regulation can assist to mitigate a profession's risk profile through defining requirements and competency. The classification allows a midwife's practice to be:

- more closely monitored through its association with Medicare Australia services in terms of activity

- benchmarked in terms of skill and competency level. For example in order to register, eligible midwives are required to demonstrate competency in midwifery practice, have a certain level of experience and ongoing professional development (see Appendix D.3 for the full set of requirements to become an eligible midwife).

The benefits however, of having additional registration requirements (as required for eligible midwives), has yet to be identified. For example, eligible midwives have not been proven so far to have outcomes that differ from other midwives. However, from a risk perspective, consultations with international insurers identified that clear and well-defined definitions and requirements, particularly around education and competency, have assisted in reducing the perception of the risk profile of PPMs.[45] This is something that could be considered in the development of an insurance product going forward that covers the full spectrum of PPM care (see Chapter 5).

## *How PPMs deliver services*

The different operating models used by PPMs to deliver services may collectively impact the risk profile developed by insurers. Research completed identified that the current method of setting premiums for the antenatal and postnatal insurance products in Australia appears to be based predominantly on caseload (ie the number of women attended by a midwife in a year).[46] In other jurisdictions, other factors relating to the operating model including, practising with more than one person in attendance, were identified as assisting to reduce the risk profile of a birth. Therefore, if models of care or practice cannot be distinguished (eg sole care versus more than one in attendance) then the premiums may be set higher than the risk that is actually being taken on by the PPM.

There are a number of different operating models which are described by the NMBA as a PPM practice. Specifically, the NMBA has defined PPM practice in light of its definition of a PPM being where a midwife is working: [47]

1. as a sole practitioner (either on a full-time or part-time basis) in a business owned solely by the midwife

2. in a partnership or collective; or where a midwife is employed (full-time or part-time) by a company that is owned solely by the midwife

3. in a partnership or collective; or where a midwife is employed (full-time or part-time) by a company that is owned solely by practising midwives, where the only directors of that company are practising midwives.

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43 MIGA, 2012.

44 IMGA, 2012.

45 Personal communication, March 2013.

46 MIGA, 2012.

47 Nursing and Midwifery Board of Australia, 2012, p.5.

However, from the literature there appears to be a limited understanding of how these different practices outlined by NMBA could affect the risk profiling of a PPM. For example, would one of these practices be assessed as being of a higher risk than another?

As an example, evidence suggests that operating as a sole PPM may be assessed as practising with a relatively higher risk than other models including group practice, particularly if these sole PPMs are managing full case loads.[48, 49] This is because of:

- **The challenge to the ability to manage more than one woman:** a midwife operating alone with a full caseload may need to manage more than one birth at once

- **Support and risk mitigation:** in group practice, there are not only multiple midwives to support multiple births, but also the ability to have professional support where more than one midwife is in attendance. Consultations with insurers in the Netherlands identified that as a result of these factors, group practice is one method to reduce the risk profile.[50] Having more than one midwife in attendance is also held to be best practice, and is a requirement within the publicly funded homebirth schemes and under certain state homebirth policy guidelines found in Australia.[51]

The higher risk associated with being a sole practitioner with a large caseload could result in higher premiums for the whole cohort of midwives if relatively flat premiums are applied for all PPMs, irrespective of the operating models of care. Therefore consideration of individually-assessed risk premiums, or alternatively, insurance provided for a particular operating model could be considered for a future PII product.

### *What services are being insured*

Consultations and literature suggest that at present there is variation in not only the practice models as discussed above, but further, both the safety and quality frameworks as well as the level of support and supervision that is provided to PPMs.

Consultations and literature suggest that at present there is variation in practice, scope and risk frameworks that define PPM practice. Understanding these elements is important for insurers when setting an appropriate premium, as it assists in determining the risk profile for PPMs and the probability that a claim may arise from services provided.

In general terms, the scope of practice for PPMs has been defined as providing care and advice during pregnancy, labour and the postpartum period.[52] More specifically, the NMBA has included other elements in the definition of scope of practice for an eligible midwife, such as clinical assessment, exercise of clinical judgment, planning, implementation, monitoring and review, responding to maternity emergencies, assessment and care of the baby, management and administration of medicines, and the judicious use of diagnostic investigations.[53]

48 A caseload refers to the number of women that are in the care of a PPM. A full caseload has been considered in previous reports to be around 40 births per year. UTS Centre for Family Health and Midwifery 2001.

49 UTS Centre for Family Health and Midwifery 2001, p.10.

50 Personal communication, March 2013.

51 South Australia Department of Health, 2007.

52 International Confederation of Midwives, 2012.

53 Nursing and Midwifery Board of Australia, 2010.

Difficulty in determining a risk profile for PPMs in part appears to be driven by the variation in:

- **Practice provided:** affected by demand and supply side factors and arrangements
- **Risk frameworks:** the frameworks used to support the consistency, quality and reliability of midwifery
- **Disciplinary processes:** that had previously been in place within states and territories prior to the establishment of the National body, the NMBA[54]

Each of these areas may affect the risk profile and the assessed probability of a claim arising.

### Practice provided based on demand and supply side factors

Currently, there are variations seen in the type of care provided not only for midwifery services (eg hospital, home services), but also the type of care provided by PPMs. Consultations suggested that the support and supervision frameworks under which PPMs practise are relatively broad, in line with other maternity service providers.[55] Therefore the ways in which services are demanded by women, and conversely are provided by PPMs, can and in practice do, differ.

Services can vary in terms of what is requested by women. Often, it was identified that these services are requested as they are not available to women within the public health services. An example of such 'demand-side' factors include:

- the location of the women (regional/remote versus metropolitan areas)
- a woman's choice for a vaginal birth after caesarean (VBAC)
- a woman's choice for a water birth
- a woman's choice for a continuity-of-care model.[56]

The availability of services or supply can also vary based on the environment in which services are provided, or the supply of PPMs. As supported by the survey of PPMs completed as a part of this report (see Appendix J.1), the supply of PPMs is believed to be driven by factors such as:

- the availability of PII
- access to health service arrangements, collaborative partnerships with other health professionals and the visiting rights to hospital (further discussion of these and the variations seen between and within states and territories can be found in Appendix E)
- education and continuing professional development opportunities for PPMs.

### Risk frameworks

Risk and quality frameworks exist for PPMs to both guide and prescribe expected practice.[57] At present there appears to be a number of risk frameworks that are available to support PPMs. Multiple frameworks provide challenges for insurers in understanding what is considered within the PPM scope

54 Note that variation in practice has been reduced as a result of the establishment of AHPRA.

55 Personal communication, November 2012.

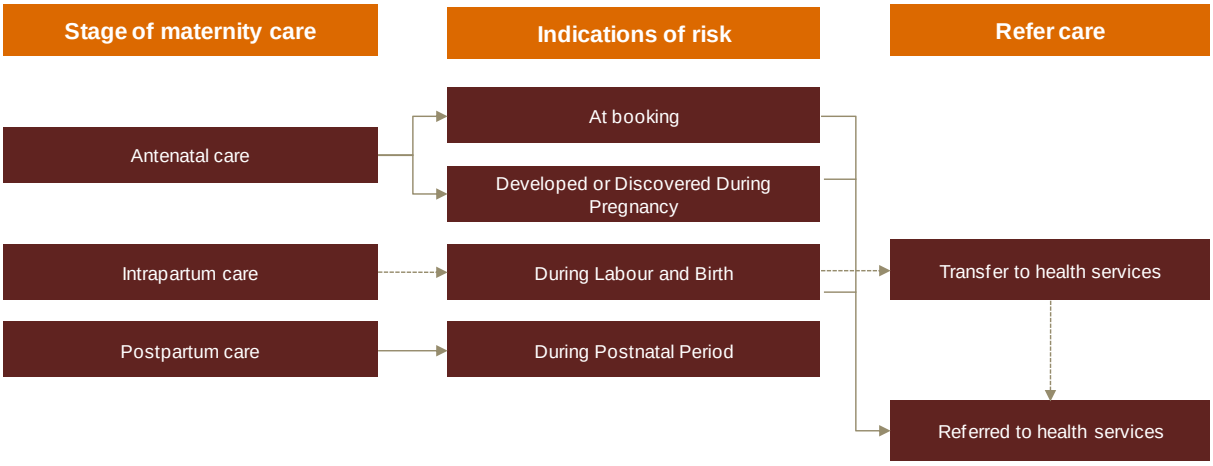
56 Department of Health WA, 2008, p.15.

57 Nursing and Midwifery Board, 2013b.

of practice and what level of support is consistently available for those they are insuring. This is particularly an issue where the frameworks vary in terms of the scope of practice outlined, but also in terms of definitional requirements.

Risk frameworks were identified by international stakeholders as important in providing guidance to insurers for the recommended or best practice of care. Frameworks assist in providing midwives with an outline of what conditions make practice safer and how to clinically assess what action is appropriate in situations that may arise.[58] As an example, Figure 7 demonstrates how a framework can provide guidance on risk mitigation activities at different stages of the birthing process, indications of risk at each stage, and the referral of care to other health professionals.[59]

**Figure 7: A framework for risk and referral during planned homebirth**




**Source:** PwC analysis

Several frameworks are currently recommended by different organisations to support the delivery of care (for a full list of standards, frameworks and guidelines, please refer to Appendix F), including:

- **NMBA:** provides codes, standards and guidelines relating to education, registration and professional conduct to support and guide the relevant professions[60]
- **ACM:** provides a clinical framework on consultation and referral for how a midwife providing homebirth services knows what is within their scope of practice. The guidelines, *National Midwifery Guidelines for Consultation & Referral (2nd edition)* (ACM guidelines), are those used for the purpose of disciplinary proceedings and regulation.[61], [62]

The challenge is that there is variation between some of the frameworks and no guidance for when a particular framework or another should be followed by PPMs. Variation was identified between:

- regulators
- professional groups

58 Australian College of Midwives, 2008.

59 Ibid.

60 Ibid.

61 Australian College of Midwives, 2008.

62 Note that the 3rd edition of the ACM guidelines were released during the finalisation of this report. As a result, the report reflects the 2nd edition. The principles still remain the same.

- states and territories
- state public health networks.

As a result, there are challenges faced by in using risk frameworks to understand the scope of midwifery (and PPMs) because of:

- **Variation between multiple frameworks across the stages of maternity care, referral of care and the indications of risk**
- **An absence of a national Australian framework for maternity services that includes birth outside of health facilities:** the ACM guidelines are not specifically intended for homebirth but for birth in general. No current national homebirth guidelines were identified. A clear and consistent national framework, that includes birthing outside of health facilities by independent practising professionals, may promote consistency of practise and support insurers in determining the level of risk PPMs assume as a part of safe practice
- **Confusion as to when one or more frameworks could be applied (eg between national and state-based frameworks):** South Australia has developed a homebirth policy that guides both publicly funded homebirth schemes and PPM practices.[63] However, the policy is different to ACM Guidelines by containing narrower considerations for what is deemed 'high-risk', and conditions on how homebirths should be undertaken. Other states such as Western Australia have a policy for maternity services and publicly funded homebirth schemes. As no publicly available evaluation is accessible, the impact of these policies on frameworks for PPMs is unknown (see Appendix G for more information about publicly funded homebirth schemes)
- **Health professional associations have not yet appeared to collaborate to support one framework:** the ACM and the Royal Australia and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) have not yet produced joint guidelines.[64]

As outlined in Chapter 4, in other international jurisdictions reviewed, there has often been one prominent framework that is followed. In jurisdictions such as the province of Ontario and New Zealand, these frameworks, particularly relating to consultation and referral, have been developed in collaboration with other health professionals.

Further, the insurer providing independent midwifery products within the province of Ontario, the Health Insurance Reciprocal of Canada (HIROC), works closely with the Association of Ontario Midwives (AOM) to assess the adequacy of relevant frameworks (see Chapter 4).[65] While MIGA in Australia has developed a care plan in partnership with the APMA and ACM, a joint assessment of frameworks does not appear to have been performed by the agencies.

A joint assessment of frameworks would be useful, as our analysis of the three risk frameworks applicable to PPM practice (ACM guidelines[66], South Australia Department of Health policy[67], and the Department of Health WA publicly funded homebirth scheme[68]) identified variation in areas such as:

- guidelines around risk practices in the **stages of maternity care**

63 South Australia Department of Health, 2007.

64 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2011.

65 Personal Communication, November 2012.

66 Australian College of Midwives, 2008.

67 South Australia Department of Health, 2007.

68 Department of Health WA, 2012.

- the definitions and classification of **high and low-risk**.

Comparing state and territory homebirth policies with ACM guidelines is challenging as the ACM guidelines are not intended to be specific to homebirth but to midwifery practice in general. However, as they are national guidelines, and used by MIGA to identify their risk profile of PPMs and support care planning, it would be a useful exercise to clarify variation in 'acceptable risk'. Also interesting is the variation between state and territory guidelines even when specific to homebirth practice.

### *Stages of maternity care*

In comparing the guidelines, variations were identified within different stages of care (an example is outlined in Table 5). This could provide confusion as to what is safe or acceptable care, when there are variations acceptable for PPMs operating within different states or territories.

**Table 5: Variations in requirements of different guidelines and policies**

| Stage of care | Requirement | ACM guidelines | SA State Policy | WA Publicly Funded Homebirth Policy |
|---|---|---|---|---|
| Informed consent | Number of times consent is signed | Once at the start of care | Two copies signed at start of care | 'Terms of Care' to be signed three times during pregnancy, at enrolment, 28 weeks gestation and 36 weeks gestation |
| Labour | Number of health practitioners required at birth | 1 | 2 | 2 |
| Transfer | Time taken to transfer from home to hospital | Not indicated | 30 minutes | 30 minutes |

**Sources:** Australian College of Midwifery, 2008; South Australia Department of Health, 2007; Department of Health WA, 2012.

### *High and low-risk*

As a result of variations in frameworks, there is currently uncertainty around the interpretation of high and low-risk. Definitions and clarity over high and low-risk may be important for an insurer because they indicate the risk the PPM is taking on in their practice, which feeds in to their risk profile. There are inherent risks in providing maternity services, including as a PPM but these can be reduced by following recommended steps outlined within frameworks for transfer and referral.

Frameworks used by states and territories aim to build upon the ACM guidelines by providing either additional criteria for PPM practice (see Table 6) or stricter criteria (see Table 7). Further benchmarking of risk frameworks can be found in Appendix H. PPMs practising within specific state and territory frameworks could, as a result, have a lower risk profile than other PPMs, which may not be taken into account by insurers when assessing the risk profile.

In certain cases, South Australia has made additional criteria for exclusion by suggesting alternative instances for excluding a woman from giving birth at home. Specific examples relating to exclusion criteria are provided in Table 6. The Western Australian framework has also been benchmarked to other frameworks on several specific indicators.

**Table 6: Examples of where State policy has added criteria to ACM Midwifery Guidelines**

| Stage of care | Specific indication | ACM guidelines | SA State Policy | WA Publicly Funded Homebirth Policy |
|---|---|---|---|---|
| At booking | Previous obstetric history where a baby has required intensive or prolonged special care | × | ✓ | × |
| Developed/ Discovered in Pregnancy | Polyhydramnios or oligohydramnios | × | ✓ | ✓ |
| In labour | Active second stage is in excess of one hour within minimal/slow progress and/or without head on view | × | × | ✓ |

Key: × indicates that the specific indication is not included in a policy/guideline; ✓ indicates that the specific indication is included.

**Sources:** Australian College of Midwifery 2008; South Australia Department of Health 2007; Department of Health WA 2012.

There are other areas where state and territory legislation appear to have a narrower scope than the ACM guidelines or that they vary on their choice of recommended option (ie whether to consult or refer to other health professionals). An example of such variations can be seen in Table 7 while applying a framework for when a midwife should:

- discuss the situation with a colleague
- consult with a medical or other health care provider
- refer a woman or her infant to secondary or tertiary care.

**Table 7: Examples of where State policy has narrower criteria than ACM Midwifery Guidelines**

| Indications | Specific indication | ACM guidelines | SA State Policy | WA Publicly Funded Homebirth Policy |
|---|---|---|---|---|
| At booking | Previous obstetric history of a retained placenta requiring manual removal | A | A | C |
| | Previous obstetric history of postpartum haemorrhaging in excess of 1L/caesarean section | B | C | C |
| Developed/ Discovered at Pregnancy | Body mass index > 35 or maternal weight of greater than 100kg | B | C | C (if > 110 kg) |
| During labour and birth | Active first stage labour in excess of 18 hours | B | C | C (if in > 24 hrs) |

Note: A – discussion, B – consultation, C – referral

**Sources:** Australian College of Midwifery 2008; South Australia Department of Health 2007; Department of Health WA 2012.

### Disciplinary frameworks

Particularly in the absence of claims data (see Finding 2) disciplinary frameworks, or the frameworks and standards to discipline health practitioners, like risk frameworks, can provide insurers with an understanding that those insured are at a certain minimal level of competency. This was identified, along with education and training, as some comfort for insurers when setting premiums in the Netherlands.[69]

Prior to 2010, variations in the frameworks existed as states and territories had their own legislation, rules and guidelines. However now under the National Law (see Appendix H), new conditions for frameworks apply. While current and future variation may be somewhat resolved, variation may be seen in outcomes, actions and the level of competency when using data prior to 2010.

From the consultations held and research completed, consistent disciplinary frameworks were considered to be useful for insurers because they:

- decrease the number of claims over time when a more stringent framework has been applied. For example in the province of Ontario there has been a decline in the number of tribunal cases over time. In the first few years of introducing guidelines there were three cases heard prior to 2004 that were identified.[70, 71] However since then there was only one further case identified that resulted in a tribunal hearing[72]

- decrease the variation of disciplinary outcomes across states (ie particular practices which are outside of scope or are not best practice can be discouraged)

- decrease the risk profile (ie PPMs who practise outside of scope or inappropriately are restricted from practising in such a way again). PPMs who are practising appropriately may then be perceived of a lower risk profile.

## *Finding 2: Data quality and availability relating to PPMs*

**The availability and quality of data is currently insufficient to confidently understand the extent of PPM practice and the associated risk**

Consultations and literature identified that the availability and quality of data is a major barrier in the development of a commercial professional indemnity insurance product for antenatal, intrapartum and postnatal care provided by PPMs. This is because it is believed to be insufficient to give insurers certainty over the scope of practice of PPMs, and therefore their risk profile, which is required when setting a premium.

> ***"No adequate and reliable data are available to develop an accurate risk profile for privately practising midwives who provide birthing services"***
>
> *Commonwealth of Australia. (2008)*

As a part of the scope of this report, data was to be collected on both PPM practice and insurance. From the research completed, it was determined that the current amount of data is limited. This was not unexpected given that the NMBA and consultations alluded to PPMs being a relatively small cohort of practitioners (and PPMs providing homebirth was likely to be an even smaller group).

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69 Personal communication, March 2013.

70 College of Midwifery Ontario, 2000.

71 Please refer to the *PwC Claims report 2013* for data limitations relating to the completeness and access to data.

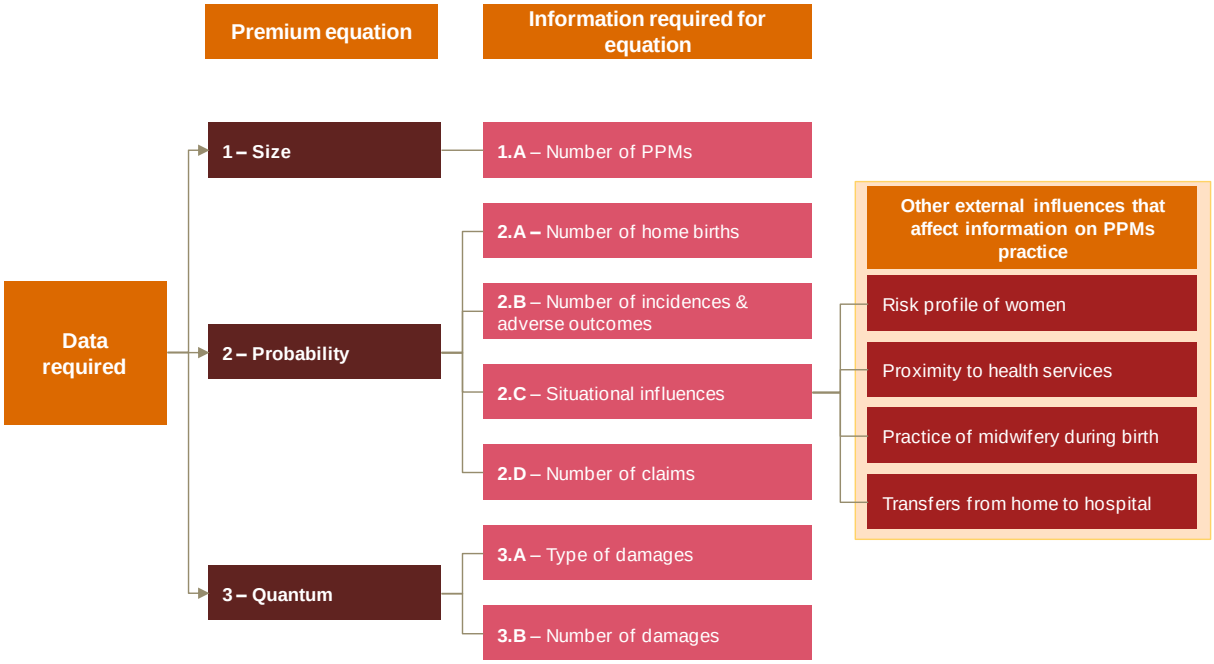
72 Note, this result is not held to be statistically significant given the number.

Data are important to provide an evidence base for insurers to set premiums within each component of the premium equation. As outlined in Figure 8, in order to be able to set a premium, an insurer may require information on factors relating to the premium equation such as:

- **Size:** the size and growth of the market
- **Probability of a claim and timing:** the potential for claims and factors increasing the risk
- **Quantum:** how much is the claim and the types of damages (ie legal, disability compensation).

These factors, along with further detail with specific regard to PPM practice, are outlined in Figure 8 and will be discussed in further detail below.

**Figure 8: Data that might be required for components of the premium equation**




**Source:** PwC analysis.

## *1. Number of PPMs (scale)*

Currently there are limited data on both the number of PPMs and the number providing care within the home, as well as how these PPMs operate. This provides uncertainty over the size of the total pool of PPMs. The reason for this is because, as part of registration, midwives do not have to nominate the models of care under which they provide services. Given that the AIHW also do not collect data on this, there is therefore limited data over time that exists on the number of PPMs. In the past, various other data sources were used, but each of these has limitations. An example of alternative data sources and their limitations is shown in Table 8.

**Table 8: Alternative evidence for the number of PPMs**

| Evidence type | Issues with using as evidence | Examples of sources considered |
|---|---|---|
| Colleges, associations and regulators in surveys | • Prior to this report, surveys have not been completed<br>• Lack of mandatory completion of surveys means the data will be incomplete | • NMBA<br>• Australian College of Midwives (ACM)<br>• Australian Private Midwives Association (APMA)<br>• Midwives Australia |
| Advertisement online from directories | • There are no mandatory PPM online directories. Therefore using this method will capture only those PPMs who advertise on the website | • Bubhub[73]<br>• Homebirth access Sydney[74] |
| Eligible midwives | • As PPMs can practise and provide services without registering as an eligible midwife, this data source is not a complete representation | • Medicare data for eligible midwives[75] |
| Number of consumer group members | • Similar to advertisements from online directories, this method requires PPMs to register and would depend on whether a PPM chooses or is allowed to be a member of the consumer group<br>• It also may result in double counting if PPMs are members of more than one group | • Homebirth Australia<br>• Homebirth Access Sydney<br>• Maternity Coalition<br>• Childbirth Australia |

**Sources:** For more information about the Colleges, regulators and consumer groups consulted with, see Appendix C.

To overcome this issue of a lack of knowledge of the number of currently PPMs, a survey was completed as a part of this project through the NMBA. The survey was made available to the broader public and sought voluntary nomination of PPMs. In doing so, this survey identified 57 PPMs currently practising in the last 12 months preceding the survey period of 8 March–8 April 2013 (further information survey information see Appendix J.1). [76]

While the survey may not be complete, as it was voluntary, it provides a good indication of market size. It is recommended that regular data capture on the number of PPMs and their practice arrangements continue so as to build a robust time series data set. This may be through for example it being a formal part of registration with the NMBA.

73 Bubhub, 2012.

74 Homebirth Access Sydney, 2012.

75 Nursing and Midwifery Board of Australia, 2013a.

76 Note that this may not represent the full number of PPMs that are current practising, only the number of survey participants who identified themselves as PPM and does not account for data limitations.

## 2. *Number and likelihood of incidences (probability)*

Research completed identified that data on PPM activity did not specifically relate to their practice as opposed to the maternity services sector as a whole. Consultations identified that more specific information on PPM activity is necessary to assist insurers to determine firstly, the probability that a potential claim will arise and secondly, in doing so, to establish the risk profile of their practice. This is to prevent PPM activity being assigned the risk profile of other maternity services practices, such as obstetrics, which, from the evidence gathered through consultations, have a higher risk profile due to their scope of practice (see Finding 5). Analysis on this data is would be useful, as it is expected to have a downward impact on premiums set.

It is recognised that out of the total number of homebirths, only a relatively small proportion of these will result in an adverse outcome. Of these, only a proportion will result in an incident (a claim being raised), and only a proportion of these may see a claim (being paid out). For insurers, there is a limited level of certainty on any of these numbers, as data do not appear to currently be collected at a sufficient level of detail. In absence of these data, it may be necessary to rely on alternate data sources.

To decrease uncertainty, the insurer may seek to know:

- information on each of the data points relating to Figure 8 that would determine the likelihood of an incident arising, and therefore the probability of a claim and a payout

- situational factors that may increase the likelihood of an incident being raised (ie geography or the location of the service being provided, and transfer requirements).

It is recognised that the low number of PPMs who currently practise coupled with the low number of homebirths undertaken each year may not make data collection at such a granular level a priority for the NMBA, AIHW or other data collectors. Therefore, our identification of areas where data are insufficient is only for the purpose of identifying information that may be of assistance to insurers to create an insurance product.

### A. Number of homebirths undertaken by PPMs

Currently, data are not sufficient to estimate the number of homebirths that have been attended by PPMs. This information may be necessary for insurers to establish the relative size of the practice being insured, and more specifically, the population from which adverse outcomes and incidences may arise. The reasons for insufficient data were identified as relating to:

- **Specificity:** the data collected by AIHW through the NPESU on the number of actual and intended homebirths are insufficient.[77] In 2010, these data indicated that there were 1,354 homebirths (please refer to Appendix J.2. for more detail). However, the AIHW data did not distinguish between homebirths by practitioners (eg PPM, publicly-funded midwifery, GPs, obstetricians), indicate whether they were free births (unattended) or the funding status (eg public or private). Therefore, the size of the PPM practice from the current information available cannot currently be determined

- **Different data collection methods:** As statistics are collected through various methods, there are challenges in collating information. An example of this is the number of intended homebirths. The 'intended' variable is important to distinguish when a homebirth was planned and meant to occur (as opposed to an emergency or unplanned homebirth), and who was planned to support the birth. Research completed identified that statistics for an intended homebirth is collected differently across states and territories. The federated nature of data collection in this respect appears to provide challenges. The AIHW shows that jurisdictions

77 Australian Institute of Health and Welfare, 2013.

collect the intended place of birth at different times during the pregnancy. As an example, Victoria, South Australia and Tasmania determine the 'intent' of a homebirth at the time of booking the birth location, while the remaining states and territories collect the intended place of birth at the onset of labour.[78]

In the absence of data, alternative data sources are available through, for example, relying on Medicare data. However, these data only relate to the activity of eligible midwives, and therefore are representative of only a cohort of PPMs.[79]

## B. Number of adverse outcomes from PPMs

Like homebirth data, information is not readily available for the numbers of adverse outcomes that have arisen from homebirths attended by PPMs. Therefore, it is not widely known how many potential incidences have occurred that could result in a claim being raised. In the place of specific data on incidences, adverse outcomes and the outcomes of PPM practice in general, other information sources were reviewed to shed light on the number of adverse outcomes including:

> ***"While there is data available on Australia's maternal and perinatal mortality rates, nationally consistent data and reporting are limited…the comprehensiveness and level of detail differ markedly"***
>
> *(Commonwealth of Australia, 2009)*

- alternative models of care including midwifery-led care
- Australian and international literature reviews into adverse outcomes.

### *Midwifery-led care*

Literature such as the Cochrane review[80] and other studies[81] show that midwifery-led care, in which midwives are the primary carer[82] to low-risk women, as opposed to the use of a medical-led or shared care, can improve:

- **Physical outcomes:** fetal loss prior to 24 weeks[83]
- **Interventions:** including the proportion of vaginal delivery, number of spontaneous births, episiotomies, analgesia during labour, number of obstetric interventions as well as see shorter length of stays in health settings
- **Psychosocial:** women feeling in control and being satisfied with care.

Other studies such as Tracy and Tracy (2003)[84] promote midwifery-led models as a cost-effective method to reduce unnecessary level of intervention for low-risk women (eg forceps, vacuum instrumental birth following an epidural).

This literature demonstrates positive outcomes for care which is led by midwives. However these reviews did not focus specifically on PPM practice or births conducted in a home setting.

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78 Australian Institute of Health and Welfare, 2013.

79 From our survey completed, of the 85 respondents only 61%, also were eligible midwives. Only 74% of those PPMs were also eligible midwives.

80 Hatem M, Sandall J, Devane D, Soltani H & Gates S 2009.

81 McLachlan HL, Forster DA, Davey MA, Farrell T, Gold L, Biro MA, Albers L, Flood M, Oats J, Waldenstrom U 2012.

82 This is a model similar to those seen in the province of Ontario and New Zealand – see Chapter 4.

83 Note that the number of fetal loss equates to a relatively small number of absolute deaths seen.

84 Tracy SK & Tracy MB 2003.

*Literature review into adverse outcomes from homebirth*

Consultations identified a common belief that the perceived outcomes from homebirths were the main driver precluding a product being available. As part of this report, a review into relevant literature was requested by the NMBA to understand the outcomes for women and babies from homebirths relating to PPM practice. To do this, publicly available statistics, journals and literature on homebirth were scanned. A list of the key studies reviewed is listed in Appendix J. Key findings from Australian studies included:

- **Maternal outcomes:** lower rates of postpartum haemorrhage (PPH), perineal tears and retained placentas were found in homebirths. This finding was supported by international studies (for more information on maternal outcomes from homebirth see Appendix J.3)

- **Perinatal mortality:** inconclusive findings from literature were identified as a result of the characteristics attributed to women included in studies (see Appendix J.4). International studies with the fewest data limitations show that differences between homebirth and hospital birth may not be statistically significant, especially for low-risk women

- **Perinatal morbidity:** inconclusive findings from literature were identified. Perinatal morbidity rates in international studies highlight that there appeared to be lower rates of perinatal morbidity associated with homebirth where nulliparous[85] low-risk women were excluded from studies (see Appendix J.4).

While the findings relating to perinatal outcomes are inconclusive, the absolute numbers of poor outcomes were found to be low. Findings and studies in relation to perinatal outcomes should, as a result, be considered in this light. For more information on the outcomes presented within the literature reviewed, please refer to the relevant Appendix.

*Issues with data quality for literature review*

As a part of the review of literature, several broad areas relating to data quality were identified that present different sets of challenges in establishing the outcomes of births overseen by PPMs. This is in line with findings from other journals.[86] These included:

- **Variation of key terms and definitions:** these vary within the available data eg high/low-risk (see Appendix J.5 for an example of the differences classifying high-risk across literature from Canada and the Netherlands)

- **Cohorts within studies:** the choice of cohorts within studies varies depending on how the terms are defined.[87] As a result, this can have an impact on study outcomes and conclusions

- **Data quality:** the data used may not be recent, could be incomplete, non-representative or statistically insignificant[88]

- **Methodology:** where the preferred methodology (randomised control trials) is not possible, the alternative study designs used may have been criticised[89, 90]

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85 Nulliparous refers to a woman who has never given birth, or given birth to a viable, or live, infant.

86 Catling-Paull C, Coddington RL, Foureur MJ & Homer CSE 2013.

87 Janssen PA, Saxell L, Page LA, Klein MC, Liston RM & Lee SK 2009.

88 Ibid.

89 Dowsell T, Thornton JG, Hewison J, Lilford RJ, Raisler J, Macfarlane A, Young G, Newburn M, Dodds R & Settatree RS 1996.

90 Hendrix M, Van Horck M, Moreta D, Nieman F, Nieuwenhuijze M, Severens J, Nijhuis J 2009.

- **Bias and subjectivity:** findings and conclusions from the studies (and criticism of these findings and conclusions) can be biased or subjective (see Appendix J.6)[91]

- **Environmental factors:** the scope of practice and risk frameworks applied in studies (which may influence outcomes) can be dependent on the birthplace environment and location (see Appendix J.5)

- **Availability and specificity:** data availability and the level of data collected may influence the outcomes that were recorded

- **Definition of adverse outcomes:** several stakeholders believed that literature on the definition of adverse outcomes focused on physical outcomes (eg maternal morbidity), with limited considerations on the psycho-social outcomes for women if an option for homebirth was not available (eg stress as a result of past experiences in traditional health settings).[92]

On review, there are a number of journal articles[93] which also critique the rigour and methodologies applied in reports. As an example, in Fahy & Tracy (2007) a review was completed of the Cochrane systematic review[94] where it presented a trend toward higher perinatal mortality in the home-like setting group, compared to a conventional hospital labour ward. From the review, Fahy & Tracy (2007) held that 85% of the deaths were not associated with intrapartum care in a home-like setting.

*Issues with adverse outcome studies – Australia*

Statistical studies in Australia also do not provide certainty on the outcomes from homebirths because of insufficient data availability and other limitations such as:

- they often do not distinguish between high and low-risk women which raises the risk profile and suggests that there is a higher likelihood of adverse outcomes

- the absence of a comparison of cohort groups in terms of comparing planned homebirth, planned midwife-led hospital birth and planned obstetric-led hospital birth

- recent studies (after 2000) to support homebirth outcomes have only been completed at a state-level[95, 96]

- the only national statistical studies completed were undertaken prior to 2000[97]

- the sample size for homebirths in Australia is small, given that, at most, only approximately 1,000 homebirths occur per year for all health practitioners.[98] For example, Kennare et al[99] used a sample size taken from South Australian data of 1,141 planned homebirths[100] compared to 297,192 births performed within hospitals over the period 1991-2006. In Catling-Paull,

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91 Kennare RM, Keirse MJ, Tucker GR & Chan AC 2010 states the bias is based on the following argument: Opponents of homebirth argue that unexpected complications do arise, with appropriate help more likely to be available in hospital. Proponents argue that such complications are rare, and are disproportionate to the frequency of childbirth interventions that have their own complications in most obstetric departments.

92 Personal communication, November 2012.

93 Fahy K & Tracy SK 2007.

94 Hodnett ED, Downe S, Edwards N & Walsh D 2005.

95 Kennare RM, Keirse MJ, Tucker GR & Chan AC 2010. Note - the academic study considered only South Australian data.

96 McMurtrie J, Catling-Paull C, Teate A, Caplice S, Chapman M & Homer C 2009. Note - the academic study considered only NSW data.

97 Bastian H, Keirse MJ & Lancaster PA 1998.

98 Australian Institute of Health and Welfare, 2013.

99 Kennare RM, Keirse MJ, Tucker GR & Chan AC 2010.

100 However, not all planned homebirths actually occur at the home. Some births will instead take place in a hospital setting based on the circumstances of the birth.

Coddington et al while a study of outcomes from nine publicly funded homebirth programs saw the rate of stillbirth and early neonatal death was 3.3 per 1,000 births, the sample size of 1,521 was recognised as potentially not having "sufficient power" to draw a conclusion about safety.[101]

- suitable alternate data sources being difficult to find as key stakeholders such as the ACM and RANZCOG use different literature to support their position about the likelihood of adverse outcomes arising (see Appendix J.6)

- studies not accessing a representative sample of the population who give birth; the types of births overseen by midwives are from mothers who appear to be both of a higher socio-economic background and older.[102, 103]

*Issues with adverse outcome studies – international findings*

Outcomes for PPMs or independent midwifery practice within other jurisdictions have been documented. These could provide more certainty in relation to homebirth outcomes given the relatively larger number of homebirths, and potential relative improvements in data quality. However, stakeholders consulted cautioned their application to Australia, highlighting that they may not be a relevant or appropriate substitute for local PPM activity. The quality of data and their collection also needs to be confirmed.

International journals and researchers may not only have the same challenges as their Australian counterparts (as previously outlined), but may also include examples of outcomes that result from births that have occurred within different operating environments. For example, the Netherlands has a higher proportion of homebirths than Australia so the scale is considered by those consulted to improve outcomes, and therefore to limit claims. However, it must also be taken in to account that the environment in which these homebirths occurred, including what some consulted with identify as a more supportive legal environment, social insurance schemes, and established clinical frameworks and systems for monitoring also impact upon the outcomes (see Chapter 4 for more information).[104] Therefore consideration of these broader environmental factors needs to be made when reviewing international literature.

As a result of the international review completed, it is inconclusive that homebirths result in better or poorer outcomes than births within other models. Given the challenges cited within literature studies at present (particularly data quality, risk levels of women and bias) a conclusive finding from literature may never be achieved. Instead, it must be reflected and accepted that women will continue to choose to have homebirths, and as a result, despite inconclusive literature, indemnity options must be considered further to protect not only the PPM but the community more broadly.

## C. Situational influences

Situational influences are those events or conditions in the wider environment that may increase the likelihood of an adverse outcome in a birth, and as a result, an increased incidence of a claim arising. Having knowledge of and data on these influences may assist insurers when assessing the risk profile of PPMs. From a review of literature, four conditions were identified as examples of situational influences:

- **Risk profile of women:** services being provided in the home to a caseload of mixed risk women (ie both high and low-risk women)

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101 Catling-Paull C, Coddington RL, Foureur MJ & Homer CSE 2013.

102 Crotty M, Ramsay AT, Smart R & Chan A 1990.

103 Woodcock HC, Read AW, Bower C, Stanley FJ & Moore DJ 1994.

104 Personal communication, November 2012.

- **Proximity to health services:** the location of health services relative to the woman's place of residence

- **Practice of midwifery during homebirths:** the number and types of interventions which arise from PPM activity in homebirths given that PPMs are only meant to provide services for women having low-risk labour and births in line with risk and clinical frameworks

- **Transfers from home to hospital:** the outcomes from transfers to hospitals and the relative number of times that transfers occur.

Currently, given the information available, there may be uncertainty for an insurer around the situational influences. Please refer to Appendix J.5 for further information and discussion on each of these.

### *3. Number and quantum of claims*

Both of the current insurers of PPMs communicated that there was reluctance generally for insurers and brokers to provide PII for intrapartum care due to a lack of information on insurance claims.[105] The importance of having an understanding of the number and quantum of claims is that without this historical data, it is difficult for a potential insurer to know how much risk will be borne in providing a product (for example, what claims would be raised against them). As a result, it is difficult to set a premium which will allow the insurer to create a profitable commercial product at an affordable price for potential clients.

However, data are not held in a central location but by different insurers and therefore, as a part of the scope of this report data were requested from commercial insurers on the number, timing and quantum of the claims made for the period prior to 2001 and the period from 2010 until present (no information was sought between 2002–2010 as no PII was available during this time, see Chapter 2). Unfortunately, information on claims was unable to be obtained. While insurers and brokers declined to provide data, several did participate in consultations. During these consultations, it was conveyed that information could not be provided for several reasons including that:

- the data were no longer recorded or held

- the data were commercially sensitive (as they are commercial insurers and not government agencies)

- data could identify clients, and refraining from providing the information respected the privacy of those who have been claimed against.

Since 2009, it appears that there have been incidences of notification to these two insurers as well as claims which have been formalised. Yet due to the low number of claims and incidences that have occurred, these have not been provided by insurers for privacy reasons. From publicly available information it however can be reported that:

- there have been no claims for midwives drawn from run-off cover scheme since 2009[106]

- other public reports for obstetrics and midwifery claims in the public health system demonstrate that there are high rates of compensation for obstetric claims each year.[107]

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105 Personal Communication, October 2012.

106 Australian Government Actuary, 2012.

107 Australian Competition & Consumer Commission, 2009.

We identified a number of alternative data sources for the number, timing and quantum of claims. However each of these (tribunals and court cases, international insurers and other professions), have limitations. Information obtained from other jurisdictions was available but only to varying degrees.

This provides a challenge, as insurers appear unwilling to participate and provide a PII product for PPMs without historical data, while those that have or currently do provide insurance, are not required to share this information at the level of PPMs publicly. This is evident in the AIHW report, *Australia's medical indemnity claims 2011-12*, where information was presented on midwifery claims, but not PPM claims specifically.[108]

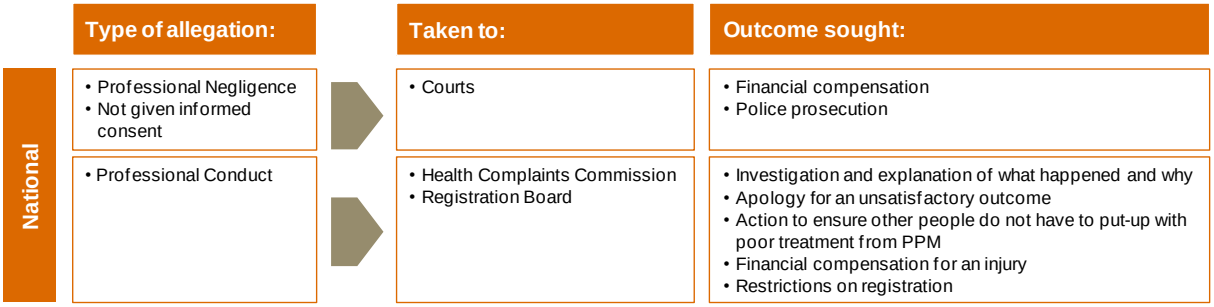
### Tribunals and court cases

PPMs may be held accountable for their actions when individuals or organisations advance claims for redress. Depending on the preferred process and the general outcome sought, as shown in Figure 9, claims against PPMs in the homebirth context may be made in relation to:

- **Professional negligence:** when an act or omission occurs during a homebirth that is below the accepted standard of midwifery practice and this act or omission directly results in injury or death

- **Professional conduct** (ie Professional Misconduct, Unprofessional Conduct or Unsatisfactory Professional Performance)**:** this includes conduct for which liability would not ordinarily be imposed in legal proceedings but which offends the traditions of the profession, even if the person suffers no loss or injury.

**Figure 9: Overview of allegation process for tribunals and courts**




Tribunals present those allegations that have gone to a Regulatory Authority for consideration of issues such as professional misconduct. While tribunals may demonstrate the number of potential incidences related to a claim raised against a PPM, they may not be reflective of claims or assist insurers because:

- not all cases made to tribunals also have a civil claim raised against them **(probability)**

- no financial compensation is sought or provided in tribunal cases **(quantum)**.

For more information on the number of tribunal cases made each year and the timing of those cases see PwC *Claims Report 2013* and Appendix K.

The number of court cases related to homebirths provided by PPMs could also be used as an alternative data source, as insurance payouts may be required as a result of court cases. However

[108] Australian Institute of Health and Welfare, 2013.

again, there are limitations in using this, as the number of court cases may not reflect the number or size of claims as:

- PPMs were operating for a large part of the period analysed (2001–2012) without PII. Therefore claims or court cases may not have been raised in the absence of financial compensation
- claims may not reflect the incidence of claims as:
  - bringing a case to court can be emotional for the plaintiff and therefore may not be raised or brought to court
  - from consultations and discussions with legal representatives, insurers and professional associations, cases may be settled outside of court.

For more information on the number of court cases made each year and the timing of those cases, see PwC, *Claims Report 2013* and Appendix K.

### International insurance claims

International insurance data provides information on the number and quantum of claims. International data were able to be collected for the province of Ontario (see Chapter 4 and Appendix K).[109] While international claims can be useful for Australian insurers to understand the extent of claims, a careful consideration of the environments and systems in which independent midwives operate in these jurisdictions is needed before any application is made.

### National obstetric claims

The size of the claim may, under limited circumstances be compared to the size of the claim for other maternity services (eg obstetric claims or hospital claims). For instance, in 2007-08 the average size of a medical indemnity claim was just over $80,000, and obstetric claims are believed, on average, to be higher than the average medical claim.[110] However consultations again identified limitations in using this information including:

- **Scope of practice:** a PPM's scope of practice is limited to providing care for a normal vaginal birth, while both of the alternative data sets (obstetric or hospital) consider obstetric interventions as well. The complexity (and associated risk) of the women and babies is expected to be higher for obstetricians and hospitals when compared to PPMs
- **Models of care:** PPMs have different models of care and services, as well as a different caseload, when compared to obstetricians and hospital staff, which could impact upon any comparisons.

## *Finding 3: Data relationships*

**Currently, the relationship between incidence and claims is not well understood, and the lack of sufficient substitute data adds to uncertainty over a PPM's risk profile, causing uncertainty over a PPM's risk profile.**

The uncertainty around the relationship between incidences and claims builds on Finding 2 which showed that at present, there are a limited meaningful data and statistics available around the practice of PPMs.

109 Insurers from England and the Netherlands declined to participate in providing us with data on claims, due to commercial reasons, and information from New Zealand was still being collected at the time of finalising the report.

110 Australian Competition and Consumer Commission, 2009, p.21.

## *Data relationships*

### Data points in isolation

Even if information on data points could be obtained for those outlined in Table 9 (eg homebirth statistics, incidence and adverse outcomes), there is currently an insufficient understanding of their interrelationships. For example, the following questions may provide key information to defining a risk profile:

- What situational factors or combination of factors are more likely to result in an incident?
- What adverse outcomes are more likely to result in a claim?
- What adverse outcomes are more likely to result in larger claims?
- What aspects of PPM practice, skills and competency are more likely to see a claim?

Table 9 provides insurance data from HIROC (province of Ontario), and shows the number of claims made is very small.

**Table 9: Insurance data for the province of Ontario[111]**

| Year | Total births by midwives | Homebirths | Number of midwives | Number Potential Loss and Damage Claims | Number Actual Loss and Damages Claims[112] |
|---|---|---|---|---|---|
| 2003-04 | 7,766 | 1,919 | 256 | 36 | 0 |
| 2004-05 | 8,629 | 1,848 | 275 | 61 | 0 |
| 2005-06 | 9,568 | 1,940 | 302 | 91 | 1 |
| 2006-07 | 10,395 | 2,043 | 334 | 102 | 1 |
| 2007-08 | 9,420 | 2,268 | 380 | 114 | 0 |
| 2008-09 | 10,570 | 2,360 | 369 | 109 | 0 |
| 2009-10 | 11,244 | 2,741 | 405 | 54 | 0 |
| **Period total** | **67,592** | **15,119** | **2,321** | **567** | **2** |

**Source:** HIROC, Insurance Data, April 2013.

[111] Note this data is the property of HIROC and is not to be used for any other purpose than in assisting Australian midwifery research for AHPRA. Data is as close of business on 31 December 2012.

112 Of the two cases in the data, HIROC acknowledge the two actual claims are for large amounts where catastrophic injuries can be attached with 100% liability to the midwife.

These data shows that from 2003-04 to 2009-10:[113]

- 2 in 15,119 of homebirths resulted in an actual claim (0.013%)
- 2 in 2,321 of midwives will be involved in an actual claim (0.086%)
- 2 in every 567 potential L&D claims lead to an actual claim. (0.36%).

What this information alone does not quantify is *why* only a small number of incidents and subsequent claims arose. Quantitative data are not only required (Finding 2), but required at a sufficiently detailed level to be able to demonstrate the relationship between situational factors, practice and competency to adverse outcomes and resulting claims.

### Future incidents – responding to a changing environment

Actuaries develop an insurance premium through, in particular, assessing data from past incidents and claims. As outlined, the relationship between these two points is not well understood at present. Additional quantitative data on situational factors and practice could assist in understanding when a claim is more likely to occur in a particular setting. It is also important to understand the factors that drive incidents and claims (and not just statistics on how many have arisen), as these factors may change over time. For example, factors driving insurance claims prior to 2002 for PPMs will need to be considered, as they may no longer be relevant to a current PPM given the regulatory and industry changes seen.

Understanding future relevant events and their potential impact on the relationship between incidents and claims will also need to be well understood, or at least considered. As an example:

- **Insurance market:** the introduction of DisabilityCare Australia. In other jurisdictions such as New Zealand and the Netherlands where social insurance exists, these appear to reduce the potential quantum of claims and the impact on premiums[114]
- **Complexity of practice:** consultations indicated that there is not only increasing complexity in practice, but also changes to how care is provided as a result of advances in technology and best practice. As a result, the precedent set from past outcomes may not always hold true and be reliable in predicting future outcomes
- **Litigious culture:** while unproven, several stakeholders consulted felt that Australia is becoming more litigious. The absence of PII for PPMs means that there may be a limited understanding for insurers on the propensity for claims that could be made if PII for intrapartum care was offered.

## *Alternative data sources*

In the absence of information supporting these data relationships, at best, other data sources can be used. Two examples as identified in Finding 2 are tribunals and courts, as well as information from other international jurisdictions. Again, as with Finding 2, there are also challenges in using these, which are further outlined.

### National courts and tribunals

Using court and/or tribunal data may be useful to demonstrate how an incident could lead to a claim. These data may also suggest potential claims outcomes in the future. Courts and tribunals however

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[113] Note this data is the property of HIROC and is not to be used for any other purpose than in assisting Australian midwifery research for AHPRA. Data is as close of business on 31 December 2012.

114 Personal communication, November 2012 and March 2013.

represent different litigation routes. Therefore, as an example using tribunals to understand the relationship between claims and claim outcomes may be challenging.

### *Courts data*

Courts in some circumstances can be a good alternative data source to demonstrate the relationship between incidents and claims, as claims are often the result of court outcomes. The information provided in the court can shed light on when and what makes a claim more likely. However, there are challenges with using court data that should be considered. These include:

- there may be one or more allegations raised that can result in one or more outcomes
- court findings can vary by legal system found across different states and territories; therefore, the claims outcome may be different in another case held in a different jurisdiction
- due to the emotional trauma and cost of court proceedings, not all adverse outcomes will result in claims being raised as it is reliant on the woman's willingness to raise the case
- different interpretations of risk translate to varying scenarios in which a court may find a PPM liable.

The courts have only had a limited number of cases and therefore have not been presented with different types of cases relating to PPMs. Limited numbers of cases have occurred because:

- PPMs have rarely had PII available over the past ten years and therefore compensation would be limited to the value of their personal assets
- the long tail or lag between incident and outcome for insurance cases for PPMs mean that current insurance cases appear unlikely to be taken up until six years from the claim.[115]

Therefore, court data may be of limited use when establishing the link between incidents and outcomes for the purpose of determining the PPM risk profile.

### *Tribunal data*

Tribunal information can provide alternate insight into the practice of PPMs and into activity where professional misconduct may result in a claim. However, there are challenges in understanding the relationships between the allegations and the outcomes of tribunal hearings:

- as with court cases, one or more allegations can result in one or more outcomes
- tribunal hearings relate to professional misconduct rather than negligence that results in claims
- not all tribunal cases also have claims raised.

Tribunals can demonstrate how, and how often, caring for high-risk women can lead to a restriction on practice. However, the care of high-risk women in itself does not lead to a case, and not all high-risk births lead to either professional misconduct or a claim. Why information on high-risk might be of interest to an insurer is that taking on high-risk women may be more likely to lead to an adverse outcome and therefore this would need to be better understood.

115 HIROC, Personal Communication, February 2013.

### International insurers

The use of international insurance data could be useful to understanding the relationship between incidences and claims (as seen in the example given in Table 9). Other claims information sourced from consultations, shown in Table 10 builds a picture of the types of claims that are brought against midwives providing homebirths.

**Table 10: Types of midwifery claims**

| Type of claim | Features of claim | Approximate value of claim |
|---|---|---|
| Maternal dissatisfaction with service | • Incidence reported<br>• Litigation fee | <$50,000 |
| Coronial investigation, death of either woman or baby | • High cost of coronial investigation | Overall greater than $100,000 (CAD) is not to be unexpected, highly unlikely to be in millions[116]<br>Non-pecuniary damages are stated to be up to $117,000 (CAD) for the claim regarding a child $40,000 (CAD) for a mother |
| Life disability to the baby occurs during complication in labour | • Long tail (ie > 5 years old)<br>• Long duration<br>• Complex<br>• Numerous stakeholders | In the millions, estimated between $2-9 million in cases of alleged negligence. |

**Sources:** Personal communication with national and international insurers, 2012; Government of Canada 2009; Government of Canada 2008b.

Consultations with a range of different national and international stakeholders identified types of insurance claims that had been seen against midwives providing homebirth services. Examples of the claims against midwives providing homebirths included poor working relationships between woman and PPMs (the Netherlands).[117] However, it should be highlighted that, as discussed in Chapter 4, international insurers operate in very different health systems, insurance and legal environments. The relationships between claims and incidences may therefore not be similar across jurisdictions. A further point to note is an element of uncertainty as to when a claim may occur. This is because it is up to a woman or a child to raise a claim. Therefore, insurance data are only relevant up to a certain point and may only provide limited assistance in predicting when a claim is likely to occur.

## 3.4 Inherent risks within maternity services

The second key theme of the literature review and stakeholder consultations was that there are certain key factors which could make professional indemnity insurance for privately practising midwives not financially viable for private insurers. There appears to be barriers for a private insurer to be able to offer a commercial product and be able to generate profits from the product as a result of the risk within maternity services (and therefore PPM practice).

116 Claims Canada, 2013.

117 Personal communication, November 2012.

**Table 11: Key findings precluding the development of a commercial PII for PPMs**

| Number | Topic | Finding |
|---|---|---|
| 1 | Scale | *The number/volume of PPMs practising currently is not sufficient for commercial insurers to provide a financially viable product.* |
| 2 | Inherent risks of birth | *PPMs, as maternity service providers, will always have inherent risks in practice that cannot be fully mitigated.* |
| 3 | High expected value of claims | *Claims can be relatively significant as they relate to human life and death or potential ongoing and long term disability.* |

## *Finding 4: Scale*

**The number of PPMs practising currently is not sufficient for commercial insurers to provide a financially viable product.**

The size of the PPM cohort may not be large enough to develop a financially viable product in terms of the impact that size has on the probability of risk borne by the insurer. While previously the number of PPMs was not known, our survey identified at least 57 PPMs who are currently practising (see Appendix J.1). While this number may not be a true representation of the number of PPMs supporting homebirths, it is still a relatively low cohort, given there were nearly 33,000 midwives registered as both a nurse and midwife and an additional 2,377 registered only as a midwife with the NMBA as at December 2012.[118] As they all register and sign as competent, it could be assumed that they all have the capacity to practise privately.

To reduce cross-subsidisation of risk, the Tito report recommended the implementation of premium pools.[119] These pool the premiums of separate products, or in this case, professions. With premium pools in place, there needs to be a sufficient market to purchase products to make the funds within the pool sufficient to cover a claim payout arising from that profession.

While the probability of any individual claim remains unchanged regardless of the number of PPMs (eg the probability of the claim arising between one or 1,000 PPMs should in theory be similar), the size of the profession affects the impact of a claim arising on the insurer. As the number of PPMs fall, the insurer is at an increased risk that any claim raised is larger than the funds from the collected premiums to cover.

**In the UK: *"awards of damages of circa £6m are no longer uncommon and predictions…foresee awards in excess of £10m in the near future. Sums of this magnitude are too high for an insurer to be able to offer a viable insurance proposition having regard to the number of midwives currently operating independently of the NHS".***

*(Flaxman Partners 2011)*

Many insurance stakeholder consultations identified this as a key reason not to participate in the market.[120] This is compounded by the profit margin and administrative costs also borne. While this

118 Nursing and Midwifery Board of Australia, 2013a.

119 Commonwealth of Australia, 1995.

120 Personal communication, 2012; Flaxman Partners, 2011.

risk can be mitigated by increasing the premiums, as seen post-2010 this could occur to an extent that which the premium becomes unaffordable to PPMs to purchase.

The issue of unaffordable cover has been mitigated in other professions through government intervention. An example of this is the Premium Support Scheme. This is an Australian Government scheme that helps eligible medical practitioners with the costs of PII through the reduction of premiums paid. If gross indemnity costs exceed 7.5 per cent of the medical practitioner's gross private medical income, a premium subsidy will be applied (60% of cost on or after 1 July 2013).[121] Some consultations, while not providing a rationale, highlighted concern over the same scheme being applied to PPMs, and have held that PPMs should only be provided with a product if it is commercially viable for insurers. It still stands however, as an option to assist in the development of a PII product for intrapartum care that may be considered (see Chapter 5).

## *Finding 5: Inherent risks of birth*

**PPMs, as maternity service providers, will always have inherent risks in practice that cannot be fully mitigated. While not a central part of the research for this report, it is widely recognised that other maternity providers have higher risks due to their qualifications, training and client profile and can access insurance cover.**

Birth is a natural act and the risk of death or disability is inherent. In the absence of disaggregated data it appears that in comparison with other health professionals, both the probability of a claim arising, and the size of the claim arising from an adverse outcome, may be higher for those professions involved in birthing services,[122] including PPMs.

In the United Kingdom (UK), the obstetrics profession had the highest payout and assessment in insurance risk.[123] Similarly, in Australian obstetricians are recorded as having the highest insurance premium of all health professionals.[124] This raises an issue of whether PPMs are grouped with, or the risk is assessed in line with obstetrics (which occurs in UK data). The practice risk associated with obstetrics practice, as a result of their scope of practice and their undertaking of complex, is held by those consulted to be higher than that associated with a PPM. However, without quality data that disaggregates the risk for obstetricians and PPMs, commercial insurers appear in some cases, to judge the probability of risk the same, and as a result, it becomes too high for them to develop an affordable product for PPMs.

Data for PPMs specifically are difficult to obtain. This project found that insurance agencies were unable and/or unwilling to share any relevant information relating to past or current products. As a result of this, data have been difficult to access relating to past and current PII products to understand the actual claims impact of services (see Findings 2, 3). However its usefulness, given that PII cover for PPMs providing intrapartum care has not been available since 2001, is limited as intrapartum care is recognised to be the point of highest risk in the birthing pathway. Therefore an understanding of the inherent risks around PPM practice was only able to be expressed qualitatively through consultations.

Even if data quality could be improved from its current state (see Finding 2), the risk profile of maternity services, whether provided as a PPM or as another health professional, will always have some inherent risk attached to their practice. To overcome the impact of this inherent risk on the premiums set as previously mentioned, other health professionals in Australia providing maternity services have had government assistance. For example, obstetricians in Australia have Commonwealth Government supported care to reduce the risk premiums.

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121 Department of Health and Ageing, 2013c.

122 Australian Competition and Consumer Commission, 2009.

123 Flaxman Partners, 2011.

124 Australian Competition and Consumer Commission, 2009.

While not raised in consultations with insurance agencies or brokers in Australia, international consultations identified that risk frameworks relating to practice can assist in reducing the risk profile and help establish an insurance product, given the practice's inherent risks as a maternity service care provider. These frameworks would support these aims by:

- determining the range of practice environments for which an insurance product provides cover
- setting uniform standards, including frameworks relating to risk and quality
- advocating for PPMs through the professional associations to develop and determine appropriate products for PPMs.

Tools which can be used to mitigate the risks include credentialing, education and competency, monitoring, a defined scope of practice and access rights to hospitals (through collaborative arrangements) (see Appendix E).

## *Finding 6: High expected value of claims*

**Claims can be relatively significant as they relate to human life and death or potential ongoing and long term disability.**

Building on the inherent probability that a claim may arise due to the nature of the practice provided by PPMs, a challenge is that this may result in a high quantum or size of a claim occurring.

When developing a premium, the relative risk of a health professional's practice is taken into consideration by actuaries to assess the probability of a claim arising.[125] Even though limited high quality data exists publicly to assess this, from what data are available, and from the use of other data sources (eg other maternity services professionals, even though these other data sources have their limitations), if a claim were to occur, there is a high probability that it would be relatively larger compared to other health professionals.

The quantum of the claims is considered to be relatively large because:

- **Large claims for life of a baby:** the baby may be impacted for the whole of its life by the incident
- **Long tail of claims:** this is the time between a claim being lodged to its determination. It has been identified that medical negligence cases can be historically long. For example, obstetric claims are long tail and the costs increase over the time of the claim occurring[126]
- **Timing of claims raised:** as identified in the *Simpson v Diamond* case, there can be a lag in maternity service claims being raised after an incident. This can provide uncertainty for insurers in terms of outstanding liabilities that they present. For the *Simpson v Diamond* case, there was a 22-year lag between incident and claim. This is the result of the inherent nature of cases in which disability may not have been identified
- **Legal and other associated costs:** where allegations go to court or tribunal, legal costs can be incurred to defend the health professional. Consultations with insurers and brokers have

[125] Australian Government Actuary, 2012.

126 Australian Competition and Consumer Commission, 2009, p6.

identified that in the past, separate insurance has been offered for legal costs as they can be significant[127]

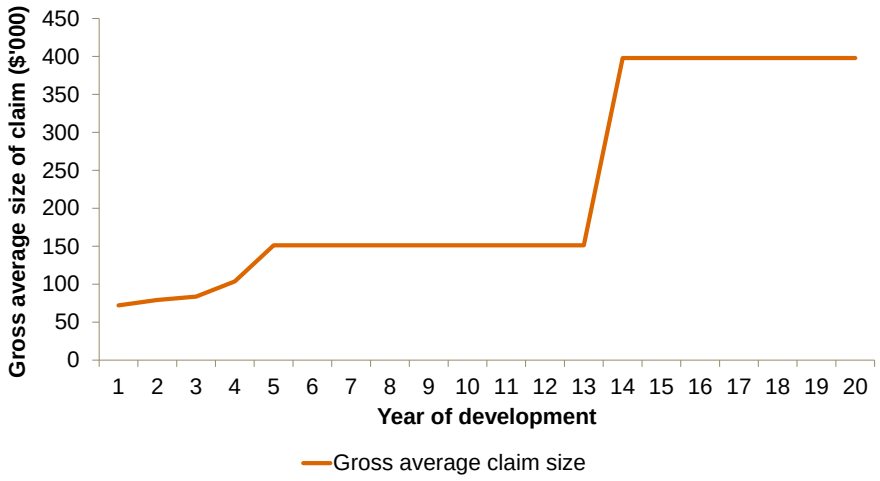
- **Past claims, tribunal and court outcomes:** the precedence of past pay-outs can provide guidance to set appropriate premiums. While Australian claims information is not publicly accessible, as outlined in the *PwC Claims Report 2013*, data from other jurisdictions highlight that while there have not been many claims raised, those that have been are substantial

- **Other schemes:** in Australia, insurers provide cover for both damages and ongoing care (including disability support), of which, the latter is believed to be a material amount (although the extent and number of large payments is unknown as a result of the lack of data available). This is unlike other jurisdictions, such as New Zealand which has no-fault compensation policies in place, or the Netherlands which has a social insurance scheme. Consultations with both New Zealand and Dutch insurers and brokers identified that these schemes have reduced the premium required based on the claims paid out only relating to damages.[128]

Currently, it appears that there is sufficient uncertainty relating to all of these factors to prevent a product being developed, due in particular, to the limited level of data available that is acceptable to the insurance industry. While the level of impact or relevance that each of these factors has on developing a premium is unknown, it is known that even if data quality is available and a premium can be set, it will not change whether the potential claims incurred are high or low.

Medical indemnity claims are modelled on the premise that small claims are generally notified and paid out in the first years of development, and larger claims (ie for conditions such as cerebral palsy) are often notified or claimed later as the extent of disability (and required support) is determined. Figure 10 shows the profile for the gross average size of a claim based on the year that the claim is notified in Australia. It shows that as the notification time of a claim increases, the higher the gross average size of a claim is expected to be for medical indemnity cases.[129] Therefore, these later claims as shown in the figure over a 20-year period can have a serious impact on the expected value of a claim.

**Figure 10: Gross average size of a claim**




**Source:** Australian Government Actuary, 2012.

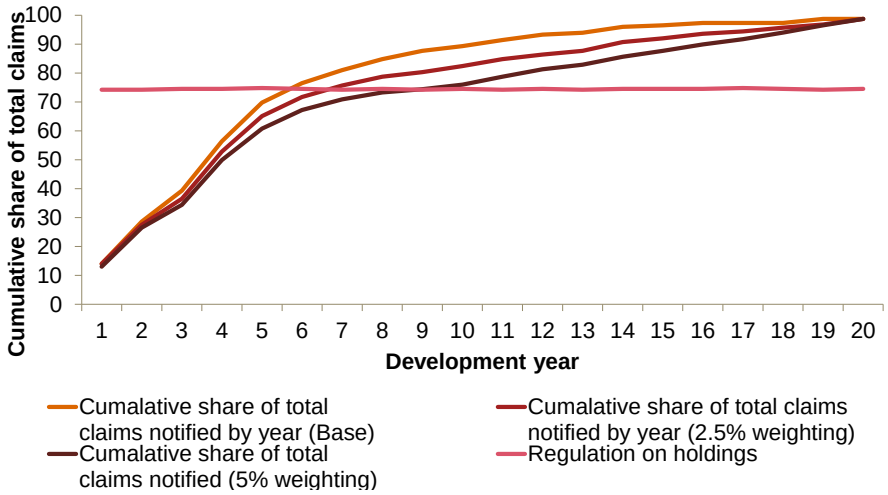
127 Personal communication, March 2013.

128 Personal communication, December 2012.

129 Australian Government Actuary, 2012.

However, the expected value of a claim is not just a factor of the size of the claim being high but also the probability of that claim being high. This is because the expected value of a claim will be a weighted average of the cost of claims made. Actuarial modelling is highly sensitive to the proportion of these late and high-claims being realised.[130] To illustrate, Figure 11 shows what may happen when a greater proportion of the high cost claims are made in the later years. From the base data[131] it is shown that an insurer will have paid out 75 per cent of the total claims made by the fifth year. However, by spreading evenly 2.5 per cent of the claims made in the first ten years in the second ten years, the insurer will not have paid out the 75 per cent of total claims for an additional one to two years. Similarly, five per cent spread evenly over the second ten years will extend out the 75 per cent payment of claims even further.

**Figure 11: Cumulative share of total claims for different probabilities of high claims**




**Source:** Australian Government Actuary, 2012.

Importantly, the high expected value of the claim will drive down profits for the insurer, as more of the premium pool will have to be paid out to claimants. However, the delay in the claim arising means that the probability of high claims later on will influence when an insurer can reward itself for profit. Insurers are unlikely to want to reward profits until the insurer has the comfort of knowing that a significant proportion of the claims have been paid.

As a result, a number of stakeholders believe that only changes to the support provided to PPMs and/or the infrastructure and environment in which they provide services (eg government regulation, insurance market or legal system), can influence the size of claims in the future.

130 Australian Government Actuary, 2012.

131 Ibid.

# 4 International insights

## 4.1 Introduction

As part of the scope of this report, a review of the claims raised against PPMs or independent midwives in four international jurisdictions was conducted. The jurisdictions selected by the NMBA were:

- England, United Kingdom
- New Zealand
- the province of Ontario, Canada
- the Netherlands.

As stated in Chapter 3 from research completed and consultations conducted, claims, including the number, frequency and quantum, were in part the result of how PPMs practise and the environment in which they provide maternity services. Therefore, direct comparisons have not been made between jurisdictions. The international models for providing PII for PPMs provide insights into the:

- professional indemnity offerings and the various factors that supported a product being developed
- associated claims raised, and, where possible the size, frequency and quantum of claims
- features of each jurisdiction's health or insurance policies that may be transferable for resolving the issue of intrapartum care PII for PPMs providing care within the home, in Australia.

The enablers of each model must be considered in the context of the environment in which midwives practice and not independently or exclusively. However, as they have been identified as supporting the insurance model in the jurisdiction, consideration should be made as to their applicability to the Australian PPM practice.

### *International PII models*

The different models for professional indemnity insurance are enabled through factors which relate to the practice of PPM and the environment in which they operate. These factors include:

- **Different aspects of the PPM practice:** including the operating models, scope of practice, frameworks and professional associations involved
- **The health system:** including the relationships between PPMs and the broader health system (including access arrangements)
- **Regulation of PPMs:** including registration, professional status of PPMs and performance or disciplinary frameworks
- **Insurance system:** specifically including the number of, and type of insurance model (eg commercial, NFP) and other social insurance schemes
- **Legal system:** including the claims process and precedent for quantum of claims
- **Culture:** including people's preference of birth location and litigious attitudes.

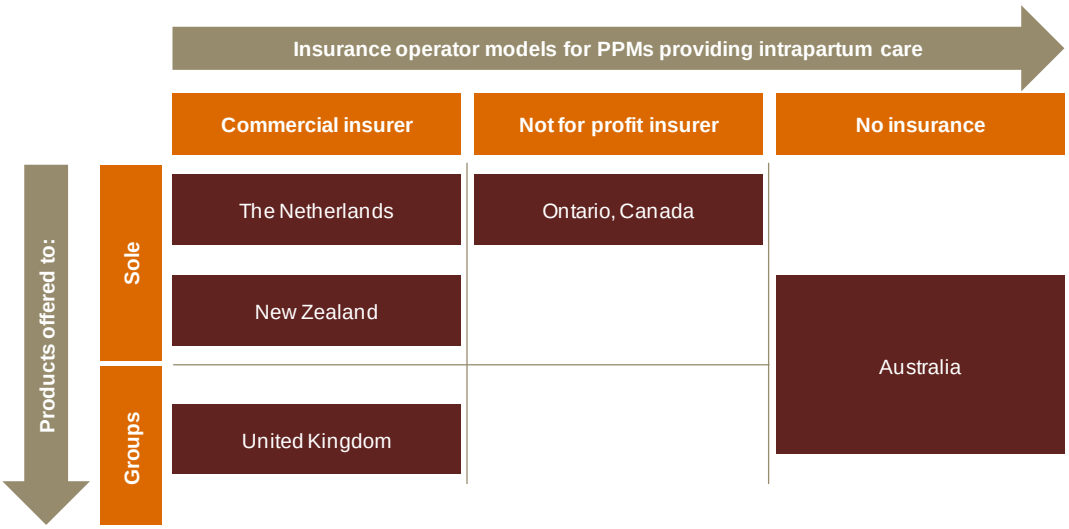
The analysis of these jurisdictions generally observed that the combination of several of these broader macro-environmental factors within each jurisdiction facilitated PII for the full care service provision for PPMs (or independent midwives). The key findings for each jurisdiction are outlined in Table 12.

**Table 12: Insurance products**

| Jurisdiction | Insurance mandatory for registration | Insurance product offered | Enablers – practising environment | Enablers – insurance incidents and claims |
|---|---|---|---|---|
| England | Not currently but changing under *EU Directive* (2014) and Finlay Scott recommendations | Yes, a commercial insurance is available if an independent midwife is practising through a legal entity | Insurance available if there is a sufficient scale of practice and there is evidence of strong risk and quality frameworks in the legal entity.<br>Group practice is enabling private practice to find insurance. | The product is only for private practice which has scale (ie sole practitioners will not have the viability to be insured under the scheme) |
| province of Ontario | Yes | Yes, insurance is available through Not For Profit (NFP) arrangement for all midwives | All midwives are insured by the insurer, who are monitored by and have a close relationship with the Association of Ontario Midwives (AOM) | The product pools all midwives premiums. Separate products are provided on a province by province basis |
| the Netherlands | No | Yes, multiple commercial products are available | Quality and normal registers for midwives are held so midwives are able to have two forms of registration to verify the quality of practice | Low litigious culture and role of independent midwives affects the commerciality of product<br>Insurance co-payments are paid, where both the woman and the midwife pay for insurance |
| New Zealand | Yes | Yes, insurance provided through New Zealand College of Midwives (NZCOM) who broker a commercial product | All midwives insured by the College, which increases the size of the premium pool as all midwives are part of the same pool | No-fault system, where regardless of the incidence, a person injured will receive a specific pay-out relating to the accident through their insurance. This reduces the size of claim. Increases ability of broker to rely heavily on the no-faults |

When comparing the insurance models, as shown in Figure 12, of particular note is the range of insurance providers, from commercial insurers to NFPs. As also shown, there are stipulations on what type of insurance is offered to different models of PPM practice (eg sole or groups).

**Figure 12: Insurance operator models for different practice by jurisdiction**




The key findings are presented for each jurisdiction through the following headings:

- **Homebirth midwifery at a glance:** this provides a brief outline of homebirth practice as well as key statistics to provide insight into the size and extent of activity in the jurisdiction
- **Insurance history:** this provides context into the insurance being provided within the jurisdiction, including drivers for certain models
- **Insurance model:** this outlines of the insurance provided and its key components
- **Enablers of insurance:** this highlights key factors that have facilitated the development of an insurance product, either as a feature of the product, or the practice or environment in which it is provided.

Further details about the operating environment for PPMs for each jurisdiction, including statistics, can be found in Appendix K.

## 4.2 England, United Kingdom

### Homebirth at a glance

In England, maternity services are predominantly provided through the public health service, the National Health Service (NHS). This is a free service at the point of use, accessible to women through the networks of health services (Trusts). With the dominance of the NHS service, only approximately 2.4% of women in England and Wales in 2011 gave birth at home, equalling 17,200 of 716,040 women who gave birth in that year.[132, 133] Note that the health practitioner in attendance (eg services provided by the NHS, an independent midwife or other private practice), if any, is not specifically recorded in data, nor is the intent of having a birth at home.

132 A maternity is a pregnancy which could result in one or more children, and includes still births. Office of National Statistics, 2011.

133 Office of National Statistics, 2011.

The approximate equivalent of an Australian PPM is called an 'independent midwife' in England. Independent midwives are defined as "midwives practising alone or in groups but not as employees of the NHS, other healthcare organisations or local authorities".[134] At present, the UK (including England) currently has approximately 170 independent midwives.[135]

Currently independent midwives operate under three different models:[136]

- **Sole:** they operate alone, or outside of a formal legal entity or structure[137]
- **Private model:** a legal entity owned by private independent midwives that work in partnership with, and under contract of NHS services.[138] One midwife cares for each woman and works with staff within the NHS to make sure that the woman is correctly referred to GPs, obstetricians and other health professionals[139]
- **Social enterprise company (SEC):** a legal entity owned and operated by independent midwives. It is in effect a form of partnership whereby profits are shared. It also holds contractual arrangements with the NHS.[140]

Independent midwives, like Australian PPMs are required to be registered with the national regulatory body, The Nursing and Midwifery Council (NMC-UK). Otherwise, there are no other or specific requirements on independent midwives to provide maternity services within the home. The models of care (private and social enterprise company) are, however, required to meet quality and safety standards set by the national health regulatory, the Care Quality Commission (CQC) as a result of being legal entities providing health services.

## *Indemnity insurance history*

### *History of past products*

Historically independent midwives were able to obtain indemnity insurance through the Royal College of Midwives (RCM).[141] Through the payment of membership fees to the RCM, insurance was available to all RCM members including those who were employed by either the NHS or other private health care settings, or who practised as independent midwives (irrespective of practice model, eg sole, private or SEC models). The cover for midwives employed by the NHS and private health settings was in addition to the vicarious liability of employers.

In 1993, as a result of two large claims relating to one self-employed independent midwife,[142] insurance premiums were expected to rise significantly (believed to be £0.5 million for the RCM).[143] As a result of a failed vote by members to increase membership fees to cover the additional costs, the RCM withdrew insurance cover for independent midwives to keep premiums affordable.[144] Until 2002,

134 Flaxman Partners 2011, p.6.

135 Birthrights, 2013.

136 Personal communication, April 2013. Consultations also highlighted that, at present, a franchising model is also being developed at present.

137 A legal entity is defined by Flaxman Partners 2011 as a 'business'.

138 In this case there is only one private model, "One-to-one" operating at the time of drafting this report, in the Wirral.

139 One to One, 2013.

140 There is only one SEC operating at the time of drafting this report, in London.

141 The Royal College of Midwives are a professional organisation and trade union for UK midwives.

142 Personal Communication, November 2012.

143 Independent Midwives, 2012.

144 Personal communication, November 2012.

all other employed midwives were able to receive cover, at which point insurance cover was then restricted to only NHS-employed midwives.

From 1994 until 2002, some independent midwives were able to obtain insurance through commercial insurers. While it is believed that there were no claims for independent midwives during this period, increasing payouts for obstetricians saw premiums rise for all maternity service providers.[145] By 2002, it became unfeasible for independent midwives to purchase insurance, with the cost of the premium estimated to be approximately £18,000-£20,000/annum.[146] Similar to Australia, it is believed that after 2002, independent midwives practised without offsetting their person liability through indemnity cover.

## *The prospect of mandatory indemnity insurance*

Currently, indemnity cover is not compulsory in England. However, it is expected to become compulsory under *The European Union Directive (2011/24/EU)* (the Directive) as the Directive requires all European Union (EU) jurisdictions (including the UK) to provide systems of professional liability insurance.[147] In response to the Directive, the four UK Health Departments (the Departments) commissioned *The Finlay Scott Review* (Scott review), an independent review of the requirement to have insurance or indemnity as a condition of registration.[148] Out of this review, 20 recommendations were made including that: [149]

*"there should be a statutory duty upon registrants to have insurance or indemnity."*

The conclusions and recommendations from the Scott review were accepted by the four UK Health Departments such that, at the time of drafting this report, public consultation is being undertaken on the draft *Health Care and Associated Professions (Indemnity Arrangements)* Order 2013.[150] This order seeks to implement the Directive through the means recommended by the Scott review.

Vicarious liability held by employers, such as the NHS through the Clinical Negligence Scheme for Trusts (CNST), or the ability to obtain commercial insurance means that the impact of the Directive may be minimal for most midwives.[151] However, independent midwives who may not have vicarious liability may not be able to continue to practise in their current form.

> ***"it will not help if some self-employed registered health care professionals, who are providing good quality and valued services, are unable to continue to practise because they cannot, through no fault of their own, meet a condition of registration despite their willingness to do so."***
>
> *(Scott, 2010)*

As the Scott review identified, "the impediment to a market solution is that the number of individuals is too small to enable the risk to be pooled and spread in a way that produces an affordable product".[152]

In addition to the Scott review, PwC UK was commissioned by the four UK Health Departments to look at the frequency of claims and costs associated with linking insurance/indemnity to registration.

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145 Personal communication, November 2012.

146 Independent Midwives, 2012.

147 Official Journal of the European Union, 2012.

148 Scott 2010, p.4.

149 Ibid.

150 Department of Health UK, 2013.

151 PricewaterhouseCoopers LLP, 2010.

152 Scott 2010, p.28.

As a part of this review, it was identified that the relatively low numbers of independent midwives precluded effective risk pooling, and the quantification of risk made offering a commercial product unviable.[153]

Subsequent to both reviews, *The Flaxman Partners report* (Flaxman report)[154] was commissioned by the RCM and NMC-UK to explain the reasons for the non-availability of PII for independent midwives. The findings outlined in the Flaxman report were similar to the findings of this report (see call out box, on page 12) and relate to how independent midwives practise, which environment they practise in, and what structure they operate under. In brief, a high risk of claims was identified by the Flaxman report as precluding indemnity insurance, driven by:

- high-risk practice in intrapartum care
- the vulnerability of midwives to allegations
- the costs and damages allowed under specific legal systems
- insufficient numbers practising to develop a sufficient but affordable premium
- the absence of a legal entity to direct, employ and control operation and performance.[155]

## *Indemnity insurance model*

Despite the challenges identified above, one insurer, RK Harris, currently offers an insurance product for public services (CNSTs) a private midwifery practice and a NFP midwifery practice. Details on their insurance product obtained from consultation with the insurer, can be found in Appendix K.

RK Harris identified key product features that allow them to minimise the risks of long tail claims, numerous small claims and the lack of practice scale:

- **Long tail claims:** RK Harris has mitigated this risk of potential liabilities in the future by not providing run-off cover. Similar to the IMGA product in Australia, this is unlike the MIGA product, in which Commonwealth Government supported run-off cover is available
- **Small claims:** an excess is applied to claims raised up to the value of £50,000. Therefore, it is more likely that the legal entity will cover those small claims raised. This then reduces the amount of small claims which are borne by the insurer, which ultimately reduces the premium price
- **Scale of practice:** there is a minimum deposit required of £25,000 – £50,000 for the insurance product. The likely result is that the product is only purchased by legal entities with a large enough scale to afford the deposit.

## *Incidence of claims raised*

In terms of the incidents or claims that have arisen, as outlined in Chapter 3, RK Harris declined to provide information on the basis that it was commercial in its nature. This response is in line with those received by the PwC UK report whereby due to the commercially sensitive nature of claims data, insurers were either unwilling or did not feel they were in a position to share information.[156] Similar to

153 PricewaterhouseCoopers LLP, 2010.

154 Flaxman Partners, 2011.

155 Ibid.

156 PricewaterhouseCoopers LLP, 2010.

the findings in Chapter 3, the PwC UK report also identified challenges in using substitutable data including:[157]

- **NHS:** that NHS claims data were not captured on a profession level and thus could not be extrapolated for frequency and severity to independent midwives' NHS claims data
- **Courts:** that there was an absence of centralised readily accessible sources on the severity of medical negligence claims through the courts
- **Private-sector organisations:** that commercial sensitivity applied preventing the use of relevant data.

## *Enablers of insurance*

Enablers of insurance are aspects of the midwifery practice, or the environment in which they practise, that could increase the likelihood of an insurance product being developed. From consultation with stakeholders in England, key enablers were identified as:

- **Group practice operating models:** that provide an insurance product to a model of group practice rather than sole practitioners
- **'Supervisor of Midwives' (SOM) model:** increased monitoring and consultation through assistance from a supervising midwife
- **Data quality:** increased certainty over the risk profile provided by information on adverse outcomes and actuarial modelling.

### *Group practice operating models*

Having independent midwives practise within groups has been identified by several reviews (particularly the Flaxman report) as being conducive to the development of an insurance product. This is because it is held to reduce the risks borne by the insurer through:

- **Scale:** it increases the scale to purchase insurance products
- **Assuring the level of risk and quality:** this is due to the requirement of the legal entity to be accredited under the risk and quality standards of the CQC
- **Monitoring, governance and collective support:** reviews suggested that a group practice could facilitate the oversight risk management through strong governance and appropriately professional management, as well as supervision or overseeing of the operational conduct and control and standards of practice
- **Vicarious liability:** this will be established within a legal entity. As groups are owned and operated by midwives, and there is a shared payment for premiums borne by each midwife in the practice, there may be a vested interest for collective best practice in the group
- **Improved transfer and access arrangements:** access to NHS resources, and a requirement to also hold contractual arrangements with the Clinical Negligence Scheme for Trusts[158] operating within the entities practice area to see intrapartum care cover, may assist in

157 PricewaterhouseCoopers LLP, 2010.

158 Clinical Negligence Scheme for Trusts are responsible for the NHS provided maternity care and have their own Maternity Standards.

reducing the risk of independent midwives operating outside of scope, or not having access to other health professionals to transfer care.

The role of group practice could be considered further as a potential way to assist in the development of a PII product (see Chapter 5).

## *'Supervisors of Midwives' model*

The 'Supervisors of Midwives' (SOM) model is an NHS scheme, where all midwives have a supervisor employed by the NHS who is an experienced midwife, was believed, in consultations, to assist in the delivery of a more consistent or higher quality of care. In this model, every midwife has a supervisor, whether they are a part of the NHS or work independently or in a private maternity unit.

The supervisor model could provide greater certainty around the practice of midwives for insurers. The supervisor provides clinical supervision of the midwives and aims to ensure that care provided meets the required standards.

> ***"Any midwifery service ought to be of a specification and quality standard no less than is provided by the NHS. Anything less than this would be uninsurable... presenting a risk profile for which commercial insurers are unable or unwilling to offer terms."***
>
> *(Flaxman Partners, 2011)*

The supervisor model may be an enabler for insurance because it may provide:

- **A source of best practice:** the midwife is able to consult with their supervisor if concerned about a woman or birth, and be provided with guidance on best practice actions to taken (including transfers to other health care settings)

- **Increased monitoring and support:** the supervisor may have insights into whether a midwife is meeting standards for care and assist in their professional development

The role of SOM models in Australia should be considered further (see Chapter 5).

## *Evidence of incidents and insurance claims*

Previously, data and information on independent midwifery have been difficult to obtain in England, which has impeded the ability of insurers to understand the risk profile of these midwives. Similar to Australia, due to the small size of practice independent to public health services, specific data have not been collected.[159] This meant that data could not be separated between maternity service health professionals, or more specifically, between NHS and independent midwives.[160] Stakeholders identified more recent improvements in both incidence data and actuarial modelling, which have been linked to the development of an insurance product.

### The Birthplace national prospective cohort study

This study, conducted as a partnership between the National Perinatal Epidemiology Unit, NHS Trusts, RCM and universities, sought to research perinatal and maternal outcomes by the planned place of birth.[161] Focusing on NHS services (not independent midwifery), the study collected and compared data from every NHS trust providing homebirth services in England, every freestanding midwifery unit (FMU), alongside midwifery units (AMU) and a random sample of 37 obstetric units (OUs).

159 PricewaterhouseCoopers LLP, 2010.

160 Ibid.

161 National Institute for Health Research, 2011.

In summary, the findings (see Appendix J) indicated that the overall incidence of adverse perinatal outcomes[162] was low in all settings. For multiparous women,[163] there were no statistically significant differences in perinatal outcomes between birth settings, while adverse outcomes were more likely (although low) only for nulliparous women[164] in homebirth settings. On the other hand, for multiparous women the perinatal outcomes were not statistically significant across settings of birth. Adverse maternal outcomes[165] tended to occur less frequently in the home and FMU groups.

This type of information, along with strong national clinical guidelines (National Institute for Health and Clinical Excellence (NICE)) and national quality standards (CQC) were identified by stakeholders as assisting insurers to mitigate potential adverse outcomes and could assist in reducing the risk profile of PPMs.[166] In particular being a collective independent study appears to have provided this report with a level of creditability relative to other prior studies. Completing a similar exercise in Australia, supported by strong risk and quality frameworks may provide assistance in addressing the perceived risk profile and establish meaningful safety and quality guidelines for PPPMs.

### Insurance actuarial modelling

An actuarial computation is a complex calculation involving a variety of variables and assumptions to determine the funding requirement for a plan. The commercial provider RK Harris assessed that in England, based on insurance actuarial modelling, private practice midwifery could be insurable.

In order to develop its insurance product, RK Harris was required to overcome various limitations in available data similar to that seen in Australia. These limitations included that:

- data are aggregated for all maternity health service professionals (eg obstetricians and midwives)
- data are aggregated for all health service settings (eg FMU, AMU, OUs, home)
- data are only available for NHS settings.[167]

One of the biggest barriers was felt to be one of perception. Insurers "perceive[d] the risk presented by midwifery in the same light as they do that of obstetrics and gynaecology… which are known for being the highest cost to the NHS in terms of clinical litigation and awards of damages".[168] The solution that RK Harris identified included that they were able to use the NHS and National Audit Office data as a substitute to independent midwifery data and were able to separate out midwifery and obstetrics data over 35 years. They also interpreted adverse outcomes attributable to birth in a different manner in comparison with other insurers. These, along with the product features and enablers outlined previously, allowed them to sufficiently reduce the risk profile of independent midwives and offer insurance to midwives.

162 This includes intrapartum still birth, early neonatal death, neonatal encephalopathy, meconium aspiration and specified birth related injuries including brachial plexus injury.

163 'Multiparous' refers to a woman who has given birth two or more times.

164 Nulliparous' refers to a woman who has never given birth, or given birth to a viable, or live, infant.

165 This refers to third or fourth degree perineal trauma, blood transfusion or admission to a higher level of care.

166 Personal communication, April 2013

167 Flaxman Partners, 2011.

168 Ibid.

# 4.3 The province of Ontario, Canada

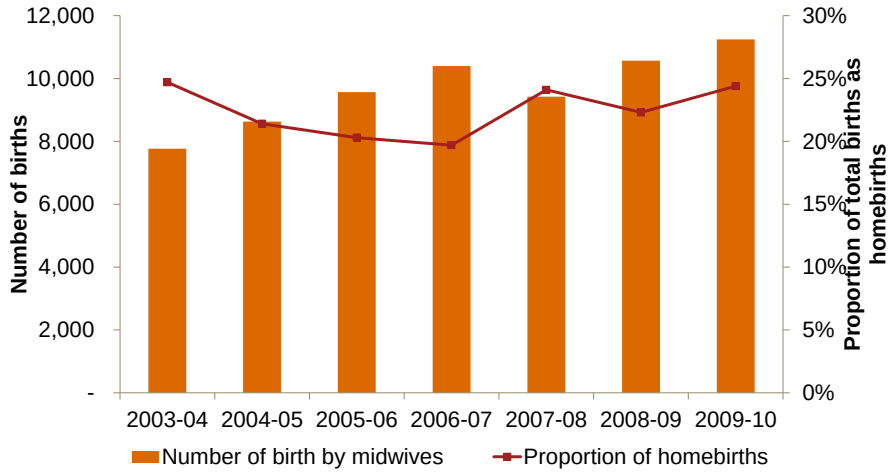
## Homebirth at a glance

It was identified that the practice of midwifery, and the environment in which midwives practise, varies between provinces in Canada. As a result, for the purposes of this report, research was focused on the largest province, Ontario.

Up until the *Ontario Midwifery Act of 1993*, midwifery in the province of Ontario was "illegal".[169] Subsequent to the Act, midwives were able to act as an autonomous health profession, regulated through the College of Midwives of Ontario (CMO) and receive training through university programs.[170]

As a result, the numbers of midwives practising in the province of Ontario have been steadily increasing since 2003. In 2009–10, there were 405 midwives recorded, an increase of 58% from 2003–04 when there were 256 midwives. The number of births has also been increasing, with the proportion of homebirths remaining relatively constant between 20–25% of total births, as shown in Figure 13.

**Figure 13: Total births by midwives and proportion as homebirths in Ontario province, Canada (2003–2010)**




**Note:** Data is the property of HIROC and is not to be used for any other purpose than this research.

**Source:** HIROC, Personal communication 2013.

All midwives in the province of Ontario are classified as 'independent'. This means that they work within independent group practices, and are not employees of health services (eg hospitals). In 2010, there were 76 midwifery practices registered.[171] Maternity services in the province of Ontario are free as they are funded by the Ontario Ministry of Health and Long-Term Care. This means that different practice settings are not differentiated based on cost of service. Midwives are paid for on the basis of all the care that is given rather than on a fee-for-service basis.[172]

169 Taylor A 2008.

170 Cameron HL 2005.

171 Ontario Hospital Association, 2010.

172 Association of Midwives Ontario, 2013c.

Key registration requirements with the College of Midwives of Ontario include that midwives must:[173, 174]

- **Attend both hospital and homebirths:** in order to maintain registration, a minimum number of births must be attended in each setting
- **Provide continuity of care:** they are required to provide full service to their clients in all trimesters, throughout labour and birth and for six weeks postpartum. This means that women often will not see any other health care practitioner during this care period
- **Hold access arrangements in at least one hospital:** this is to allow the midwife to continue to provide care for the woman and baby. This allows the midwife to be able to admit and discharge a woman and care for her fully within the health service
- **Be a member of the Association of Ontario Midwives:** this is to maintain safety, quality and competency standards
- **Hold professional indemnity insurance**.

As identified above, registration to practise as a midwife with the College of Midwives of Ontario requires membership with the Association of Ontario Midwives. The Association of Ontario Midwives is a professional organisation that represents and advocates for midwives, provides midwives with support and continuing professional development, clinical guidelines and frameworks for care (there are currently 11 frameworks), as well as PII.[175]

## *Insurance history*

It was recognised by The Interim Regulatory Council on Midwifery (IRCM)[176] that all midwives should be covered individually by PII, and this was mandated as a requirement of registration by the College of Midwives of Ontario.[177] As a result, upon the recognition of midwives in 1993, PII was provided during the 1990s by two commercial insurers.[178] However, these insurers exited the market following the events of September 11th as that event had a significant impact on the insurance market.[179] However, in 2001, the Association of Ontario Midwives approached the Healthcare Insurance Reciprocal of Canada (HIROC), which commenced providing insurance in 2003 to midwives, on the basis that the profession was regulated.[180]

HIROC is the largest liability insurance organisation in Canada, providing insurance services exclusively to NFP healthcare organisations, which become members (or subscribers) of the organisation. In doing so they form an insurance reciprocal exchange, where the subscribers agree to share each other's losses. As this was previously available only to health services (as opposed to associations/organisations), for Association of Ontario Midwives to become a subscriber, the reciprocal by-laws were changed.

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173 College of Midwives of Ontario, 2013a.

174 Association of Ontario Midwives, 2013a.

175 Association of Ontario Midwives, 2013b.

176 The IRCM was an interdisciplinary body formed in 1989, prior to the regulation of midwifery in Ontario. The purpose of this body was to develop the regulatory framework for the profession, creating policies, standards of practice, and qualifications for entry to practice.

177 College of Midwives of Ontario, 1994.

178 Personal communication, November 2012.

179 HIROC, 2013a.

180 Ibid.

## Insurance model

The insurance model for HIROC works through subsidising risk across subscribers. This is different from the development of premium pools. With 52 current subscribers, HIROC spreads its risk across a number of different professions.[181] When no further claims are expected, excess funds are redistributed to subscribers. In 2011, this was $3.8 million (CAD).[182]

The premiums range dependent on the province, but HIROC sets a premium between the values of $16,000-$25,000 (CAD).[183] The premiums are determined per individual, based on the individual's experience and risk exposure. While HIROC seeks to make premiums affordable, it sets the premiums so that it can share risk by equitable amounts. To enable a product to be provided, this model does not provide run-off cover.

## Incidence of claims raised

The data for incidences and claims for homebirth (see Appendix K and Table 9) demonstrate that there is relatively low number of claims raised. HIROC was able to provide us with aggregated data on claims and incidences.[184] What this information shows is that since 2003, there have only been two damages claims out of 567 incidences reported (0.35%).[185]

## Enablers of model

The key enablers of PII in the province of Ontario identified through literature and consultations are:

- **Integrated midwifery practice:** midwifery being provided interchangeably at home or in hospital, for the same fee and allowing for continuity of care
- **Insurance mandate and structure:** the requirement for insurance, and the fact that its assists in a product being developed
- **Risk frameworks:** clinical practice guidelines and risk management documents supporting practice
- **Partnership between AOM and HIROC:** risk is managed jointly by the Association of Ontario Midwives and HIROC to support midwives and assure quality
- **Government support:** support for midwifery practice in the province of Ontario to be able to have increased continuity of care.

### Integrated midwifery practice

Midwifery in the province of Ontario is integrated in to the health system. The requirement not only for all midwives to have PII but to support homebirths to maintain registration appears to provide scale for an insurance product.

181 HIROC, 2013b.

182 Ibid.

183 HIROC, Personal Communication, 2013.

184 Note this data is the property of HIROC and is not to be used for any other purpose than in assisting Australian midwifery research for AHPRA. Data is as close of business on 31 December 2012.

185 Ibid.

Like other jurisdictions and the publicly funded homebirth schemes in Australia, the College of Midwives of Ontario, in accordance with national standards requires two midwives, or one midwife and a qualified second birth attendant, to attend every homebirth.[186] This is believed by the reciprocal to reduce the risk profile as midwives are not acting independently.[187]

> ***"The midwifery practice model in Ontario reflects the tenets of continuity of care, informed choice and choice of birth place."***
>
> *(College of Midwives of Ontario, 1994)*

Where a transfer may be required to other health settings from the home, access arrangements are in place to support the continuity of care. From an insurance perspective, access arrangements were held by those consulted to result in a reduction in adverse outcomes as women seeking a continuous care provider may be more likely to transfer early, if required. From an insurance perspective, using the province of Ontario as an example, an integrated care model appears to reduce the risk profile of midwives. How to support such a model in Australia should be considered further.

## *Risk frameworks*

Consultations identified that the clinical practice guidelines and risk frameworks in place for midwives have been important in reducing the risk profile of midwives.[188] Guidelines have been developed by the College of Midwives of Ontario, and joint guidelines between Association of Ontario Midwives and the Ontario Medical Association (OMA). An example of relevant guidelines includes:

- College of Midwives of Ontario *Indications for Mandatory Discussion Consultation and Transfer of Care*[189]
- Association of Ontario Midwives/Ontario Medical Association *Guidelines for Maternal/Neonate Transfers from Home to Hospital*
- Association of Ontario Midwives/Ontario Medical Association *A Joint Statement of Professional Relations Between Obstetricians/Gynaecologists and Registered Midwives in Ontario.*[190]

The joint development and partnership between organisations and professional groups is recognised by those consulted, as important to facilitate safe care and better outcomes. Effective inter-professional communication and collaboration in providing optimum patient care was also recognised as having the potential to reduce the risk profile of midwives, particularly those that are providing services within the home.[191]

## *HIROC model, services and philosophy*

The overarching model of HIROC as a NFP supports the ability for an insurance product to be developed for midwives. HIROC is not driven by profits; any project or excess surplus is returned to its subscribers (its members). As the members as a result, have a vested interest in all members reducing the number of claims, there is a possibility that there is a greater interest in improving safety and reducing adverse outcomes.

186 Ontario Hospital Association, 2010.

187 Personal communication, November 2012.

188 Ibid.

189 College of Midwives of Ontario, 2013e.

190 Ontario Hospital Association, 2010.

191 Ibid.

HIROC identifies that "have a defined and important role to play in helping to create a culture of patient safety".[192] As a result, HIROC is actively involved in working with organisations as well as providing additional tools to subscribers. Tools such as 'Risk Management Self-Appraisal Modules' and holding 'Risk Management conferences' for subscribers can assist in limiting adverse outcomes, with the net effect believed to be the reduction in premiums charged.

***"Reciprocals provide subscribers with premium stability and loss reduction programs, based primarily on a pooling of insurance coverage and risk sharing across a large subscriber base"***

*(HIROC, 2013c)*

The model of risk sharing between professions allows the reduction of the risk associated with midwives as there is a greater scale for pooling risk; subscribers have agreed to share in each other's losses including those from midwives. This is in contrast to premium pools that are applied in Australia.

## *Partnership between Association of Ontario Midwives and HIROC*

Consultations identified that the active working relationship between HIROC and Association of Ontario Midwives is imperative in the provision of an insurance product. There were three important components of the relationship identified.

### Risk management

HIROC is involved in providing Association of Ontario Midwives with guidance around their risk, as well as any mitigation that is necessary in terms of the product offered and premiums set. This assists the Association of Ontario Midwives in developing appropriate clinical guidelines and risk frameworks.[193] Consultations with HIROC identified that this involvement assists them in understanding the practice better, as well as the risks involved in care delivery. As HIROC identifies:[194]

> *"...promoting healthcare safety is at the core of HIROC's mandate. We are working with our partner organisations to contribute to risk reduction, in general, and specifically to reduce the frequency of adverse events".*

HIROC, working in partnership with Association of Ontario Midwives appears to assist in achieving a beneficial reduction in claims for all parties. While MIGA in Australia works with the ACM, further strengthening of the relationship between professional association and insurers may assist in agencies understanding the practice and risk, and as a result appropriately assessing the risk profile of PPMs (see Chapter 5).

### Identification of incidence and claims

The Association of Ontario Midwives works with HIROC in identifying incidences and claims made. This provides the Association of Ontario Midwives with better oversight of the insurance claims and can target training and development appropriately, if required in response to particular claims, or trends that present. This is believed to assist HIROC reduce its ongoing risk profile.

### Understanding of training and disciplinary processes

Competency of midwives is held to be a factor in reducing the risk profile of midwives providing birthing services in the home. Association of Ontario Midwives is involved in ongoing clinical training and development. Evidence of this is believed to assist HIROC in setting the premium, particularly as it has an indication of the competency levels held by those it insures.

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192 HIROC 2013c, p.2.

193 Personal communication, November 2012

194 HIROC. 2013c, p.2.

The insurer HIROC similarly can see how the Association of Ontario Midwives disciplines midwives. In the early 2000's three disciplinary hearings occurred which set a precedent for future cases of a similar nature. The cases are believed by the Association of Ontario Midwives, to have occurred due to a change in regulation where midwives who were used to practising in a particular way, were subsequently regulated more stringently.[195]

Furthermore, the Association of Ontario Midwives is working to improve data quality for midwifery practice through a new system to understand and monitor outcomes.[196] This should assist with future actuarial modelling.

## *Government support*

The insurer HIROC noted that the court system provides comfort around the quantum of the claim provided.[197] The comfort stems from the legal system having developed a cap which the Court of Appeal will not go beyond for non-pecuniary damages (ie loss of care, guidance and companionship from the deceased).[198] This litigation culture can provide some certainty for insurers around non-pecuniary damages and therefore the quantum of potential claims. These were stated in 2010 to be up to $117,000 (CAD) for the claim regarding a child $40,000 for a mother (CAD).[199]

The Ontario government is believed to have supported homebirth and maternity services being provided by midwives by enforcing changes in legislation through the *Ontario Midwifery Act of 1993*. However, the Government also recognises a growing need for more midwives in the province of Ontario, where the province is viewed as underserved for maternity care.[200] The health system and the Government support can also be seen through the Ontario Ministry of Health and Long-Term Care paying for maternity services.[201] It could be held that as a result, a midwife has an incentive to report correctly the number of women in his or her care to receive payment for services. As a result, the practice of the midwife may be held to be transparent and this has the potential to increase the certainty when forming premiums for PII. Consultations suggested that the Government saw benefit in the model from:

- **Increasing women's choice:** making homebirth an available option for women which increases the scale of practice and makes PII more affordable
- **Reducing financial cost:** midwifery-led care was estimated at $800 lower if provided in a health setting compared to obstetrics, and $1,800 lower if provided at home.[202] This evidence of the affordability of the practice led may have influenced the Government to invest in the education of midwives and increase the size of the practice
- **Increasing women's satisfaction:** a 98.7% satisfaction rate was reported among clients using midwifery services.[203] This may have also encouraged the demand for midwifery services and hence, the demand for insurance by midwives.

195 College of Midwives of Ontario, 2013b.

196 Personal communication, March 2013.

197 Personal communication, November 2013.

198 Claims Canada, 2013.

199 Ibid.

200 Association of Ontario Midwives, 2013c.

201 Cameron HL 2005.

202 Financial benefit was through reduced rates of C- section episiotomy, fewer re-admissions into hospital and shortened hospital stays, Association of Ontario Midwives, 2013c.

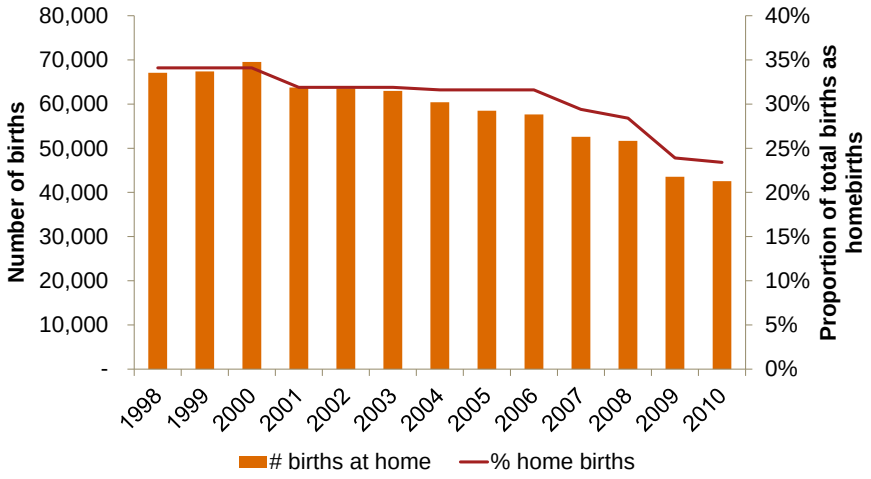
203 Association of Ontario Midwives, 2013c.

## 4.4 The Netherlands

### Homebirth at a glance

As Wiegers et al state, "the Dutch system of maternity care, with its high proportion of planned homebirths, received much attention from other industrialised countries".[204] In 2010, 23 per cent of women gave birth at home,[205] with 181,837 births in the Netherlands being comprised of 42,550 being at home, 136,923 in the hospital and 2,182 being undertaken elsewhere. While this number is relatively high compared to each of the other jurisdictions researched, it has been declining, as shown in Figure 14.

**Figure 14: Number and proportion of births at home**




**Source:** Statistics Netherlands, 2013.

Literature suggests the reason for the decline is driven by many factors including the support of government and other health professionals (eg obstetricians) for homebirths, the perceived medicalisation of maternity services, as well as a change to the maternity care system.[206, 207]

In the Dutch maternity care system midwives are qualified to provide independent care for women with uncomplicated pregnancies. Since the 1970s women have had the choice between home or hospital birth as well as who their primary care provider is. Under a tiered care model, the majority of care is provided by midwives or GPs in the community under a primary maternity care model. In 2008, 99.5 per cent of these homebirths under this model were attended by a midwife, with the remaining 0.5 per cent attended by a GP.[208] Secondary care models involve obstetricians and specialised 'clinical' midwives in general hospitals, and tertiary care comprises of obstetricians in academic hospitals.[209]

Maternity services are paid for under a women's health insurance plan, in a form of co-payment. Under the *Health Care Insurance Act*, it is compulsory that all Dutch citizens and those working in the

204 Weigers TA, van der Zee J, Kerseens JJ & Keirse MJ 1998.

205 Statistics Netherlands, 2013.

206 Wiegers TA, Keirse MJ, van der Zee J & Berghs GA 1996.

207 Personal communication, April 2013.

208 Statistics Netherlands, 2013.

209 Weigers TA, van der Zee J, Kerseens JJ & Keirse MJ 1998.

Netherlands hold a standard insurance plan (in which maternity services is covered).[210,211] These costs are approximately €1,100 with an income related contribution of up to €500 per year. Midwives are registered with the insurance agencies to receive payments.

In 2011 there were 2,612 midwives in the Netherlands who provided care either independently (self-employed) (73 per cent) or in a hospital (27 per cent).[212] Those that provide homebirth services operate as:[213]

- **Sole:** operate alone. Comprises of 5.7 per cent of all primary care midwives
- **Group practice:** operate as a member of an organisation. These groups often have their own premises, with a midwife on call 24/7
- **Locum:** temporary, or replacement midwife. This comprises of 12% of all active midwives.

Midwives in the Netherlands are required to be registered under a national register (the BIG register) and must meet a set of requirements to maintain registration. The key one of these is the amount of time spent working as a midwife (2,080 hours in five years).[214]

## *Indemnity insurance history*

As one consultation stated, the Netherlands is an "insurance-minded country" with insurance for all types of activities. Therefore, it appears that with the majority of births historically being provided in the home, PII has been traditionally available from commercial insurers in an active market (however this could not be verified).

## *Indemnity insurance model*

Like England, indemnity insurance is not a requirement of registration under the Netherlands' BIG register. However, consultations highlighted that as the cost is relatively low (approximately €350 annually[215]) it is believed that the majority of midwives hold insurance.[216] Also like England, the Directive from the EU will place a responsibility on the Netherlands to provide systems of liability insurance and so it could become mandatory in the future.[217]

As mentioned previously, PII in the Netherlands is able to be purchased as insurance through an active commercial market. Some of these are healthcare member organisations (eg VVAA), while others are subsidiaries of multi-national insurance for profit agencies (eg Meéus). In Appendix K there is varying detail of three different providers of indemnity insurance for midwives (eg De Goudse, Meéus and VVAA). The features of PII in the Netherlands are driven by the insurance product; all provide cover for approximately €1.5 million to €2.5 million (variation depends on whether additional premiums are paid, and the amount claimed per year), some also provide run-off cover (up to 20 years), as well as legal aid for product holders (VVAA).

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210 In some circumstances (eg living alone, earning under €47,520/year) compensation is available.

211 Undutchables, 2013.

212 KNOV (The Royal Dutch Organisation of Midwives), 2012.

213 Ibid.

214 Ibid.

215 See Appendix K.

216 Personal communication, April 2013.

217 Official Journal of the European Union, 2012. The European Union Directive (2011/24/EU) (the "Directive") states that there is responsibility on member states of the European Union to provide systems of professional liability insurance, or a guarantee or similar arrangement that is equivalent or essentially comparable as regards its purpose and the extent of the risk, are in place for treatment provided on its territory.

## *Incidence of claims raised*

As the insurers are commercial, information was unable to be obtained on the number of incidence of claims from these insurers. However from consultations held, stakeholders did disclose that the number and quantum was relatively low (the largest case reported was for €1 million approximately 10-15 years ago).[218] The relatively low number of claims that were raised was linked to several factors including:

- **Enablers of model:** disciplinary frameworks in place and the lack of a litigious culture
- **General Tax for Special Illness**.

### *General Tax for Special Illness*

Insurers identified that the majority of claims raised concern a complaint about a baby that has become disabled due to the actions of a midwife.[219] In the Netherlands, the *Exceptional Medical Expenses Act* (AWBZ) insures the often long-term costs of treatment, support, nursing and personal care, when these costs are extremely high.[220] Citizens who are employed or receive a pension pay the AWBZ premium indirectly through their pay/allowance.

As the AWBZ can also cover disablement, the quantum of a claim on the premium pool may be brought down. Therefore, if there are disability claims then these can be covered more frequently by social insurance rather than PII.

## *Enablers of model*

Given the widespread practice of homebirths, much discussion from academics, researchers and professionals internationally has focused on trying to understand what it is that makes the homebirth model 'work' in the Netherlands from both a service provision and PII perspective.

From consultations, there were several key factors of the overarching environment in which midwives practice, that were identified as important in assisting with the development of an active PII market:

- **Midwifery practice:** the large scale of homebirth services and models of practice
- **Service access:** the location of midwives and women requiring their service, as well as access to health services
- **Quality and safety of practice:** a defined scope of practice and referral, as well as training and competency
- **Data:** the level and specificity of data collected
- **Disciplinary frameworks:** also including the resolution of complaints
- **Culture:** attitude toward social health, homebirths and lack of a litigious culture.

218 Personal communication, April 2013

219 Ibid.

220 Government of the Netherlands, 2013.

## *Midwifery practice*

### Scale of practice

In Chapter 3 Finding 4, scale of practice was identified as important to insurers in the Netherlands. It provides that there are a sufficient number of product holders to cover any significant claims. While the number of homebirths appear to be declining in the Netherlands (see Figure 14), they still account for over one in five births. To support these, as outlined previously, there are nearly 2,000 midwives providing homebirth maternity services. Consultations with the insurance representatives identified that this scale, in combination with the other enablers outlined, is sufficiently large to support the development of a product.[221]

### Models of practice

As previously outlined, the majority of midwives providing homebirth services in the Netherlands operate within a group practice (which have at least two to three midwives). In 2012, 519 primary care independent midwifery practices were registered.[222] Group practice has been identified as important to insurers, as it assists in decreasing the risk profile of midwives. Unlike England where group practice and insuring a legal entity was important to share the risk, insurance in the Netherlands is not only optional, but purchased by individuals and not legal entities.

In this case, group practice is held to provide a collegial and supportive environment for midwives in which best practice principles can be shared. Insurers from the Netherlands identified that it also assists in supporting women's safety (and the potential for adverse outcomes) as midwives can cover other colleagues' births if required.[223] The system is such that if a practice is unavailable to attend to a woman, midwives from a neighbouring practice, or a locum, can attend in the place of the intended midwife.

Like the publicly funded homebirth schemes in Australia, two health professionals are required to attend each homebirth. However in the Netherlands, the second attendant can be a maternity assistant as opposed to a midwife. This is again believed to reduce the risk profile of midwifery practice, as a second opinion can be given in addition to the provision of additional support for a birth. The extent of group practice and extending the need for multiple attendants may be considered further by Australian decision-makers (see Chapter 5).

## *Service access*

### Location of midwives and women requiring their service

The geography of the Netherlands is also held to assist in reducing the risk profile of midwives providing birthing services in the home. The jurisdiction is relatively densely populated, particularly in terms of the network of midwives and hospitals or health services. This means that midwives are relatively close to women, and to transfer to other health services if required, providing midwives with timely access to women requiring their service, as well as required services.

Additional registration requirements within *The Obstetric and Midwifery Manual* (the Manual) on practice are based on timings for transfer. For example, the midwife is expected to live with 15–30 minutes from the place of the residence of the woman requiring their service.

Some local stakeholders felt that the Netherlands model was not applicable to Australia given that the land mass is significantly larger, with a more dispersed population. However, insurers in the Netherlands identified that it was not the size of the land mass, but the density and timely access and

221 Personal communication, March 2013.

222 KNOV (The Royal Dutch Organisation of Midwives), 2012.

223 Personal communication, March 2013.

distance of the women to the midwife and other health services that was important in reducing the risk profile of midwives.[224] Focusing on distance through this lens may provide insurers in Australia with additional comfort when determining the risk profile of PPMs.

### Access arrangements to health services

In the Netherlands, every hospital is required to accept referrals from midwives providing homebirth services.[225] Timely access to health services was specifically highlighted by insurance representatives consulted in the Netherlands.[226] It reduces the risk of midwifery practice as interventions can occur if and when they are required.

As described above, the midwife is expected to live within a relatively close proximity to the woman's residence. In addition to this, if an ambulance is required then the ambulance must be able to transfer within three-quarters of an hour from the time the phone call is made as it is expected that transfers from the home to other health services occur by an ambulance. From consultation it was identified that the commutes from home to health services are on average, 10 minutes in duration.

In Australia, consultations identified that some PPMs and/or women were reluctant to transfer to other health services due to the ability for continuity of care, as well as a perceived negative attitude and lack of acceptance of the service by other health professionals. Consultations highlighted that these issues are also present in the Netherlands; however, transfers are accepted as a part of the continuum of care as required under quality frameworks.

## *Quality and safety of practice*

### Scope of practice

Since 1959, the Manual has provided a clear and common national risk management framework (including recommendations on when to transfer and distance from a health service). It defines scope of practice by providing a list of pre-existing pregnancy and perinatal-related disorders where:

1. the care of a primary midwife is considered sufficient
2. an obstetrician should be considered
3. the care definitely has to be shifted to an obstetrician
4. the labour and birth should be given in a hospital but can be supervised by a primary care midwife.

While the Manual is respected and generally followed, it is intended for use as a guideline providing health professionals the option to make autonomous decisions.

The Manual appears to demonstrate collaboration between:

- Health services and primary care midwives through option d

> ***"Risk selection, a clear distribution of tasks and a close mutual cooperation between… different strata [primary, secondary and tertiary care] forms the strength of the Dutch system"***
>
> *(KNOV, 2012)*

224 Personal communication, March 2013.

225 KNOV (The Royal Dutch Organisation of Midwives), 2012.

226 Personal communication, March 2013.

- Midwives, GPs, obstetricians and government authorities, all of whom are involved in updating the Manual.

Consultations highlighted that there is currently debate about the content of the Manual. Even so, it was agreed that collaboration, debate and productive discussion on the Manual between all health professionals was important.[227]

### Training and competency

Insurers identified that the quality of midwives plays a role in insurance provision. Insurers believe that the standard of education is high in the Netherlands and this reduces the risk of malpractice or professional misconduct.[228] The understanding that insurers have of the competency of those that they employ they believe, assists in determining the risk profile.

In addition to student training, there is a 'quality register for midwives' that allows midwives to show that they have invested in ongoing professional development.[229] This quality register, maintained by the Royal Dutch Organisation of Midwives (KNOV), while voluntary, has 80% of midwives registered.[230] To remain on the register, a midwife has to show a portfolio containing a minimum of 200 hours of training and additional education over five years.[231]

## *Data*

In Chapter 3, the importance of specific and reliable data was identified as important for insurers to apply actuarial modelling on the probability of claims and their quantum in setting the premium. Stakeholders in the Netherlands felt that their data were relatively robust and reliable, particularly around registration.[232] They identified, however, that making comparisons between maternal and perinatal outcomes in the Netherlands and other jurisdictions should be performed with care, and show cognisance of data definitions and the environment in which the outcomes were seen. They identified, for example, that different levels of specificity of data may skew comparative outcomes (eg the Dutch registration of foetuses with a minimal birth weight of 500 grams as a perinatal death which is not the same in other jurisdictions).[233]

## *Disciplinary*

Insurers have identified that there are a low number of claims in the Netherlands which assists with establishing an acceptable risk profile to provide cover.[234] Some stakeholders suggested this was due to the disciplinary framework in place. Complaints on malpractice and professional misconduct were cited as more often being resolved prior to being made formal within the courts.

227 Personal communication, March 2013.

228 Ibid.

229 KNOV (The Royal Dutch Organisation of Midwives), 2013a.

230 KNOV (The Royal Dutch Organisation of Midwives), 2012.

231 Note that stakeholders believe this register reflects the expectations of the NMBA and is believed by some to be less complex than the MidPlus Safety and Quality program offered by ACM.

232 Personal communication, November 2012.

233 KNOV (The Royal Dutch Organisation of Midwives), 2012.

234 Personal communication, March 2013

The common process appears to be that:

1. **Women approach the midwife directly:** this is to discuss the complaint

2. **Complaints are escalated to an independent section of KNOV:** this provides assurance of professional conduct and quality without financial compensation for the woman

3. **Medical court:** this is called the Tuchtcollege and hears specific medical cases

4. **Criminal court:** this is applied as the final stage.

Consultations identified that the women were often only seeking to be heard, receive an apology and know that their issue will be addressed in the future. As a result, many claims are not put forward, as the complaint often does not move beyond the first stage.

## *Culture*

### Attitudes towards litigation

Malpractice litigation is held by stakeholders to be rare in the Netherlands, as even if the claims are brought to court, it is believed by those consulted, that Dutch judges are very reluctant on this matter to prosecute.[235] It has been estimated that the number of malpractice claims filed against Dutch physicians (albeit a poor comparator for primary care midwives) is less than one tenth of the related number in the United States. Moreover, malpractice claims in the Netherlands decreased steadily from 1980-90.[236]

Consultations also suggested that the specifics of the laws could also contribute to their low-claims culture. Insurers are regulated by national law around indemnity which defines liability narrowly. Consequently, insurers do not, as part of liability, need to insure what is legally not defined. This might also reduce the number of claims made.

### Attitudes towards homebirths

Finally, one of the most important points perceived by those consulted with, is the attitude held in the Netherlands toward homebirths. Consultations identified that there is a perceived culture that birthing is natural. The attitude that "birthing is part of life when things go wrong"[237] is held, coupled with the relationship formed between woman and their midwife, has been suggested to lead to low claims (less than ten identified by those consulted).[238]

235 KNOV (The Royal Dutch Organisation of Midwives), 2012.

236 Veldhuis M 1994.

237 Personal communication, April 2013.

238 Ibid.

## 4.5 New Zealand

### Homebirth at a glance

Like the Netherlands, New Zealand Government agencies define childbirth as a life process rather than a medical event,[239] and have structured their maternity services within a primary health care model. This model puts women at the centre of choice over their care. In 1996, women have been required to nominate a lead maternity caregiver (LMC) who provides them with continuity of care throughout their pregnancy and birth into the first six weeks postpartum. The LMC can be a midwife, doctor or obstetrician, and is a free service for women, paid for by the Government.[240] Such models are increasingly supported within literature and may provide consideration as to their appropriateness in the Australian context.[241]

In 1990, the *Nurses Amendment Act* allowed midwives in New Zealand the ability to practise independently, without the supervision of a medical practitioner. This along with changes to financial remuneration and the LMC have resulted in an estimated 80 per cent of primary care being provided at present by midwives.[242, 243]

Midwives can provide services in different roles such as:

- community-based/self-employed midwives (independent midwives)
- hospital midwives (core midwives)
- educators and managers.

Independent midwives are the equivalent of PPMs in Australia. These midwives can work independently, but most often work within small practices. Under section 88 of the Ministry of Health's *Primary Maternity Services Notice*, LMCs (including independent midwives) can obtain access arrangements with other public health service facilities.[244, 245] While the other health professional (eg an obstetrician) will be responsible on transfer for making care decisions, the LMC midwife can continue to provide support to the woman.[246]

Like Australia, the number of independent midwives and homebirths is not known as data are often not collected. Consultation, consumer groups and researchers suggest that five per cent of midwives oversee homebirths,[247] and between six to ten per cent of women have a homebirth.[248, 249, 250]

All midwives, including independent midwives, must be registered with the Midwifery Council for New Zealand and attend compulsory annual and triennial updates, as well as professional activities (eg teaching) to remain registered. Like the KNOV, the New Zealand College of Midwives (NZCOM) is a

239 Guilliland K 1999.

240 Ibid.

241 Iglehart JK 2013.

242 NZCOM, Personal Communications 2012, where New Zealand was communicated as not having private practitioners.

243 Kutinova A 2008.

244 Ministry of Health (NZ), 2007.

245 See link for more information on access arrangements: www.health.govt.nz/publication/section-88-primary-maternity-services-notice-2007

246 New Zealand College of Midwives, 2013a.

247 Personal communication, November 2012.

248 Ibid.

249 Guilliland K 1999.

250 Wastney M 2012.

professional body that supports midwives. While membership with NZCOM is not mandatory, it is recommended.

## Indemnity insurance history

From consultations held it is understood that insurance has always been available for midwives. However, this could not be verified. PII is not compulsory for midwives in New Zealand. It is however required by the Ministry of Health for all health practitioners holding an access arrangement with a public health service.[251] Therefore, by virtue that access arrangements to other health facilities are widely held to be a necessary component in the provision of safe care, midwives most often will hold PII.

## Indemnity insurance model

NZCOM provides PII for midwives to all members (estimated to be 90% of practising midwives[252]), regardless of their practice setting. NZCOM provides two forms of assistance:

- **An insurance product:** this covers public liability damages incurred in the home as well as within health services for all legal matters in relation to regulation bodies, the Health and Disability services Commissioner, Coroners Courts, ACC investigations and civil courts (Medical misadventure)
- **Legal support:** NZCOM assists in finding a lawyer to provide legal services.

PII is included as a part of the NZCOM membership. At present, the membership fee is approximately $800-$900 (NZD), of which approximately $100-$110 (NZD) relates to the insurance premium. This is a relatively low fee in comparison to other jurisdictions researched, as a result of:[253]

- **Subsidy:** the product for members being subsidised by NZCOM
- **Quantum:** the product only covers up to $1 million (NZD) per year.[254, 255] This is relatively low compared to other jurisdictions. The size of the quantum is linked to the social insurance scheme (ACC) – see 'Enablers of model'
- **Group cover:** QBE, the insurance underwriter, provides group cover to NZCOM as opposed to individual cover for each member
- **Risk-cost sharing arrangement:** QBE, the insurance underwriter is subsidised by NZCOM
- **Role of NZCOM:** the support and risk management by NZCOM – see 'Enablers of model'.

## Incidence and claims

Consultation with the broker and NZCOM indicated that there has been a low incidence and level of claims (approximately 30 per year), such that the rate of NZCOM membership has grown faster than the number of claims (approximately ten per cent growth in midwives compared to five per cent growth in claims).[256] This low incidence and level of claims is in part driven by the involvement of

251 New Zealand College of Midwives, 2013a.

252 Personal communication, April 2013

253 Personal communications, November, January and March 2013

254 New Zealand College of Midwives, 2013b.

255 There are an unlimited number of times that a product holder can place a claim during the year.

256 Personal communication, March 2013.

NZCOM as well as the impact of accident compensation insurance (see 'Enablers of model' below). Consultations identified that claims paid normally range between $1,000 and $1,500 (NZD).

We have been informed through consultation that there has only been one big claim of approximately $300,000 (NZD) raised in the past[257] and no significant PII outcome issues specifically in relation to homebirth in the 15 years that NZCOM has held cover for its members as LMCs.[258, 259]

## *Enablers of model*

There have been three key enablers identified through literature and consultation that appear to facilitate the provision of PII for independent midwives. These are:

- **Accident compensation insurance:** the impact of the Accident Compensation legislation (ACC)
- **Defined roles and frameworks:** scope of practice, risk frameworks and collaboration between maternity service providers
- **Involvement of NZCOM:** facilitation and relationship between NZCOM and insurers, and training.

### *Accident compensation insurance*

Since 1974, the accident compensation scheme came into operation under the administration of the Accident Compensation Corporation (ACC). Currently administered under the *Accident Compensation Act 2001* (NZ), this insurance scheme provides cover for all, through levies allocated to employers. Where an injury has occurred, compensation and support can be provided in the form of treatment, work and home assistance (eg childcare, home help, equipment), and rehabilitation for long-term injury.

As it covers all forms of injury and death regardless of fault, age, or cause of injury, adverse maternal or perinatal outcomes in birth are also included. The result is that compensation is not claimed against midwives for ongoing care. This has a relatively significant impact on the quantum of claims raised.

> ***"The Guidelines are owned and respected by all parties and help assist everyone to make sound and safe decisions about when another level of care is required. Midwives know that if they need to transfer to hospital they will be received by obstetricians that respect their expertise and support the woman's right"***
>
> *(Guilliland K, 2011)*

### *Defined roles and frameworks*

In New Zealand, the Ministry of Health, with input from an expert working group including midwifery, obstetrics, paediatrics and anaesthetics as well as consumer representatives, developed a national risk framework, the *Consultation and Referral Guidelines* ('Guidelines').[260]

257 Ibid.

258 Ibid.

259 At the time of finalising this report, data from New Zealand were still being collected.

260 See link for more information on the Guidelines: www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines

This framework provides:

- a list of conditions and criteria about referring pregnant women for consultations with other clinicians
- guidelines for transferring clinical responsibility for care to specialists
- guidelines for transferring care in emergencies.[261]

The literature has highlighted that while midwifery-led practice is not fully supported by all health practitioner associations, there was productive involvement and consensus on these referral guidelines or 'risk list'.[262] In combination with access arrangements, these guidelines supported by a multidisciplinary team (MDT) contribute to safe practice, and in effect, may reduce the perceived risk profile of midwives by insurers as they:

- **Uphold women's choice:** women are likely to be supportive of transfer because continuity of care may be seen with a midwife. As a result, midwives may also refer on a more timely basis
- **Define scope of practice:** there is a clear and consistent framework under which midwives in New Zealand provide care. This allows insurers the ability to understand what they are insuring
- **Support best practice and consensus:** agreed frameworks across the MDT may give insurers comfort that the Guidelines reflect best practice activities.

A consistent and agreed framework could be considered further as to its applicability in Australia to assist in reducing the risk profile (see Chapter 5).

### *Involvement of NZCOM*

NZCOM is an active participant in facilitating PII for midwives (including independent midwives). Representatives from both NZCOM and the broker considered that NZCOM's involvement was important to facilitating the development of an insurance product, including brokering the arrangement and the subsidy and involvement in managing incidents and claims.[263]

A key component of the PII model is the group-cover arrangement facilitated through NZCOM.[264] In New Zealand, individuals do not purchase a separate personal policy. Instead, the group who are solely composed of NZCOM members are insured as a whole. This assists in risk profiling as risk assessment is of a broader group, providing the necessary scale of practice.

NZCOM also provides a subsidy to midwives for the cost of PII. This may make the premium more affordable for midwives, compared to those within other jurisdictions. With the premium costs absorbed in the NZCOM membership fees, more midwives may be likely to purchase the cover (even those that may already be covered under their employer's vicarious liability). This is because they are already paying the premium as a result of purchasing the membership as opposed to wanting to purchase PII directly. The result of this is that the scale of practice may indirectly increase, impacting favourably on the risk profile of the group (as a form of risk subsidisation).

NZCOM also actively assists in the processing of adverse incidents, which reduces the cost of premiums. Incidents are received by NZCOM and are processed through their in-house legal team.

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261 Ministry of Health (NZ), 2012.

262 Guilliland K. 1999.

263 Personal communications, November, January and March 2013.

264 Personal communication, March 2013.

This filtering process assists in reducing the number of claims, resolving many of them prior to being submitted to the insurer. This also reduces the cost borne by the insurer in managing incidents in addition to using affordable legal assistance.

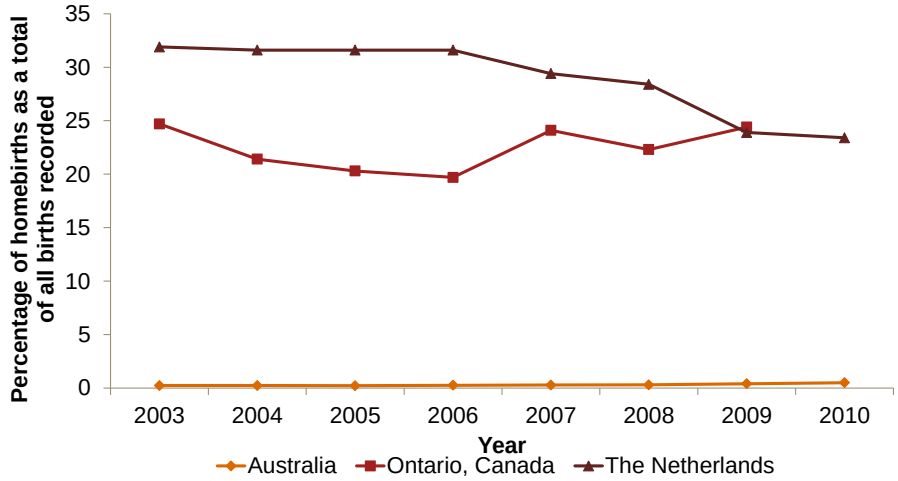
NZCOM also manages the risk of claims through the development of strong Quality Assurance frameworks negotiated in partnership with the Midwifery Council of New Zealand. It also provides ongoing education, training and development for midwives.

## 4.6 Summary of findings and lessons learnt

In analysing the four international jurisdictions, several components of the models were evident in assisting or enabling the development of PII for PPMs. In some cases, these components were evident in more than one jurisdiction. While each component must be considered within the context and environment that midwives practise, they do provide insight or consideration for the Australian market.

One key finding is the level of homebirths internationally is markedly higher than that seen in Australia. Using data from the Netherlands and the province of Ontario (statistics were not available for England and New Zealand), this can be seen in Figure 15.

**Figure 15: Comparison of homebirths percentage of a total of births per jurisdiction (Australia, the province of Ontario, Canada and the Netherlands)**




**Sources:** Australian Institute of Health and Welfare 2004b-2013; Commonwealth of Australia 2008b; Statistics Netherland 2013; HIROC, Personal Communications, 2013; Statistics Canada 2009, 2013.

While the variation may not all be linked to PII, it does make an interesting comparison in relation to the environment and perception of homebirths within different jurisdictions. From the enablers presented supporting the practice of independent midwives, key lessons from the insurance models within the four jurisdictions were identified. These have been outlined in line with the premium equation:

- size of practice
- probability of claims and timing of claims
- quantum of claims.

## *Size of practice*

From assessing the four jurisdictions, as outlined in Table 13, it appears that the development of an insurance market appears viable in a number of different ways, based on the practice size and how practice is defined.

**Table 13: Size of practice: enablers for insurance**

| Enablers for insurance | Lessons learnt |
|---|---|
| Number of midwives | A limiting factor to being able to provide an insurance product is related to the number of midwives who provide intrapartum care at home, given that the number is relatively low. For example, English insurers saw that 170 independent midwives was a limiting factor for providing individual insurance cover. |
| Pooling of midwives for insurance | Expanding the insurance products to be accessible to all midwives, as opposed to just midwives providing homebirth services through cross subsidisation, was a method in which scale was increased within other jurisdictions, eg the Netherlands, New Zealand and the province of Ontario.<br>However, in the province of Ontario, all midwives are required to provide homebirth services. Also, in most of these jurisdictions, midwives are often not covered under the vicarious liability of their employer (as they operate within private practices). |
| Operating entity of midwives | Where there are only a limited number of midwives who are providing intrapartum care in the home, different operating entities ranging from sole practitioner to group practices affect the viability of insurance products.<br>In England, PII was only available to group entities due to the cost of the premium, that the premium supported by the company, and vicarious liability provided through the entity.<br>Other jurisdictions insured midwives independently (eg the Netherlands) due to a sufficient scale of practice.<br>In other jurisdictions (the province of Ontario, New Zealand), the scale of practice was built through the involvement of the relevant professional association. |

## *Probability of claims*

There were several components within each jurisdiction that assisted in reducing the risk profile in relation to the probability of a claim arising. A summary of these are outlined in Table 14.

**Table 14: Probability of claims: enablers for insurance**

| Enablers for insurance | Lessons learnt |
|---|---|
| Risk management frameworks | Clear and consistent national risk management frameworks and interpretation of these frameworks appears to help reduce the probability of a claim being made.<br>Insurers in each of the jurisdictions identified that the development of frameworks that clearly articulated the scope of practice of midwives (including homebirths), and guidelines for referral, consultation and transfer were important to reduce the risk profile.<br>An understanding by insurers of these risk frameworks was also seen to be of |

| Enablers for insurance | Lessons learnt |
|---|---|
| | assistance in developing a product for them to understand best practice care. |
| Collaboration on governance and professional management | The Flaxman Report in the UK held that PII was attractive when an entity has strong governance and appropriate professional management, specifically in supervision or overseeing of the operational conduct and control and standards of practice.<br>Strong relationships and cooperation by maternity health care professionals in the development of frameworks and governance was seen to be important. For example, both the Netherlands and the province of Ontario had guidelines developed in partnerships between relevant bodies. |
| Additional quality registers, training and competency | Additional quality registers can be used to give more comfort to insurers around the practice of midwives. KNOV in the Netherlands has an additional quality register for midwives. Similarly, independent midwives in the UK have a separate register for midwives.<br>The level of skill, training and ongoing professional development within registers as well as membership with professional associations in each jurisdiction were identified by insurers as providing additional comfort on the quality and skill of the cohort they were insuring. |
| Specificity of data available for outcomes from homebirth | All insurers identified that specific data were essential for assessing the practice of PPMs and to complete actuarial modelling. Insurers in all jurisdictions except the Netherlands identified deficiencies in data collection. Some had taken it on themselves to collect data, while others had suggested improvements to national data collection. |
| Access arrangements | Access to other health services by the midwife was identified as important in increasing the safety of practice. Access arrangements support the timely transfer of mothers as they are aware that continuity of care can continue in the other health sites. While access arrangements and clinical privileging where rights to provide care within health settings were only available in New Zealand and the province of Ontario, arrangements to continue to support the women (eg the Netherlands) were seen as beneficial.<br>The benefit of access arrangements were only seen to be fulfilled when coupled with collaboration and mutual understanding of roles by all health professionals. |
| Geographical distance | Some jurisdictions such as the Netherlands identified that the location of the midwife to the woman, and the woman to other health services is important. The geography of the jurisdiction was not seen as important. |
| Litigation culture | It was held that if fewer claims are likely to be made then there is more chance that a product is provided. The Netherlands has a litigation culture where few claims are made and this is one of the reasons provided to explain the competitive market for insurance.<br>This was supported through the disciplinary processes that supported the claims. Understanding what mothers were seeking from their claims was held to be important to reduce the number of claims put forward. |
| Involvement of professional associations with insurers | Relationships and partnerships between professional associations and insurers were also seen to be important to assist in the development of an insurance product. It was evident that each party in the relationship provided different functions to assist the provision of a product. For example, in New Zealand, NZCOM has an in-house legal team to assist with incidents |

| Enablers for insurance | Lessons learnt |
|---|---|
| | reported, while HIROC, the insurer in the province in Ontario, provides additional training for product holders to improve the quality of professionals insured. |
| Profit motives of insurers | NFP insurers such as HIROC held different motives for entering the market. As HIROC exists for members and is owned by members, it means that members have agreed to share losses. This is linked to their model of sharing risk, and therefore the absence of a premium pool. While premiums are set on risk, the losses are covered by all. |
| Operating entity provides financial capacity to deal with claims | Having the scale of practice of two or more midwives was shown in England to provide operating entities with better capacity, both financially and legally, to deal with claims. |
| Practice models | In most of the practice models within each jurisdiction, there was a requirement for more than one health professional to be in attendance. In some jurisdictions, this was another midwife (New Zealand), and in others a maternity assistant (the Netherlands). Insurers noted that this provided them with comfort over the safety of the birth, and a second opinion for appropriate and timely transfer.<br>Other jurisdiction (England) also had a supervisor model which assisted in providing support. |

## *Quantum of claim*

The quantum of claims internationally demonstrates that the claims for disability or death can be high. However, the international models also demonstrated several mechanisms that can bring down claims as seen below in Table 15.

**Table 15: Quantum of claims: enablers for insurance**

| Enablers for insurance | Lessons learnt |
|---|---|
| Actuarial understanding of quantum | Actuarial modelling shows that the quantum of the largest claims, ie disability, has been historically high for PPMs. Separating out claims relating to certain forms of disability (as seen in England) can assist in assessing potential payments required. |
| Social insurance | Social insurance schemes such as those seen in the Netherlands and New Zealand assist in reducing claim size. This is because payments for support and cover in the case of disability are covered through other social insurance payments. |
| Caps on claims[265] | Caps on claims make legal fees lower and can bring down the quantum of a claim. Caps exist in the province of Ontario and therefore reduce the size of the claim made. |

265 Consideration on DisabilityCare Australia is made in Chapter 5.

# 5 Considerations and next steps

## 5.1 Future directions

### Summary of key findings

From the investigations into national and international PPM practice and PII arrangements, issues identified were grouped into six key findings as outlined in Table 16.

**Table 16: Summary of key areas appearing to make the PII market for PPMs unattractive to commercial insurers**

| | Title | Description |
|---|---|---|
| **Communication of practice and available data:** | | |
| 1 | Practice | There is variation and/or lack of clarity in midwifery service provision and the risk frameworks that guide quality and safety, creating uncertainty about how to insure services. |
| 2 | Data quality | The availability and quality of data is currently insufficient to confidently understand the extent of PPM practice and the associated risk. |
| 3 | Data relationships | Currently, the relationship between incidence and claims is not well understood, and the lack of substitute data adds to uncertainty over a PPM's risk profile. |
| **Inherent risks with maternity services:** | | |
| 4 | Scale | The number/volume of PPMs practising currently is not sufficient for commercial insurers to provide a financially viable product. |
| 5 | Inherent risks | PPMs, as maternity service providers, will always have inherent risks in practice that cannot be fully mitigated. |
| 6 | High expected value of claims | Claims can be relatively significant as they relate to human life and death or potential ongoing and long term disability. |

Experiences in other jurisdictions have shown ways in which the level of uncertainty and inherent limitations has been addressed to provide PII to PPMs.

### Future avenues available

While the findings above have identified potential barriers to current PII provision, they do not easily highlight the way forward in Australia. They provide some insight into why PII for intrapartum care provided by PPMs does not exist and how the current context of PPM practice does not meet the needs of insurers in terms of the premium equation. The scope of this review did not require recommendations on how to address these issues and so the following considerations instead have been provided to assist in moving the resolution forward.

Despite the challenges and given the international evidence, birthing with PPMs is believed to be a reasonable choice for certain expectant mothers to consider and carry out. It will therefore continue in

some form or another and any legislation to remove or further prevent PPMs from practising would be likely drive the practice 'underground', further contributing to broader risks.

Consultations highlighted that due to the complexity of the issue of PII for PPMs, there is no 'quick or easy fix'. Stakeholders identified that the issue of PII for PPMs is more complex than many other insurance arrangements and that to resolve PII for PPMs by producing a feasible product it may require a suite of changes to either (or both) of the following:

- the way in which all available maternity services are provided and supported on a holistic level
- the PII insurance market and how indemnity is provided to maternity services.

Consultations highlighted many steps that could be taken to address issues relating to each of these points. For example, collecting information on PPM activity could be easily implemented by NMBA as a part of the registration process for midwives, which would assist data quality.

To move forward in relation to the issue of PII for PPMs, there appears to be only two realistic avenues available. Each has both benefits and challenges which need to be considered to determine the future steps to be taken.[266]

### *1 Remove the exemption and establish the market*

This option involves removing the exemption within the National Law and with the support of the Federal Government and the PPM industry (and likely broader midwifery and obstetric engagement), put in place the foundations necessary for insurers to construct and deliver sufficiently comprehensive insurance products. The result of doing this would to effectively create the market forces necessary to establish the PPM insurance market. Such an option may require Government subsidy in the short term until data and confidence can be determined.

- **Benefits:** Active steps are taken to facilitate PII for PPMs in the future which would resolve the issue of the exemption
- **Challenges:** There are a range of challenges for this avenue. One challenge is in identifying what steps to take, what will have the biggest influence and when they should occur. Another is the number of key influencers from which 'buy in' may be needed to resolve this issue. As a regulator, the NMBA has a mandate over several components of PPM practice, including for example, registration (and the adherence to a safety and quality framework, renewal of registration, continuing professional development requirements) and disciplinary matters, but not all necessary areas to support this avenue. From the inception of the new scheme, over the past three years, the NMBA have been working closely with other agencies including the DoHA, state and territory bodies and this would need to continue.

  Collaboration and participation of other key stakeholders may include, for example, state and territory in addition to Federal government health departments, Colleges and associations representing maternity service providers, health care service providers, as well as insurers, consumer representatives and PPMs themselves. Therefore the NMBA should be encouraged to continue to work in a collaborative way to facilitate ongoing discussions.

### *2 Status quo*

This is the 'do nothing' option in which the exemption is kept in place indefinitely.

- **Benefits:** PPMs can continue to provide services as they are currently

266 An example of the benefits and challenges are outlined below; however, this list is not exhaustive.

- **Challenges:** This option does not resolve the issue that PII is not available for intrapartum care provided by PPMs in the home. PPMs remain exposed to claims in the delivery of intrapartum care and the intent of the National Law (that all health practitioners hold PII) is not upheld for this cohort. This option also fails to address the current issues within the delivery of maternity services: that women remain exposed to risk through lack of insurance; and have their choices reduced as many women are unable or unwilling to access non-insured services even though such services may be their preference.

The option of removing the exemption without any further action could have the potential to limit choice for women, placing reliance on publicly funded homebirth schemes (which are not currently available in all states and territories or available to all women) (see Appendix G) for women to access birthing services in the home. This avenue may result in unintended consequences, including an increase in the number of women having free births,[267] or an increase in 'birthing assistants' who are unregulated as the service is driven underground. These latter issues are likely to increase individual risks for women and babies, and would have impacts on the health system downstream as some women and babies will ultimately arrive in mainstream health services requiring care.

## 5.2 Considerations

In order to resolve the issue, a number of steps may need to be taken. However, it is unclear which actions would be the most influential in resolving intrapartum care PII for PPMs providing care in the home.

The reason for the uncertainty is that the environment in which PPMs operate in Australia is unique, particularly in relation to the barriers and lack of support for PPMs to obtain PII. While international practice and PII arrangements can provide insight into PII for PPMs, insurance arrangements exist within their own cultural, legal, health and insurance contexts. However, the following points should be considered in the context of any next steps taken:

- **Insurers:** it should be recognised that commercial insurers assess profit when developing a product. Profit is determined through a risk assessment when setting a PII product premium through consideration of size of the market and the probability and quantum of potential claims. The way PPM risk is assessed influences the ability for a PII product to be developed. The emphasis on profit is less for NFP or reciprocal insurance providers

- **PPM practice:** current PPM practice is driven by the context in which it operates. PII may only be able to be provided for intrapartum care if there is clarity in the services that PPMs provide and clarity in guidelines for the selection of women, consultation and referral to mainstream services and documentation and collection of outcomes

- **Stakeholders:** there are many stakeholders that can influence the ability to provide PII for PPMs.

With all of this in mind, research completed and consultations held identified eight broad actions or options which may be considered further. These options are in line with the findings presented in Chapter 3 (see Table 17). As such, this table does not reflect a priority listing of considerations.

267 Free births are defined as unassisted births where women give birth intentionally without the assistance of a health practitioner.

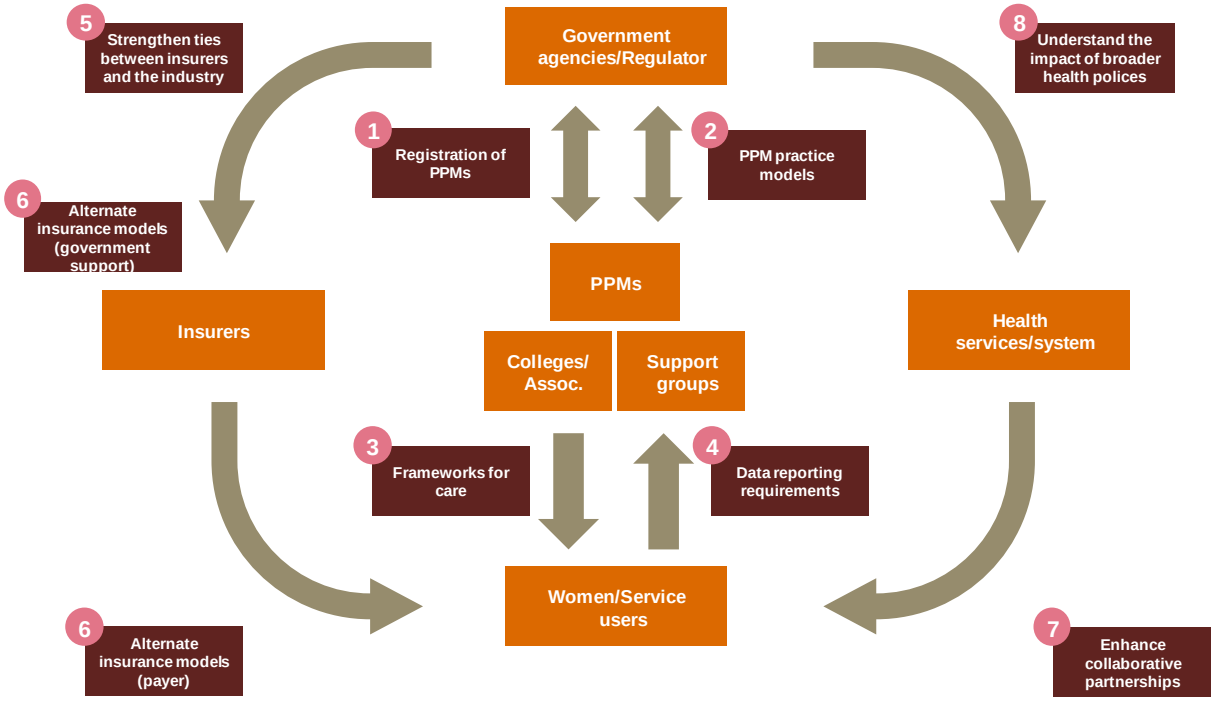
**Table 17: Options for further consideration and discussion**

| Option | Title | Description |
|---|---|---|
| **To address the communication of practice and available data:** | | |
| 1 | Specific registration of PPMs | Consider the requirement for PPMs to register as a separate sub-class or as an eligible midwife, or be required to practise in a professionally networked supportive model of practice in order to access PII. |
| 2 | PPM practice models | Explore the facilitation of different options for private midwifery practice, ie partnership or group legal entities as mandated for service delivery to the extent that it does not restrict practice or violate trade and practices legislation. |
| 3 | Frameworks for care | Develop clearer national safety and quality (including risk assessment) frameworks for births in the community as well as support models for PPMs that address compliance, complaints and the capability to meet the framework requirements. |
| 4 | Data reporting requirements | Assess the feasibility of improving data quality and collection. Ensure that data collection systems can identify women attended by PPMs, place of birth and transfers from home to hospital. |
| **To address inherent risks of maternity services:** | | |
| 5 | Strengthen ties between insurers and the industry | Encourage stronger relationships between insurers, the NMBA, state/territory and Federal governments, midwifery and medical practitioner representatives. |
| 6 | Alternate insurance models | Consider the range of insurance models and enabling factors seen internationally for the provision of PII. |
| 7 | Enhance collaborative partnerships | Identify factors prohibiting collaborative partnerships between PPMs and health services that could mitigate PPM practice risk for PII development. |
| 8 | Impact of broader health policies | Consider the impact of policies, particularly enablers that will support the provision of PII for PPMs. |

In Figure 16, these findings can be seen to:

- be interrelated
- relate to various components of the broader context of PPM practice
- involve multiple stakeholders.

**Figure 16: Interrelationship of options for consideration**




These options are presented to evoke further conversation and discussion in the relation to the issue of PII for PPMs.

## *Communication of practice and available data*

The findings identified an issue in relation to the availability and communication of data which appears to have led to risk assessments being influenced by claim and counter claim, ultimately driving a lack of confidence and certainty within the insurance market on PPM practice. As a result, variation in practice and frameworks as well as a broad definition of the practice, impact upon insurers having the necessary information to complete an accurate assessment of PPMs.

### *Option 1: Registration of PPMs*

**Consider the requirement for PPMs to register as a separate sub-class or as an eligible midwife, or be required to practise in a professionally networked supportive model of practice in order to access PII.**

Consultations highlighted that broadening the requirement for all PPMs to be registered beyond the midwifery requirements of the NMBA should be considered. Evidence to support this consideration would be of assistance in determining its benefit. Options for consideration include:

- requiring PPMs to register as eligible midwives
- developing a separate sub-class for PPMs to register under
- requiring PPMs to practise with an eligible midwife to obtain PII.

One thing that in the interim could easily be completed would be requiring the nomination of type of practice as a part of registration as a midwife with the NMBA. This information could also be added to the AIHW data collection at time of registration. This would at least allow information to be gained over time on the relevant numbers, activities and method of service delivery.

### Register as an eligible midwife

As per Finding 1, eligible midwives are a sub-class of registration for midwives in Australia that allows a midwife to be eligible for Medicare Benefits and Pharmaceutical Benefits Scheme reimbursement. At present, only one of the insurers (MIGA) requires PPMs to register as eligible midwives (or to demonstrate the intent to do so), in order to be able to purchase PII. As a result, not all PPMs are eligible midwives, as there is no requirement to be so. As highlighted in our survey, only 74% of survey participants that identified as a PPM also identified as an eligible midwife (see Appendix D.1).

Requiring PPMs to register as an eligible midwife may provide additional registration requirements for PPMs including competency, skill, professional development and experience. It is for this purpose and not others (eg the associated payment scheme) that eligible midwives should be considered. Consultations both internationally and nationally identified the importance of these components to the risk assessment of PPMs and their ability to successfully provide care within their scope of practice. Making this a requirement could be beneficial for:

- developing and applying a baseline of competency and experience across PPMs for the purpose of risk assessment of PPMs
- supporting the monitoring of practice and outcomes, given that data is currently collected by Medicare Australia (and there is scope to collect additional information).[268]

For this option, consideration should also be made of the unintended consequences of having an additional registration requirement. Consultations identified that mandating PPMs as eligible midwives may lead to PPMs exiting the market due to the requirements of being an eligible midwife. This was supported in the survey where 42% of those that did not identify themselves as being eligible midwives gave the reason for this as registration restrictions. Other consultations identified issues around meeting the requirements to become an eligible midwife including holding collaborative arrangements with medical practitioners, the size and location of PPMs currently practising. Further consideration should be made of any potential legal implications of this requirement, particularly around restrictive trade practises.

It may be that instead, that consideration should be made on the requirement for PPMs to meet elements of an eligible midwife but not be required to register as one.

### Separate sub-class for registration

Building on the requirement of being an eligible midwife is the alternate development of a separate sub-class for registration. A separate registration class for PPMs was identified by some who were consulted as the preferred option because:[269, 270]

- registration for eligible midwives was not developed specifically for the purpose of PII for PPMs
- there are additional components to those required for the eligible midwifery status that may be assessed as necessary to support PII for PPMs (eg group practice and data collection/recording)
- there may be components of the eligible midwifery status that are not necessary for PII for PPMs and that may be precluding PPMs from registering
- some stakeholders held the belief that components or requirements for eligible midwives required an update or needed to be iterated and modified subsequent to their introduction.

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268 To the extent that Medicare Australia plays a role in monitoring practice and outcomes.

269 Personal communication, November 2012.

270 Personal communication, November 2012 and March 2013.

Unintended consequences similar to those discussed in the previous section were identified in consultations which the NMBA should consider when assessing this option of a separate registration class.

### Require PPMs to practise with an eligible midwife

It was identified in consultations with a range of stakeholder groups that registering either as an eligible midwife or as a PPM within a special class may prohibit practice or cause unintended consequences. An alternative option raised within some consultations was to require PPMs to practise with an eligible midwife. The intent suggested is that an eligible midwife, with additional requirements to become eligible and monitoring requirements may support improved safety and quality in practice. International consultations identified that an additional experienced attendant at the birth assists in reducing the risk as there is an assumed level of competency. Having an eligible midwife in attendance could achieve several functions:

- **Supports a group model:** as outlined in Option 2, group models are seen to support safe practice and can support the professional development and competency of midwives
- **Competency:** it provides insurers with an understanding of a certain level of competency, experience and skill in attendance at the birth
- **Monitoring and data:** it has the potential for additional information to be collected and provided by the eligible midwife which otherwise would not have been provided.

These have each been identified within our research as important to reduce the risk profile of PPMs for the purpose of PII. However, whether these functions would be achieved needs to be investigated further.

The challenge with this model in Australia is that there is a relatively small number of midwives registered as eligible midwifes. As a result, there may be an insufficient number to facilitate this option. Requiring a small number of health professionals to work together when there are not enough of them may have the unintended consequence (not directly related to PII for PPMs) where service accessibility to women is reduced. The alternative, looking to models in other jurisdictions, is requiring more than one in attendance. This is discussed in further detail in Option 2 below.

## *Option 2: PPM practice models*

**Explore the facilitation of different options for private midwifery practice, ie partnership or group legal entities as mandated for service delivery to the extent that it does not restrict practice or violate trade and practices legislation.**

Each jurisdiction researched identified the importance of the following, for the development of PII for PPMs:

- **Training and development:** Midwives should hold a certain level of competency
- **Collegiate support:** Midwives should have support in terms of service delivery as well as training.

As a result, the research offers several considerations for the NMBA:

### Supervisor models

NMBA should consider avenues to support the level of competency in PPMs including establishing performance standards and developing assurance mechanisms that these are being maintained. This is because a certain level of competency in PPM practice has been identified within consultations as important. It provides a level of comfort over the person being insured, and assumes a level of risk that would be undertaken based on experience and skill. Completing ongoing training and professional

development was identified as important so that ongoing best practice can be understood. As a result, many insurers, including MIGA, provide training and development as a part of the product.

Building on training and development, several consultations highlighted that the implementation of supervisor models could improve the risk profile of PPM by enhancing safe practice. Supervisor models (see Chapter 4 – England) involve each midwife being assigned a supervisor. These supervisors are intended to provide guidance and support for midwives in their care of women.

> ***"Supervision, where it works well, seeks to foster an environment of supportive, safe and effective practice"***
>
> *(Lewis P, 2012)*

There were two schools of thought from those consulted, in relation to supervisor models which would need further consideration by the NMBA. Some stakeholders felt that while this model could support not only training and development but safe care, its value was lost if PPMs were not provided with PPM supervisors. This was because it was felt that other midwives (such as those that do not currently practise in the community) could not provide sufficient and relevant insight into the challenges of PPM practice. Given the current number of PPMs, assigning a sufficient number of supervisors could be problematic. In contrast, others believed that given the scope of practice of midwives adequately allows a PPM to be assigned a non-PPM supervisor.

Furthermore, the literature states that increasing regulation and bureaucracy in the model, as well as the negative approach undertaken (ie where midwives are policed in practice and criticised or punished for adverse outcomes) can diminish its benefits.[271] Therefore, further consideration of the structure and practical application of the supervisor model would need to be tested further for applicability in the Australian context.

### Group practice

Group practice is a model that many who were consulted with felt should be considered by the NMBA to regulate as a requirement of practice, or alternatively, be a requirement of insurance. This is for several reasons, each making PPM practice more favourable in terms of PII:

- **More than one attendant at birth:** having more than one attendant at a birth was identified in each jurisdiction researched, whether they were other midwives or other health professionals. This assisted the risk profile as there was another person to assess the woman and provide assistance in the delivery of safe care and decision-making

- **Cover for workload:** it was identified that by having a group practice, it was possible for midwives to share workloads, particularly when more than one mother was in labour at the same time. Through this, timely and safe practice could still be provided

- **Insurance arrangements as a legal entity:** as shown in the English independent midwifery PII model, the insuring of a legal entity (ie a group practice) facilitated the development of a PII product (see Chapter 4 and Option 6)

- **Quality accreditation:** as a group practice, as seen in the English model, additional quality accreditation standards were required to be met as a part of registering the entity as a health care provider. This gave the insurer insight, through official accreditation, over the risk assumed by the entity

- **Collegiate support:** one success identified of the legal entity model was that there was a vested interest in the owners of the practice to support the development and competency of

271 Lewis P 2002.

other joint owners of the business, not only for collegiality but also in terms of the risk attached to premiums for the business. As a result, they could assist one another. This was seen to support the development of a PII product.

Again, issues were identified in terms of the group practice, the main one being the small number of PPMs currently practising which would need to be overcome (eg through having multiple locations of practice). If a group practice was mandated, then this may result in the same unintended consequences as described in the previous Option, of limiting access of birth options for women. In their role, the ACM may be an appropriate entity to pursue this consideration further as opposed to the NMBA in their regulatory role. Another consideration is whether this would be considered as restrictive trade practice. Therefore further investigation on the practicalities of this model may be required by entities such as the Australian Competition and Consumer Commission (ACCC).

### *Option 3: Frameworks for care*

**Develop clearer national safety and quality (including risk assessment) frameworks for births in the community and support models for PPMs that address compliance, complaints and the capability to meet the framework requirements.**

Currently, the findings identified uncertainty around:

- the scope of practice of PPMs (and other health professionals) in terms of the frameworks under which PPMs practise
- assessment of best practice
- indicators that mark a requirement to transfer and refer care to other health professionals.

Despite efforts for a nationally consistent framework of care, including the ACM guidelines, variation in guidelines and frameworks were found. Issues identified (see Chapter 3) included:

- no one nationally consistent framework for midwifery services (let alone PPMs) in place
- numerous frameworks that appear to be equally applicable to the same practice and PPM (eg state-based); varying in terms of requirements and recommendations, particularly for transfer and referral
- maternity service professional associations not appearing to agree on any one framework, and therefore having individual frameworks in place for their members.

A key enabler identified by stakeholders in each jurisdiction that was analysed by this report was the strength of their risk and quality frameworks. These frameworks included several components, such as:

- **A level of training and professional development:** a certain number of hours of training was required to be completed per registration period as well as a number of births attended (eg in the Netherlands and the province of Ontario)
- **Quality accreditation of the practice:** additional standards were required of the organisation in which the independent midwives practise (eg England)
- **Consistent national risk and quality frameworks:** there were developed by all maternity service professionals (eg in New Zealand and the province of Ontario).

In the first instance, NMBA should consider its role in facilitating discussion on developing national risk and quality frameworks building off existing work completed and current standards, guidelines and frameworks. As identified above, consultations identified the importance of the collaborative

development of the frameworks by all maternity service providers. For the development of consultation, transfer and referral guidelines, this is important not only for determining the scope of practice of midwives (and it was identified as important to be led by midwives), but also for a mutual understanding of each professional's role in the care pathway. It was also found to assist in the development of collegiality between the groups, through a better understanding of scope of practice and risk assumed by each partner.

While the need for flexibility in the frameworks was identified as important so they are applicable to the local context, a consistent framework was identified by insurers as important to both develop a risk profile of PPMs and to promote consistency in best practice.

### *Option 4: Data reporting requirements*

**Assess the feasibility of improving data quality and collection. Ensure that data collection systems can identify women attended by PPMs, place of birth and transfers from home to hospital.**

The key issues identified in our findings (see Chapter 3 – Finding 2 and 3) relating to data quality were that data:

- have never been collected
- have not been collected at a level of detail that is sufficient to understand the practice of PPMs, activity levels, incidents, adverse outcomes, and causal factors of incidents and outcomes
- do not distinguish between public and private maternity services
- vary and are collected differently across jurisdictions
- have been lost or archived and cannot be located (this has been identified in the case of insurance products held prior to 2002 by brokers[272])
- are unable and/or unwilling to be shared due to their being commercial-in-confidence or that they may give an unreasonable disadvantage to private companies, eg insurers.[273]

NMBA should explore methods to improve the specificity, consistency and accessibility of data to support the risk profiling of PPMs. Examples of each are shown in Table 18.

**Table 18: Examples of improvement to data quality**

| | Description | Examples |
|---|---|---|
| Specificity | Data being collected at a level that improves the ability for a risk assessment to be completed on PPM practice | Attendance by a health professional at birth (identifying which health professional, and whether private or publicly funded)<br>Place of birth<br>Transfers from home to hospital<br>Registered and unregistered outcomes |

272 Personal communication, February 2013.

273 Personal communication, November 2012.

| | Description | Examples |
|---|---|---|
| Consistency | Data being collected in the same way with consistent definitions applied to data within each state and territory | Time of transfer<br>Intended place of birth |
| Accessibility | Making data available to, for example, policy makers, regulators, statistical organisations (eg ABS, AIHW), or potentially the broader insurance market | Number of incidents<br>Number of claims<br>Number of insurance product holders |

Other jurisdictions have also increased their sophistication in relation to data collection, particularly in the Netherlands and in the province of Ontario. Central recording of information has also been seen in other jurisdictions. These improvements should also be considered.

Consideration of improvements to data quality should be cognisant of the cost-benefit relationship. It is recognised that much of this data cannot be collected (for reasons identified above), or may be costly to obtain. There also may be unintended consequences of improving data quality. For example, commercial insurers may assess that it is more cost-effective to exit the market if it was mandated that they share confidential information. The costs and benefits will need to be weighed up when assessing the extent to which data improvements can be made.

## *Inherent risks of maternity services*

The findings identified that beyond data quality and PPM practice, there are inherent risks within maternity services (including obstetric and midwifery care), combined with a small PPM market that result in limitations to insurance offers. It is necessary to explore these options external to the direct practice of PPMs, and look to the broader health system and insurance models, as has been successful in other jurisdictions.

### *Option 5: Strengthen ties between insurers and the industry*

**Encourage stronger relationships between insurers, the NMBA, state/territory and Federal governments, midwifery and medical practitioner representatives.**

NMBA should consider the relationship between the NMBA, ACM and the insurers as well as both state and territory and Federal governments. Strong relationships with insurers between regulatory authorities and professional associations were common in each jurisdiction analysed (see Chapter 4). Consultation identified that where stronger relationships can be formed, improvements to data quality, risk frameworks and the understanding of the relationships between incidences and claims may result. It could also provide insight as to the necessary role that each of the organisations must provide to support PII for PPMs.

### *Option 6: Alternate insurance models*

**Consider the range of insurance models and enabling factors seen internationally for the provision of PII for PPMs.**

Given that the indemnity exemption ends for intrapartum care provided by PPMs in July 2015, consideration should be given now as to what options are available in terms of PII arrangements, and what actions should be taken. As outlined previously, options available range from removing the exemption to making changes to the way in which PII is provided. If the latter were selected, as the research into international PII models highlighted, the model selected will need to be cognisant of, and appropriate to the Australian environment.

Various options exist in terms of PII models, but each will require varying degrees of change to the way in which not only PII is developed, but also how services are delivered. This is evident in the options below which have been developed as a result of the findings outlined, and international research

completed. Each of these, and their components, may be appropriate for the Australian market, and it is suggested that each of their components should be considered further.

These options given as examples of PII arrangements vary in terms of the payer and provider (ie who is paying for services, and who is being insured). Given that each option has dependent variables, only the key benefits, enablers and challenges are identified. This list is not intended to be exhaustive.

As there is significant complexity in each of the models, information is provided to assist in future discussions. It is recommended that there is further consideration of the mechanics of each of the options and their assessment against an agreed list of requirements:

- individual insurance model
- legal entity funded insurance model
- not-for-profit insurance model (NFP) (eg NFP, professional association, Government supported)
- co-payment insurance model.

### Individual insurance model

This model would be similar to the existing PII arrangements. The variation to existing PII would be a change to the practice arrangements for PPMs in line with some of the considerations outlined in this Chapter.

- **Benefits:** There may not need to be significant changes to the existing practice for this model to work. However, this is unknown at present
- **Enablers:** There are numerous potential enablers to the existing insurance model which have been identified throughout this report: improvements to data quality; improved support to and collaboration with PPMs by other health professionals; support for continuity of care; changes to registration requirements; standardised risk and quality frameworks; standardised scope of practice; changes to practice arrangements (eg group practice, supervisor models); caps on premiums; and establishing or improving disciplinary frameworks. Each of these enablers has been identified as having the potential to assist in reducing the risk profile of PPMs either through making practice 'safer' or of 'higher quality', or improving the understanding of its risk
- **Challenges:** It is unknown whether changes to, or the addition of each of the enablers identified, collectively or in combination, will be sufficient for a PII product to be successfully developed.

### Legal entity funded insurance model

In line with the English model, PII may be offered only to PPMs through a legal entity. In this model, PPMs must form a group and it is the group, not the individual that is insured.

- **Benefit:** This is the only model researched whereby a commercial insurer was able to overcome the issue of scale of practice (and quantum claims). While commercial insurers operate both in the Netherlands and New Zealand, scale was overcome as all midwives were required to have cover, and there were other social insurance schemes in place to assist in terms of the quantum of claims
- **Enablers:** This model still requires a commercial insurance company to assess the risk of PII for PPMs as sufficiently low to develop an affordable product. Sufficient data quality, specificity and actuarial modelling are required as well as potential amendments as to how risk is perceived. Other enablers in terms of the product may need to be considered. For example, the English model included the entity to have minimum excess, a minimum number of births/year, a certain level of quality and also fulfil risk requirements

- **Challenges:** Given the small number of PPMs, forming group practices may be challenging. This may have the unintended consequence of reducing the number of PPMs available and therefore reducing accessibility of services for women. Like the individual insurance model, more stringent PII arrangements may drive practice underground if PPMs feel unable to fulfil them but desire continuing their practice.

### Not-for-profit (NFP) insurance model

There were several versions of an NFP insurance model that were identified within our research and literature:

- **NFP:** One NFP model was found in HIROC, the insurer in Canada. This model involves a NFP entity owned by members who share any profits (or losses) between them. While a risk-based premium is applied, some level of risk subsidisation applies. This model is similar to that recommended within the 'Tito report'

- **Professional association:** Building on the HIROC model, this model involves a professional association or College entering in to a contractual arrangement on behalf of its members. Premiums can be subsidised by the association and may also be paid through membership fees. The professional association enters into a contractual arrangement on behalf of its members

- **Government subsidised:** Under this model, the Commonwealth or state/territory Governments may provide a PII product. Consultations identified that this may be an appropriate interim model to test whether PII for PPMs is profitable, and under what arrangements and conditions.

Hybrid models could also be considered in terms of a potential insurance model by the NMBA.

- **Benefits:**

*NFP* – A PII product can be provided through the risk mitigation of supporting agencies, focusing away from commercial profit.

*Professional association* – This provides a scale of practice as each of the members of the association or College is being insured. This model also has been identified as beneficial in improving the risk profiling of PPMs through a working relationship between the insurer and the association or College.

*Government* – The involvement of the government may also see improvement in data quality and transparency of practice for PPMs, which could lead to commercial insurers providing PII into the future.

- **Enablers:**

*NFP* – The research completed did not identify a NFP PII organisation practising at present. Support may be needed from the Government to establish such an organisation, and legislative requirements to do so may also need to be considered. This organisation would also require scope of practice and a portfolio of products under which it can manage its risk.

*Professional association* – The willingness of associations or Colleges to enter in to the arrangement is required. An insurer will still need to assess the risk profile as sufficiently low to develop a product.

*Government* – This would require the support of the Government Actuary and be prudently assessed as appropriate. Legislative requirements again would need to be considered.

- **Challenges:**

*NFP* – This model may require a cross-subsidisation of risk and given the PII history in Australia, this may not be possible. It also requires multiple large health service entities to be members. In Australia, these could be the equivalent of members within TMFs.

*Professional association* – There are many associations or Colleges specifically for PPMs. This model may mean that the majority of members (eg those not practising in the home) may be subsidising the premium for others. This is not an issue in other places where this model is in operation (eg the province of Ontario and New Zealand), as every midwife while still cross subsidizing the risk, is effectively required to hold individual PII cover.

*Government* – Consultations identified that for varying reasons, there may be significant resistance to this option from other health professional groups. Some felt that PII should only be provided if commercially and financially viable, and should not be subsidised. Some believed that it should not be the role of the government to support and provide PII. Others voiced that this could encourage unsafe practice, and should only occur unless under strict requirements (eg collaborative arrangements, risk and quality frameworks).

### Co-payment insurance model

Similar to other industries, such as the horse racing business, this model involves the mother holding private health insurance (PHI) and providing an insurance co-payment to the PII held by the PPM.

- **Benefits:** Risk is shared between the mother and the PPM. The mother is accepting a level of risk within the relationship

- **Enablers:** Sufficient information would need to be provided to the mother, as well as appropriate legal documentation supporting the co-payment arrangement. From our research, PHI arrangements were not identified to provide this level of information and documentation at present, and therefore changes to PHI may need to be considered. This may have flow-on impacts to PHI more broadly. This again would also require insurers providing PII to assess that this model sufficiently reduces the risk profile for them to develop intrapartum care cover

- **Challenges:** This model has been identified in consultations to have challenges, such as the potential impact on accessibility for mothers. If PHI was required, mothers may not be able to afford the cover. Further investigation of the difference between PHI premiums and PPM fees would need to be completed. Also, access to alternate homebirth services including publicly funded homebirth schemes should be considered by the NMBA.

## *Option 7: Enhance collaborative partnerships*

**Identify factors enhancing collaborative partnerships between PPMs and health services that could mitigate PPM practice risk for PII development.**

The World Health Organization articulates that a multidisciplinary collaborative and coordinated approach is essential to deliver safe maternity care.[274] In light of this, collaboration between PPMs and other maternity service providers and health services is identified as a key area to be addressed. Access to collaborative arrangements with health services would ensure that effective pathways for consultation, referral and collaboration are in place.

Consultations both nationally and internationally, with professional associations, consumer groups, Department representatives and insurers, raised collaborative partnerships as a key issue. Without key

274 United Nations Population Fund, 2011.

tools for collaboration including privileging rights and more broadly, acceptance and respect between PPMs and the broader health service, the risk profile of PPMs in terms of PII appears to be increased. Literature supports that nurses and midwives should be 'full partners' with other health care professionals, including medical practitioners in redesigning the system.[275] NMBA should consider its role in facilitating conversation, or in assisting other government agencies, professional associations and colleges to support good collaborative arrangements.

The research completed has identified several national reviews and pieces of research that have already been completed in relation to collaborative arrangements and partnerships; most notably, the National Health and Medical Research Council (NHMRC) 2010 guidance, *National Guidance on Collaborative Maternity Care* (further discussion on the NHMRC guidance, and collaborative arrangements in general can be found in Appendix E). Within the NHMRC guidance, there were nine principles that outlined the aims of collaborative partnerships, what they should involve and notably, challenges to collaboration. Both the principles and the challenges identified (see Appendix E) were supported by the findings within this report.

> ***"Good outcomes require the supportive continuum of care that may be needed by an individual pregnant woman from all those who provide maternity services. This collaboration is the chain that links community-based primary midwifery care with district and regional care from hospital-based midwives and medical specialists"***
>
> *(Guilliland K, 2011)*

The biggest challenges identified by this project to facilitating effective collaboration (concurring with those identified by the NHMRC (see Appendix E for a full list) were:

- **Defined roles in collaboration:** consultations identified that other professions should not necessarily define the scope of practice for PPMs but should accept and understand it. Agreement on roles in care, particularly around transfer and referral is believed to be important. It was also apparent through consultations, particularly those internationally, that midwifery activity could be or is perceived as competitive to other health professionals. An understanding of roles could reduce this perception

- **Perceptions of litigation:** consultations highlighted that maternity service providers and services felt potentially exposed through relationships with PPMs, in that negligent behaviour would be potentially attributed to them

- **Access arrangements:** unlike in the province of Ontario or New Zealand where care can continue to be provided within the hospital, the limiting or excluding of any of the roles of PPMs from access arrangements in Australia can be seen to be detrimental, and has the potential to delay necessary transfers.

Efforts to enact some of the findings of the NHMRC relating to access arrangements and clinical privileging was proposed through the DoHA's *National Maternity Services Plan* in 2010 (also see Appendix E for further discussion). While the plan seeks consistent frameworks and monitoring to be in place, the onus is on jurisdictions to create frameworks and monitor in the most appropriate form for their state or territory. Consultations highlighted that this has led to variation in access and frameworks between jurisdictions, leading to recommendations for stronger national oversight and leadership.

As a result, examples of effective access arrangements, such as in Queensland, and frameworks, such as in South Australia on clinical privileging, should be further considered. However this should be to the extent that they do not provide additional burden, or are unachievable as some professionals

275 Iglehart JK 2013.

warn.[276] The involvement of an oversight body to assist in the development of generic frameworks should also be considered to drive collaboration and make the risk profiling of PPMs consistent.

Also, the role of public health services in supporting PPMs and providing access to health services should be explored. The NHMRC suggests the development of Memorandums of Understanding (MOUs) or credentialing as possible mechanisms to negotiate hospital access for midwives. Research for this report could not identify whether any further investigation had been completed into either of these options, and therefore this could be something driven further. Supporting access arrangements may be one way to reduce the risk profile of PPMs and facilitate the development of PII.

## *Option 8: Understand the impact of broader health policies on PPMs*

**Consider the impact of policies, particularly enablers that will support the provision of PII for PPMs.**

One of the key findings from this project has been that PPMs do not practise within a vacuum. Their practice is impacted upon by the broader health context. Therefore, in assessing the next steps for PII for PPMs, consideration should be given to enablers within the macro-environment influenced by the Federal, state or territory governments that either currently (or may) exist, or should exist. To explain, here are several examples meriting further consideration:

### DisabilityCare Australia

DisabilityCare Australia is a Commonwealth Government scheme progressively being rolled out across Australia. DisabilityCare Australia is a scheme in which long-term, high-quality support is to be provided for people with permanent disability.[277] Funding is provided to those persons with a disability, based on actuarial assessment of need.

In principle, DisabilityCare Australia appears similar to other social insurance schemes within the Netherlands and New Zealand, but only to the extent that support and funding is to be provided to those with a disability. Further consideration could be made to understand, for example:

- **What is the current status of DisabilityCare Australia?** When will the scheme be fully operational?
- **What would the impact of the DisabilityCare Australia be on PPM adverse outcomes, particularly where they result in a disability?** When DisabilityCare Australia is rolled out fully, would funding cover for outcomes from births in which PPMs assisted?
- **What would the flow-on impact be on actuarial assessments on risk and quantum of claims?** If adverse outcomes from PPM-assisted births were supported in part or in full, what impact would this have on PII?

### Medicare Locals

The role of Medicare Locals as the primary care coordinator in communities should be considered by the NMBA in assessing the future state of PII for PPMs.

As a part of the National Health Reforms, a network of Medicare Locals was established nationally. As defined by DoHA: 'Medicare Locals are primary health care organisations established to coordinate primary health care delivery and tackle local health care needs and service 'gaps'.[278] It is intended that

276 Barclay L & Tracy SK 2010.

277 Commonwealth of Australia, 2013.

278 Department of Health and Ageing, 2013b.

Medicare Locals drive efficiencies through their role as a local coordination point for services. Many health care community programs are being commissioned and led through Medicare Locals.

There may be a role for Medicare Locals in driving PPM activity given their role in primary health care. With more services being driven through Medicare Locals, it will be important to establish any role that they may have, including in partnerships with PPMs. This is because there may be flow-on impacts to PII based on the assessment of risk profile from being in partnership with a Medicare Local.

### Publicly funded homebirth schemes

The future role, expansion and delivery of publicly funded homebirth schemes may impact upon PII for PPMs and should therefore be considered further.

Currently, there are homebirth services provided publicly in several states but not all (see Appendix G). Publicly funded homebirth schemes are based within the public hospital system with PII cover for the midwives provided through vicarious liability of the hospital as part of their employment.

These products (homebirth and publicly funded homebirth schemes) are relatively substitutable to the extent that they both provide homebirth services, and any changes to either model should be considered by decision-makers. For example, if publicly funded homebirth schemes services were increasingly supported, funded and expanded, then the demand for PPM services may fall. This could have a flow-on effect to the scale of PPM practice.

### Cap on claims

Cap on claims refers to the extent of funding that can be claimed, or sought within the courts. In other jurisdictions such as the province of Ontario, this has been found to be important to reduce the risk profile of midwives, as the limit to the quantum of claims paid out is known. While this is not in place at present in Australia, the role of a cap on claims, or limits to payments made could be considered further.

# Appendices

# Appendix A Glossary

## A.1. Glossary listing

**Table 19: Glossary for report**

| Term | Definition |
|---|---|
| Alternate dispute resolution (ADR) | ADR is an umbrella term for processes, other than judicial determination, in which an impartial person assists those in a dispute to resolve the issues between them.[279] Examples of ADR include negotiation, mediation and arbitration. |
| Analgesia | The relief of pain without the loss of consciousness.[280] |
| Antenatal | Antenatal care includes recording medical history, assessment of individual needs, advice and guidance on pregnancy and delivery, screening tests, education on self-care during pregnancy, identification of conditions detrimental to health during pregnancy, first-line management and referral if necessary.[281] |
| APGAR score | APGAR is a quick test performed on a baby at 1 and 5 minutes after birth. The 1-minute score determines how well the baby tolerated the birthing process. The 5-minute score informs the health professional how well the baby is doing outside the mother's womb.[282] |
| Augmentation | Augmentation of labour refers to the use of medication or other intervention to accelerate the process of labour.[283] |
| Case | A case is a proceeding in a court of law whereby an individual or entity seeks a legal solution or remedy for a perceived injustice. The case will generally result in a judge, judges or jury making a judgement about the proceeding, based on the facts and their interpretation of the law.[284] |
| Case load | A caseload refers to the number of women that are in the care of a PPM. A full caseload has been considered in previous reports to be around 40 births per year.[285] |
| Cerebral palsy | A disorder thought to result from brain damage that occurs before, during, or immediately after birth. The primary indications include disturbances in speech and a noticeable lack of muscle coordination.[286] |
| Claim | An application for benefits from an insurance company. |

279 National Alternative Dispute Resolution Advisory Council, 2013.

280 Online Medical Dictionary, 2013.

281 World Health Organization, 2013.

282 Medical Encyclopaedia, 2013.

283 Virtual Medical Centre, 2013.

284 University of Melbourne Law Library, 2013.

285 UTS Centre for Family Health and Midwifery, 2001.

286 Online Medical Dictionary, 2013.

| Term | Definition |
|---|---|
| Clinical privileging | Clinical privileging is the process by which a health care professional is granted permission by a health service (eg a hospital) to provide care services within defined limits. These limits are based on an individual's qualifications, experience and registration status.[287] |
| Collaborative arrangements | Informal and/or formal recognition of the terms of collaboration. |
| Credentialing | A process undertaken through a professional organisation by an individual to ensure they meet competency standards, or in some cases, advanced practice. |
| Eligible midwife | A midwife registered with AHPRA that who meets the requirements of the NMBA and renders a Medicare rebatable service in a collaborative arrangement or collaborative arrangements of a kind or kinds specified in the regulations, with one or more medical practitioners, of a kind or kinds specified in the regulations. The midwife must have a Medicare provider number, be working in private practice, have professional indemnity insurance and have collaborative arrangements in place with a specified medical practitioner.[288] |
| Fitness to practise | Fitness to practise hearings relates to misconduct, lack of competence, and character issues of poor health of a practitioner.[289] |
| Free birth | Intentionally giving birth without the assistance of a medical or professional at the birth. \ |
| Health service arrangements | Arrangements held with health services. |
| High-risk | A term used by clinicians to describe women who have a history of problems in a previous pregnancy or have an existing medical condition or have some potential risk of complications that might require speedy or specialist treatment.[290] |
| Hypoxia | Reduction of oxygen supply to a tissue below physiological levels despite adequate perfusion of the tissue by blood.[291] |
| Intrapartum | The birthing stage of the pregnancy pathway. |
| Long tail | The liability for claims that do not proceed to final settlement until a length of time beyond the policy year.[292] |
| Medical Negligence | Breach of the standard of care owed by a medical professional to a patient in medical treatment.[293] |

287 National Health and Medical Research Council, 2010.

288 Nursing and Midwifery Board of Australia, 2010.

289 Nursing and Midwifery Council UK, 2013e.

290 Department of Health WA, 2007.

291 Online Medical Dictionary, 2013.

292 IRMI Online, 2013.

293 LexisNexis AU, 2013.

| Term | Definition |
|---|---|
| Memoranda of Understanding | Provides a written statement of agreement about the roles and functions of, for example, a hospital or health service and the visiting midwife. It will highlight their joint commitment to women's care and agreed objectives of both parties to achieve this care.[294] |
| Midwife | A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.[295] |
| Oligohydramnios | A deficiency in the amount of amniotic fluid.[296] |
| Polyhydramnios | A high level of amniotic fluid.[297] |
| Postnatal | Period of time after birth. |
| Premium | The cost of an insurance product that is paid by a professional person to an insurer to gain access to the terms and conditions of the product over the period of the product cover. |
| Premium Pools | Where premiums are collected for different groups or people. |
| Privately Practising Midwife (PPM) | Health professional practising the nursing and midwifery profession who attends a homebirth in the capacity of a sole practitioner, within a partnership or collective, or employed by a company owned solely by the midwife or practising midwives.[298] |
| Professional indemnity insurance (PII) | Arrangements that secure, for the practitioner's professional practice, insurance from civil liability incurred by, or loss arising from, a claim that is made as a result of a negligent act, error or omission in the conduct of the practitioner. This type of insurance is available to practitioners and organisations across a range of industries and covers the costs and expenses of defending a legal claim, as well as any damages payable. Some government organisations under policies of the owning government are self-insured for the same range of matters.[299] |
| Quantum of cover | The amount the insurer or reinsurer is legally liable to pay for the claim. |

294 National Health and Medical Research Council, 2010.

295 International Confederation of Midwives, 2012.

296 Online Medical Dictionary, 2013.

297 Ibid.

298 Nursing and Midwifery Board of Australia, 2012.

299 Ibid.

| Term | Definition |
|---|---|
| Retroactive cover | PII arrangements which cover the insured against claims arising out of, or as a consequence of, activities that were undertaken in the course of the practitioner's professional practice, prior to the date of commencement of the insurance.[300] (NMBA, 2011) |
| Run-off cover | Insurance that protects a practitioner who has ceased a particular practice against claims that arise out of, or are a consequence of, activities that were undertaken when he or she was conducting that practice or business.[301] |
| Tort | A civil wrong occurring between two more persons. A tort is not necessarily illegal but does cause harm. |
| Tribunal | Generally, a body appointed to adjudicate disputes. In administrative law, a Tribunal is a body that reviews administrative action or makes primary decisions. A Tribunal may conciliate or determine disputes or complaints or administer a regulatory scheme.[302] |

300 Nursing and Midwifery Board of Australia, 2011.

301 Ibid.

302 LexisNexis AU, 2013.

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World Health Organization, *Health services coverage statistics*, viewed June 2013 at: www.who.int/healthinfo/statistics/indantenatal/en/index.html, accessed 12 November 2012.

# Appendix C Stakeholder consultation

The following stakeholders in Table 20 were consulted by PwC in the process of completing this project. Stakeholders were identified by NMBA to participate. While we sought to present insights from the consultations, it should not be inferred that those consulted as a part of this project share the views and opinions of this report.

PwC would like to acknowledge the support of the following organisations, with thanks to the stakeholders for their time and valuable information and insight.

**Table 20: Stakeholder consultation listing**

| Organisation | Stakeholder |
|---|---|
| **National – Australia** | |
| Australian Competition and Consumer Commission | Representative |
| Australian and New Zealand Council of Chief Nurses | Fiona Stoker, Chair |
| Australian College of Midwives | Ann Kinnear, Executive Officer<br>Sarah Stewart, Professional Officer |
| Australian Health Practitioner Regulation Agency | State office managers (per state) |
| Australian Medical Association | Dr Gino Pecoraro, Council member<br>Belinda Highmore, Senior Manager – Medical Practice |
| Australian Nursing Federation (Victorian Branch) | Representative |
| Australian Private Midwives Association | Marie Heath, National President |
| Childbirth Australia | Debbie Slater, Chair |
| Department of Health and Ageing | Rosemary Bryant, Commonwealth Chief Nurse and Chief Midwifery Officer<br>Colleen Gibbs<br>Gay Santiago, Capacity branch, Health Workforce Division<br>Graeme Rossiter<br>Julien Wickes<br>Robyn Bilston |
| Department of Health (Queensland) | Dr Belinda Maier, Midwife, Nursing and Midwifery Office Queensland |
| Health Professionals Insurance | Caroline Anderson, CEO |
| Homebirth Australia | Michelle Meares, Secretary |

| Organisation | Stakeholder |
|---|---|
| | Heather Crawford, Midwife |
| Homebirth Access Sydney | Virginia Maddock, Chair |
| Marshall Brokers | David Marshall, Director |
| Maternity Coalition | Ann Catchlove, National President |
| Medicare Australia | Kate Medwin, Director Quality & Communications Section<br>Jason Fairbrother, Statistical Information Section |
| Midwives Australia | Elizabeth Wilkes, President |
| MIGA, the Medical Insurance Group | Mandy Anderson, CEO and Managing Director<br>Cheryl McDonald, Claims Department Manager |
| Royal Australian and New Zealand College of Obstetricians and Gynaecologists | Professor Michael Permezel, President<br>Peter White, Chief Executive Officer |
| Sawtell and Sainsbury | Greg Sawtell, Director |
| University of Technology, Sydney | Eamon Merrick, Research assistant |
| **International** | |
| **Canada:** | |
| Health Insurance Reciprocal of Canada (HIROC) | Peter Flattery, Chief Executive Officer<br>Mike Boyce, Vice President – Claims<br>Susan Flattery, Vice President – Western Region |
| Association of Ontario Midwives | Bobbi Soderstrom, Director of Insurance and Risk Management |
| **England:** | |
| Independent Midwives UK | Brenda van der Kooy, Political Secretary |
| R K Harrison Insurance Services | Mark Riley-Pitt, Trust Manager – Client services |
| Royal College of Midwives, UK | Louise Silverton, Director for Midwifery |
| The Nursing and Midwifery Council | Carmel Lloyd, Standards Development Manager<br>Darren Shell, Policy Manager – Corporate Governance |

| Organisation | Stakeholder |
|---|---|
| **The Netherlands:** | |
| De Goudse | Insurance representatives |
| Frisia | Insurance representatives |
| Royal Dutch Midwives Association (KNOV) | Franka Cadee, Midwife and International Projects Coordinator |
| VVAA | Insurance representatives |
| **New Zealand:** | |
| Health Practitioner Disciplinary Tribunal | Gay Fraser, Executive Officer |
| Forward Planning Limited, NZ | Russell Forward, Insurance broker to New Zealand College of Midwives |
| New Zealand College of Midwives | Karen Guilliland, Chief Executive Officer |
| NZ Midwifery Council | Sharron Cole, Chief Executive Officer |

# Appendix D Definitions

## D.1. Midwifery definition

### International Confederation of Midwives definition

A midwife is defined by the International Confederation of Midwives (ICM) (International Confederation of Midwives) as:[303]

> *"a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery*
>
> *Scope of Practice*
>
> *The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.*
>
> *The midwife has an important task in health counselling and education, not only for the woman, but also within the family and community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.*
>
> *A midwife may practise in any setting including the home, community, hospitals, clinics or health units."*

## D.2. PPM definitions

### National Law definition

Currently, under section 284 of the National Law,[304] private midwifery means practising the midwifery profession:

1. In the course of attending a homebirth
2. Without appropriate professional indemnity insurance arrangements being in force in relation to that practice
3. Other than as an employee of an entity.

Legislation has meant that PPM practice should not be insured if they are not operating as an employee of an entity.

---

[303] International Confederation of Midwives, 2012.

[304] Nursing and Midwifery Board of Australia, 2012.

### *NMBA definition*

The NMBA define private midwifery practice within the *Guidelines for professional indemnity insurance arrangements for midwives*[305] to be broader than the operating entity the PPM should be practicing under.

The NMBA states private midwifery practice is where a midwife is working:[306]

1. As a sole practitioner (either on a full-time or part-time basis) in a business owned solely by the midwife

2. In a partnership or collective; or where a midwife is employed (full-time or part-time) by a company that is owned solely by the midwife

3. That is owned solely by practising midwives, where the only directors of that company are practising midwives.

## *D.3. Eligible midwife definition*

Currently, the only requirement to practice as a PPM is to meet the requirements of the AHPRA midwifery accreditation. From November 2010, midwives, including PPMs, can also be registered under a more regulated sub-class called an 'eligible midwife'.

The sub-class of eligible midwives was developed from the recommendations contained in the 2009 DoHA report *Improving Maternity Services in Australia: The Report of the Maternity Services Review*.[307] The intent was to assist the government in creating a PII product (currently provided by MIGA) and also to support the eligibility of midwives for the Medicare Benefits and Pharmaceutical Benefits schemes.

Registered midwives are not automatically able to apply for registration as an eligible midwife. There are additional requirements that must be met. These are outlined in Table 21.

**Table 21: Registration requirements of an eligible midwife**

| Classification | Eligible Midwife |
|---|---|
| Registration | Current general registration as a midwife in Australia with no conditions on practice |
| Education | Successful completion of, or formal undertaking to complete within 18 months of recognition as an eligible midwife:<br>• An Australian Nursing and Midwifery Accreditation Council (ANMAC) accredited and Board approved program of study to develop midwives' knowledge and skills in prescribing medicines, or<br>• A program that is substantially equivalent to such an approved program of study, as determined by the Board. |
| Experience | Midwifery experience that constitutes the equivalent of three years full-time post-registration as a midwife. |

[305] Nursing and Midwifery Board of Australia 2012.

[306] Ibid.

[307] Commonwealth of Australia 2008a.

| Classification | Eligible Midwife |
|---|---|
| Proven competency | Successful completion of an approved professional practice review program for midwives working across the continuum of midwifery care which demonstrates continuing competence in the provision of pregnancy, labour, birth and postnatal care to women and their infants. |
| Professional development | An eligible midwife is required to undertake an additional 20 hours of specified continuing professional development (CPD) per year relating to the continuum of midwifery care, in addition to the 20 hours of CPD for general registration as a midwife. This CPD must be relevant to the continuum of midwifery care. |

**Source:** Nursing and Midwifery Board of Australia 2010.

Consultations and the survey completed (see Appendix J.1) highlighted that there were difficulties in meeting some of these registration requirements. As a result, this appears to have impacted upon PPMs registering as an eligible midwife. At present, of the PPMs that responded to the survey, 74% identified themselves as an eligible midwife.

Having a collaborative arrangement is not a requirement to become an eligible midwife; the relationship works the other way: only eligible midwives who are legislated as an 'authorised midwife' are able to obtain a collaborative arrangement.[308]

[308] Commonwealth Government, 2010.

# Appendix E Access to health services and collaborative partnerships

## E.1. Definition and issues with health service arrangements

Health service arrangements were identified through consultations to refer to agreements between health services and independent health professionals to be able to provide care and services within a health facility and have access 'rights' to practise within the facility.

Access to health service arrangements could be important from an insurance perspective because they may have the potential to decrease the PPM risk profile. Consultations identified that women often sought continuity of care, and where it was not possible to have this (eg in the case of a transfer to a health service), they may in some cases, be unwilling to be transferred or referred. In these circumstances, the risk of an adverse outcome may increase if risk framework guidelines which require transfer and referral at different stages of the birthing process (see Chapter 3) are not followed.

From consultations held, it appears that currently:

- PPMs have variable access to health service arrangements within and across states and territories as a result of challenges faced around securing collaborative partnership arrangements
- Future standardisation within states and territories of access to health service arrangements is planned, but the nature of these future arrangements is still being defined.[309]

## E.2. Collaborative partnerships

At present, access to health services appears to be restricted by the PPM's ability to organise collaborative arrangements with a health practitioner[310] and clinical privileging rights.[311]

Collaborative arrangements or the informal and/or formal recognition of the terms of collaboration[312] were recognised within the National Health and Medical Research Council (NHMRC) 2010 guidance, *National Guidance on Collaborative Maternity Care*, as important to:

> *"support the delivery of maternity care and ensure that women receive access to appropriate expertise and treatment, as the need arises" (p. 1).*

The NHMRC guidance[313] listed nine principles for maternity collaboration as outlined in Table 22.

309 Department of Health and Ageing, 2012.

310 Collaborative arrangements are a key requirement to be an eligible midwife, where a midwife must have medical practitioner that must provide for consultation with a specified medical practitioner; referral of a patient to a specified medical practitioner; and transfer of the patient's care to a specified medical practitioner, as clinically relevant, to ensure safe, high quality health care.

311 The right to be able to practise and use the drugs required in a hospital.

312 National Health and Medical Research Council, 2010.

313 Ibid.

**Table 22: Principles for maternity collaboration**

| Principle | Description |
|---|---|
| 1 | Maternity care collaboration places the woman at the centre of her own care, while supporting the professionals who are caring for her (her carers). Such care is coordinated according to the woman's needs, including her cultural, emotional, psychosocial and clinical needs. |
| 2 | Collaboration enables women to choose care that is based on the best evidence and is appropriate for themselves and for their local environment. |
| 3 | Collaboration enables women to make informed decisions by ensuring that they are given information about all of their options. This information should be based on the best evidence, and agreed to and endorsed by professional and consumer groups. |
| 4 | Collaborating professionals, regardless of the model of care, establish a clearly defined and inclusive reciprocal communication strategy using sensitive language to support professional trust. |
| 5 | Collaboration has an underpinning safety and quality framework that includes monitoring health outcomes for mothers and babies, regular multidisciplinary discussions about how the collaboration is working (involving women who have used the service) and public reporting. |
| 6 | Collaborating professionals respect and value each other's roles, provide support to each other in their work and provide education to meet each other's needs. |
| 7 | Collaboration is committed to joint education and training, following a consistent, agreed care plan and research focused on improving outcomes. |
| 8 | Collaboration aims to maximise a woman's continuity of care and carer, throughout pregnancy, birth and the early postnatal period. |
| 9 | Collaboration aims to maximise a woman's continuity of carer by providing a clear description of roles and responsibilities to support the person that a woman nominates to coordinate her care (her 'maternity care coordinator'). |

## *E.3. Efforts to improve collaboration, agreements and access rights*

In reflection of the principles outlined above, the NHMRC guidance[314] identified key challenges that exist in establishing and maintaining effective collaborative partnerships and in some cases, provides considerations to overcome these. These are outlined in Table 23.

[314] National Health and Medical Research Council, 2010.

**Table 23: Identified potential issues based on the principles of maternity care collaboration**

| Potential issue | Description |
|---|---|
| Roles and responsibilities | The roles and responsibilities of each collaborating partner should be clearly defined and the maternity care coordinator should be identified (as nominated by the woman receiving care).<br>Where possible, a woman's care coordinator should maintain their role in the care.<br>Relevant accountability, legal liabilities and health insurance issues should be clarified with the service, jurisdiction or insurance provider. |
| Shared documentation | Shared and reciprocal documentation, including some form of woman-held record, will ensure that all members of the collaboration are aware of the essential information throughout the episode of care. |
| Transfer plans | Transfer plans identify who the collaborating partners are and what the plan is, if or when a woman's care needs to be relocated or escalated. They include agreement on consultation and referral guidelines, transport plans, and methods of documenting and consultation and transfer. |
| Care pathways | There should be documented pathways of primary, secondary and tertiary clinical care. Plans should identify and address any potential barriers to continuity of care. |
| Access to hospitals | Midwives, particularly PPMs, will need access to all hospitals at which they intend to practice for prenatal, intrapartum and postnatal care of women. Services and hospitals will need processes to allow access for midwives in line with the principles of collaborative maternity care.<br>Memorandums of understanding (MOUs) are a possible mechanism for services to negotiate hospital access with midwives. These could operate in a similar way to hospital clinical privileging processes where midwives are able to practise at the hospital within defined parameters. |
| Credentialing | This could be a way to establish midwives' access to hospitals. |
| Hospital bookings | All women should be advised to book into a hospital, regardless of their birthing plan. There should be no implication that this will be a required step; however, booking ensures continuity of care and facilitates transfer and escalation processes, when required. |
| Admission status | The admission status of the woman (as a private or public patient) should be clarified with the service (and insurer if appropriate) at the time of booking. |
| Postnatal care | There should be clear opportunities for communication with, and transfer to, the woman or her family's local health and wellbeing service community, including GPs, maternal, family and child health nurses, and early childhood and community services. |
| Competition | There may be real or perceived competition between maternity health professionals. Even a perception of competition has the potential to damage trust or influence professionals who are part of the credentialing process to refuse access to hospitals for others. |

| Potential issue | Description |
|---|---|
| Dealing with conflict | Due to many of the issues previously discussed in this Guidance, collaboration can be a challenge. Due to the complex interaction of morals, ethics, laws, policies, cultures, as well as the ways they can be interpreted by each individual, there are many areas where conflicting opinions may lead to disagreements. In turn this could potentially result in a breakdown of collaboration, poorer outcomes for women and their babies, and create tension in the working environment for maternity care professionals. |

While the identification of issues and considerations are useful, it appears from consultations that overcoming them is still, at present, challenging. Many of the considerations presented to the NMBA within this report are reflected in the NHMRC review.

To assist in improving collaborative partnerships, DoHA's *National Maternity Services Plan* was released in 2010 to provide a five-year vision for maternity services. This plan sets out priorities for maternity services in terms of access, service delivery, workforce and infrastructure. The National Maternity Services Plan aims to ensure that at a jurisdictional level, there has been development of consistent approaches to clinical privileging and access rights for PPMs.[315]

The *National Maternity Services Plan Annual Report* details the work at a jurisdictional level which has been undertaken to ensure consistent approaches to clinical privileging and access rights for PPMs. The current status of the work is detailed in Table 24.

**Table 24: Documented progress for access arrangements for PPMs by state and territory**

| State/Territory | Progress made at jurisdictional level to ensure a consistent approach to clinical privileging and access arrangements |
|---|---|
| NSW | A statewide credentialing project is underway as is the development of a policy to facilitate clinical privileging for PPMs in NSW public maternity services.[316] |
| Vic. | The Victorian Government has engaged a project officer and established a statewide reference group to develop a statewide approach to clinical privileging of eligible midwives in Victorian public maternity services.[317] A framework for use by Victorian public hospitals considering a private practice midwifery model has been drafted and is being reviewed by the Department of Health (Vic).[318] |
| Qld | Queensland Health has not established a publicly funded homebirth schemes but is working to support PPMs to receive access to health services. A pilot site for collaboration was established in Toowoomba. There are currently three collaborative agreements in place in Toowoomba, Gold Coast and Caboolture. The collaborative partnerships differ between these three sites.[319] |
| WA | The WA Government has been working with the Office of Safety and Quality to review the existing medical officer credentialing policy to include eligible midwives. A request has been sent to the credentialing committees to include |

315 Commonwealth of Australia, 2011.

316 Department of Health and Ageing, 2012.

317 Ibid.

318 Department of Health, Victoria, 2012.

319 Personal communication, April 2013.

| State/Territory | Progress made at jurisdictional level to ensure a consistent approach to clinical privileging and access arrangements |
|---|---|
| | midwives on the committee to facilitate the process. WA is currently developing strategies to support eligible midwives into health services until the policy is changed. |
| ACT | The ACT Government has established a working group to progress clinical privileging. |
| Tas. | The Tasmanian Government is conducting a review of the current credentialing framework for health professionals with a view to extension to include eligible midwives. |
| NT | In the NT, midwives working in an Aboriginal Community Controlled Organisation (ACCO) have been given clinical privileging to follow women through to birthing at the Alice Springs Hospital, thus facilitating a continuity of care model. |

**Sources:** Department of Health and Ageing 2012.

These approaches seem to be varied and are at different levels of establishment and support. Therefore, it is evident that there is still variation in how these arrangements and rights are being established across states and territories. This is expected to continue given, for example, the ability of eligible midwives to secure clinical privileges, admitting and practice rights to public health facilities. DoHA's *National Maternity Service Plan*[320] identified inconsistencies in the process for eligible midwives to secure these privileges and rights. The outline of the proposed plan for clinical privileging, admitting and access rights is outlined in Table 25.

**Table 25: The National Maternity Services Plan Action – 1.2.2 (2010)**

| The initial year (2010) | The middle years | The later years | Signs of success |
|---|---|---|---|
| Jurisdictions develop consistent approaches to the provision of clinical privileges within public maternity services, to enable admitting and practice rights for eligible midwives and medical practitioners. | Jurisdictions use best endeavours to facilitate the clinical privileges, admitting and practice rights of eligible midwives.<br>Jurisdictions monitor the provision of consistent clinical privileges, admitting and practice rights for eligible midwives and medical practitioners. | Jurisdictions evaluate access to clinical privileges, admitting and practice rights for eligible midwives and medical practitioners in maternity services. | Eligible midwives have the opportunity to access clinical privileges, admitting and practice rights in public health care settings.<br>There is a consistent approach to the provision of clinical privileges, admitting and practice rights for eligible midwives and medical practitioners in all jurisdictions. |

**Sources:** Commonwealth of Australia 2011.

DoHA's *National Maternity Service Plan* has provided further updates on the implementation of clinical privileging (outlined in Table 26). This has implied that states and territories should use their

320 Commonwealth of Australia, 2011.

own resources to create a generic process for clinical privileging and that it should fall on jurisdictions to find the most appropriate solution that suits and complements the health system in place. However, there is an emphasis on a generic or consistent approach to be implemented and monitored for securing access.

Consideration around the best approach to support access arrangements and improved collaboration between health professionals should be considered further. This is because the evidence presented demonstrates its importance from an insurance perspective to assist in reducing the risk profile of PPMs.

**Table 26: The National Maternity Services Plan Action – 1.2.2 (2012–2013)**

| The initial year (2010) | The middle years | Responsibility | Funding | Signs of success |
|---|---|---|---|---|
| Jurisdictions develop consistent approaches to the provision of clinical privileges within public maternity services, to enable admitting and practice rights for eligible midwives and medical practitioners. | Jurisdictions implement a consistent process for eligible midwives and medical practitioners to secure clinical privileges, admitting and practice rights to public health facilities.<br><br>Jurisdictions develop and implement a monitoring framework and reporting structure for the clinical privileges, admitting and practice rights of eligible midwives and medical practitioners. | Jurisdictions | Within jurisdictional resources | A generic process for eligible midwives and medical practitioners to secure clinical privileges, admitting and practice rights to public health facilities is implemented and monitored. |

**Sources:** Commonwealth of Australia 2011; Department of Health and Ageing, Standing Council on Health 2012.

# Appendix F Risk and quality frameworks

## F.1. Risk and quality frameworks used by organisations

There are a variety of risk and quality frameworks that have been developed by organisations within Australia. Examples of these are listed in Table 27.

**Table 27: Examples of risk and quality frameworks by organisation**

| Organisation | Risk and quality frameworks |
|---|---|
| Australian College of Midwives | • National Midwifery Guidelines for Consultation and Referral<br>• Guidelines and Assessment Framework for Registration Standard for Eligible Midwives and Registration Standard for Scheduled Medicines for Eligible Midwives |
| Nursing and Midwifery Board of Australia | • Code of ethics for midwives in Australia<br>• Code of professional conduct for midwives in Australia<br>• Midwifery Competency Standards, January 2006<br>• Guidelines for Professional Indemnity Insurance Arrangements for Midwives<br>• Nursing and Midwifery Professional Indemnity Insurance Arrangements Registration Standard<br>• Guidelines and Assessment Framework for the registration Standard for Eligible Midwives and Endorsement for Scheduled Medicines<br>• Professional Boundaries for Midwives |
| Royal Australia and New Zealand College of Obstetricians and Gynaecologists | • Standards of Maternity Care in Australia and New Zealand |
| State and territories frameworks | • Government of South Australia, Department of Health, Policy for Planned Birth at Home in South Australia, 2007 |
| Publicly funded midwifery programs | • WA Women's and Newborn's Health Network, Policy for Publicly Funded Homebirths including Guidance for Consumers, Health Professionals and Health Services, 2012<br>• NSW Department of Health, Maternity – Public Homebirth Services, 2006 |

**Sources:** Australian College of Midwives 2008; Nursing and Midwifery Board of Australia 2013c; NSW Health 2006; South Australia Department of Health 2007; Department of Health WA; The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2011.

# Appendix G Publicly funded homebirth schemes

## G.1. Publicly funded homebirth schemes

Under DoHA's *National Maternity Services Plan,*[321] consideration was given to the demand of maternity services and the availability of a range of models of care. As a part of this, different states and territories have undertaken different actions to support homebirth, including the continuation or development of publicly funded homebirth schemes.[322]

Publicly funded homebirth schemes are based within the public hospital system, catering to women who are at low obstetric and medical risk with PII cover for the midwives provided through vicarious liability of the hospital as part of their employment.[323] These programs are often linked with, or arise from, existing birth centres or midwifery group practices.[324] As a potential substitutable product for PPM practice, understanding the practice and operation of these schemes may provide lessons, particularly around:

- **How services are delivered:** the method of service delivery and what is deemed acceptable or required (eg the publicly funded homebirth scheme requires two attendees at birth)
- **What services are delivered:** the risk and quality frameworks that are applied to homebirth midwifery services
- **Who provides services:** the relationships held with other health professionals and collaborative models of care
- **Why services are delivered:** the drivers behind the model and the demand of women (eg is the demand for homebirth services or a continuity of care model).

As shown in Table 28, not all states and territories have publicly funded homebirth schemes in place. Consultations outlined that this was for a variety of factors including the support of state or territory governments as well as other health practitioners and maternity service providers. Variation in the offering of publicly funded homebirth schemes could present different levels of demand and accessibility to homebirth models of care.

**Table 28: Publicly funded midwifery schemes available by state and territory**

| | NSW | Vic. | Qld | WA | SA | Tas. | ACT | NT |
|---|---|---|---|---|---|---|---|---|
| Publicly funded midwifery scheme available | ✓ | ✓ | × | ✓ | ✓ | × | × | ✓ |
| Number of hospitals providing service | 6 | 2 | - | 1 | 2 | - | - | 2 |

**Source:** Pregnancy Birthing and Beyond 2012; Catling-Paull, Coddington, Foureur & Homer 2013.

321 Commonwealth of Australia, 2011.

322 Commonwealth of Australia, 2011.

323 Caitling-Paull C, Coddington RL, Foureur MJ & Homer CSE 2013.

324 Caitling-Paull C, Foureur MJ & Homer CS 2011.

Literature has highlighted that the success of setting up publicly funded homebirth schemes included:[325]

- Consumers who feel comfortable with their choice of place of birth
- Funding to cover risk management tasks, technology (access to computers/printers/email), equipment (such as homebirth kits including resuscitative equipment and medication) and workload (staff to cover leave commitments)
- Safe and effective consultation and referral pathways, especially consultation with obstetricians
- Ability for midwives to be able to practice within the scope of a midwife without being constrained by hospital derived policies that are overly restricted.

[325] Caitling-Paull C, Foureur MJ & Homer CS 2011.

# Appendix H Benchmarking of risk frameworks

## H.1. Benchmarking risk frameworks

As a part of the research completed, it was identified that there were variations between the Australian risk frameworks used to guide the practice of PPMs. Table 30 provides examples of variation in the recommended actions to particular indications, as provided within three frameworks:

- **ACM:** National Midwifery Guidelines for Consultation & Referral (2nd edition)[326]
- **SA State policy:** Policy for Planned Birth at Home in South Australia
- **WA State policy:** Policy for Publicly Funded Homebirths including Guidance for Consumers, Health Professionals and Health Services.

It is recognised, in line with discussion in Chapter 3, that while the ACM guidelines are not designed specifically for homebirth, they are a national set of guidelines that are recommended for use by PPMs, and are used by MIGA in establishing its recommended care plan. Therefore, they have been included in the comparison, along with an example of two state-based homebirth guidelines.

**Table 29: Key for benchmarking**

| Symbol | Key |
|---|---|
| **A** | Discuss the situation with a colleague |
| **B** | Consult with a medical or other health care provider |
| **C** | Refer a woman or her infant to Secondary or Tertiary Care |
| ✓ | Excluded from PPM practice by State or Network policy |
| × | Not indicated in policy or guidelines |

**Table 30: Benchmarking of frameworks**

| Indications | Specific indication | ACM guidelines | SA State Policy | WA Publicly Funded Homebirth Policy |
|---|---|---|---|---|
| At booking – Previous obstetric | Retained placenta requiring manual removal | **A** | × | ✓ |
| | Caesarean section | **B** | ✓ | ✓ |

[326] At the time of finalising this report, the 3rd edition has been released.

| Indications | Specific indication | ACM guidelines | SA State Policy | WA Publicly Funded Homebirth Policy |
|---|---|---|---|---|
| history | Postpartum haemorrhage in excess of 1L | **B** | ✓ | ✓ |
| | Shoulder dystocia | **B** | ✓ | ✓ |
| | Perinatal death at term of a normally formed infant | **B** | ✓ | ✓ |
| | Baby requiring intensive or prolonged special care | × | ✓ | × |
| At booking – Medical history | Pre-pregnancy BMI > 35 | **B** | × | ✓ |
| | Any significant medical condition | **B/C** | ✓ | ✓ |
| | Uncorrected female genital mutilation | **B** | ✓ | ✓ |
| | Alcohol or drug dependency | **B** | ✓ | ✓ |
| At booking – Other | Domestic violence | × | ✓ | ✓ |
| | Will not accept blood and blood products if required | **B/C** | × | ✓ |
| | Previous baby with Group B Streptococcus (GBS) neonatal sepsis | × | × | ✓ |
| | Baby or child at risk of harm | × | ✓ | ✓ |
| | Lack of easy access | × | ✓ | × |
| | Lack of running water and/or electricity | × | ✓ | × |
| | Lack of cleanliness and hygiene | × | ✓ | × |
| Discovered or developed during pregnancy | Body mass index> 35 or maternal weight greater than 100 kg | **B** | ✓ | ✓ (Greater than 110 kg) |
| | Antepartum haemorrhage | × | ✓ | ✓ |
| | Abnormal placentation (including placenta praevia) | **C** | ✓ | ✓ |
| | Hypertension and/or pre-eclampsia | **C** | ✓ | ✓ |
| | Gestational diabetes | **B** | ✓ | ✓ |
| | Suspected intrauterine growth restriction or small for gestational age | **B** | ✓ | ✓ |
| | Suspected fetal abnormalities | **A** | ✓ | ✓ |

| Indications | Specific indication | ACM guidelines | SA State Policy | WA Publicly Funded Homebirth Policy |
|---|---|---|---|---|
| | Polyhydramnios or oligohydramnios | × | ✓ | ✓ |
| | Pre-labour rupture of membranes | **C** | ✓ | ✓ |
| | Post-term pregnancy (greater than 42 weeks) | **B** | ✓ | ✓ |
| | Multiple pregnancy | **C** | × | ✓ |
| | Breech presentation after 37 weeks | **C** | × | ✓ |
| During labour | Abnormal presentation | **C** | × | ✓ |
| | Breech presentation | **C** | × | ✓ |
| | Active genital herpes in late pregnancy or at onset of labour | **C** | × | ✓ |
| | Gestational hypertension | **C** | × | ✓ |
| | Pre-eclampsia | **C** | × | ✓ |
| | Pre-term labour before 37 weeks | **B** | × | ✓ |
| | Pro-longed rupture of membrane (PROM) > 24 hours – appropriate IV antibiotics for GBS prophylaxis should be commenced if GBS positive | **C** | × | ✓ |
| | Vasa praevia | **C** | × | ✓ |
| | Placenta abruption | **C** | × | ✓ |
| | Uterine rupture | **C** | × | ✓ |
| | Prolapsed cord or cord presentation | **C** | × | ✓ |
| | Fetal death during labour | **C** | × | ✓ |
| | Need for continuous fetal monitoring | **C** | ✓ | ✓ |
| | Evidence of infection or maternal temperature | **B** | ✓ | ✓ |
| | Lack of engagement of the fetal head | **B** | ✓ | ✓ |
| | Meconium-stained liquor | **A/C** | ✓ | ✓ |
| | Fetal-heart rate abnormalities | **C** | ✓ | ✓ |
| | Intrapartum haemorrhage | **C** | ✓ | ✓ |

| Indications | Specific indication | ACM guidelines | SA State Policy | WA Publicly Funded Homebirth Policy |
|---|---|---|---|---|
| | Absence of progress in established labour | **C** | ✓ | ✓ |
| | Active first stage labour in excess of 18 hours | **B** | ✓ | ✓ |
| | Active second stage is in excess of one hour within minimal/slow progress and/or without head on view | × | × | ✓ |
| | Reference to partogram action lines | × | × | ✓ |
| At Postpartum | Retained or incomplete placenta | **B** | ✓ | ✓ |
| | Postpartum haemorrhage | **C** | ✓ | ✓ |
| | Third or fourth-degree tear | **C** | ✓ | ✓ |
| | APGAR score of less than 7 at 5 mins | **C** | ✓ | ✓ |
| | Neonatal respiratory problems | **B** | ✓ | ✓ |
| | Neonatal convulsions | **C** | ✓ | ✓ |
| | Congenital abnormalities | **C** | ✓ | ✓ |
| | Low birth weight (less than 2500 grams) | **B** | ✓ | ✓ |
| | Neonatal temperature below 36.5°C or above 37.4°C on more than one occasion | **B** (less than 36)/ **C** (greater than 37.4) | × | ✓ |

**Sources:** Australian College of Midwives 2008; South Australia Department of Health 2007; Department of Health WA 2012.

# Appendix I Discipline and legislation of Health Practitioners

Insurers appear to look toward disciplinary frameworks to provide certainty that anyone who is not practising within the defined scope, or not within professional guidelines, is disciplined. Therefore, through standardised disciplinary frameworks PPMs provide consistent and predictable levels of care.

The disciplinary framework used in Australia is a potential source of uncertainty for insurers, given that legislation for tribunal processes varied by state and territory prior to 2010. Examples of the changes in legislations seen in several states are demonstrated in Table 31.

Variations have historically existed in the disciplinary processes across states and territories. In March 2008, the National Health Workforce Council, a Commonwealth taskforce, wanted to create a single national registration and accreditation system for ten health professions including chiropractors, dentists, medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists.

The National Registration and Accreditation Scheme (the National Scheme) for health practitioners in Australia commenced on 1 July 2010 and involved the implementation of a *Health Practitioner Regulation National Law*. As mentioned, midwives are one of the professional groups regulated through the National Scheme under the authority of the Board. Since July 1 2010, all midwives have been regulated by the same legislation. New conditions for disciplinary frameworks have only been operating for the past three years.

**Table 31: Legislation changes occurring in July 2010**

| State | Legislation after 1 July 2010 | Legislation before 1 July 2010 |
|---|---|---|
| NSW | Health Practitioner Regulation National Law (NSW) No 86a | Nurses and Midwives Act 1991 (NSW)<br>Health Care Complaints Act 1993 (NSW) |
| Vic. | Health Practitioner Regulation National Law (Victoria) Act 2009 | Health Professions Registration Act (2005) (HPR Act) |
| Qld | Health Practitioner Regulation National Law Act 2009 | Nursing Act 1992 (Queensland) |

**Sources:** Australian Health Practitioner Regulation Agency 2013; State Government of Queensland 2013; Department of Health, Victoria 2013.

# Appendix J Data quality

## J.1. Survey for PPMs

### Introduction

As part of its review of national PII arrangements and claims, PwC developed a short survey to gather further information relating to PPMs. The survey focused on areas of significance around PII for PPMs to generate an evidence base to help inform decision-making in determining the minimum amount of insurance cover needed for midwives.

The survey was voluntary and was live for one month on the NMBA website. It was communicated to potential participants through the NMBA website, and notifications were also provided to consumer groups and relevant Colleges.

### Highlights

- **85** individuals participated in the survey
- **78** participants are currently registered with the Australian Health Practitioner Regulation Agency/Nursing and Midwifery Board of Australia
- **81** participants have practised as a midwife in the last 12 months
- Of the 81 practising midwives, **71** have provided maternity services to women in their home in the last 12 months
- **72** participants have provided maternity services to women in their home in the last 12 months
- **79%** of participants providing maternity services to women in their home are privately practising
- The majority of participants providing homebirths in private practice provide Antenatal, Intrapartum and Postnatal care (**65%**)
- **39** participants have collaborative arrangements in place
- Of the 81 participants who have practised as a midwife in the last 12 months, 50 (**62%**) are 'eligible midwives'
- Of the 57 participants who are privately practising, 42 (**74%**) are 'eligible midwives'
- The most frequently cited reason for not being an eligible midwife is the **restriction of the requirements of being an eligible midwife**
- **8%** of participants have received a complaint or notification against them in the last 10 years in relation to the practice of midwifery
- **No participants** reported having received an insurance claim against them relating to the practice of midwifery within the last 10 years.

## *Why have participants not provided maternity services to women in their home in the past 12 months?*

**13** participants had not provided maternity services to women in their homes in the last 12 months. These participants were asked to select the reasons why they had not provided services or provide their own response. Note – participants could select or provide more than one reason.

| Reason | | Count of responses | % of respondents |
|---|---|---|---|
| Employed in a public health maternity service | | 3 | 23% |
| Employed in a private health maternity service | | 1 | 8% |
| Not currently practising as a midwife | | 3 | 23% |
| Not intending to provide homebirth services | | 3 | 23% |
| Other:<br>Primary Health Clinic<br>Work in a teaching capacity<br>Ceased insurance<br>University appointment | Employed as a GP nurse<br>Practised overseas, awaiting registration in Australia | 6 | 46% |

## *How are homebirth services being provided?*

Participants who had provided maternity services in the home in the past 12 months were asked how they provide services. **79%** are privately practising, as a sole practitioner, within a partnership or collective, or are employed by a company owned solely by either themselves or practising midwives.

| Method of provision | Count of responses | % of respondents |
|---|---|---|
| Privately practising | 57 | 79% |
| Practise through a public health service | 3 | 4% |
| Community midwifery program | 2 | 3% |
| Antenatal and postnatal home visits only, no homebirths | 1 | 1% |
| As a private eligible midwife, providing only antenatal care | 1 | 1% |
| Birth Centre | 1 | 1% |
| Group Practice Midwifery model of care | 1 | 1% |
| I am not providing homebirth services because no insurance available for homebirth | 1 | 1% |
| Provide antenatal/postnatal services at home with birth in hospital | 1 | 1% |
| Provide services via a private obstetrician as well | 1 | 1% |

| Method of provision | Count of responses | % of respondents |
|---|---|---|
| Other | 1 | 1% |
| Not applicable | 1 | 1% |
| No response | 2 | 3% |
| **Total count** | **73** | |

## *What services are provided in the home?*

Out of the 78 participants who responded to this question, the majority of those providing homebirths in private practice provide antenatal, intrapartum and postnatal care (**65%**).

| Services provided | Count of responses | % of respondents |
|---|---|---|
| Only antenatal care | 3 | 4% |
| Only intrapartum care | 1 | 1% |
| Antenatal care & postnatal care | 5 | 6% |
| Antenatal care, intrapartum care & postnatal care | 51 | 65% |
| Not applicable – privately practising homebirth services not provided | 18 | 23% |
| **Total count** | **78** | **100%** |

## *Key factors impacting on the provision of services*

Participants who provide homebirth services or wish to provide homebirth services were asked to choose in priority order three factors that impact the extent of services offered. 70 participants responded to this question.

- **33%** cited 'PII cover arrangements' as having the greatest impact on the extent of services provided.
- **22%** cited 'Access to admitting rights in health services' as having the greatest impact on the extent of services provided.
- **16%** cited 'Access to collaborative arrangements with other health professionals' as having the greatest impact on the extent of services provided.

| Factor | 1st priority | 2nd priority | 3rd priority | 4th priority |
|---|---|---|---|---|
| Access to admitting rights in health services | 15 | 1 | 1 | |
| Access to collaborative arrangements with other health professionals | 11 | 5 | 1 | |
| Emergency support | 3 | 0 | 2 | 1 |
| Legal liability in the case of adverse events | 3 | 2 | 5 | |
| Professional indemnity insurance cover arrangements | 23 | 4 | 1 | |
| Public profile of a potential adverse event | 3 | 0 | 1 | |
| Risk management and quality frameworks currently in place | 0 | 0 | 0 | |
| Support for services from professional associations | 1 | 1 | 2 | |
| The level of support available in the provision of care to women | 4 | 1 | 2 | |
| Transfer arrangements from home to a health service | 4 | 2 | 0 | |
| Other | 3 | | | 1 |
| **Total count** | **70** | | | |

## *Understanding of the professional indemnity insurance products available*

Participants who are PPMs were asked to rate their understanding of the professional indemnity insurance products available. 81 participants responded to this question.

10 = complete understanding of the products available

1 = minimal or no understanding of the products available

- **46%** rated their understanding of professional indemnity insurance products as 8 or above (high understanding)
- **4%** rated their understanding of professional indemnity insurance products as 3 or below (little or no understanding).

| Rating of understanding | Count of responses | % of respondents |
|---|---|---|
| 1 | 1 | 1% |
| 2 | 0 | 0% |
| 3 | 2 | 2% |
| 4 | 7 | 9% |
| 5 | 11 | 14% |
| 6 | 4 | 5% |
| 7 | 9 | 11% |
| 8 | 17 | 21% |
| 9 | 8 | 10% |
| 10 | 9 | 11% |
| Not applicable | 13 | 16% |
| **Total count** | **81** | **100%** |

### *How do privately practising midwives meet continuing professional development registration requirements?*

**83** participants responded to this question. The most widely used methods of professional development are:

- Attending publicly available paid courses (eg university, TAFE institutions) – 70% respondents
- Completing training offered through professional institutions – 69% respondents
- Completing online training – 68% respondents.

| Method of professional development | Count of responses | % of respondents |
|---|---|---|
| Attend publicly available free seminars/conferences | 44 | 52% |
| Attend publicly available paid courses (eg university, TAFE institutions) | 46 | 55% |
| Attend publicly available paid seminars/conferences | 59 | 70% |
| Complete midwifery courses within public health services | 54 | 64% |
| Completed no ongoing training | 1 | 1% |
| Complete online training | 57 | 68% |
| Complete training offered through private practising associations | 36 | 43% |

| Method of professional development | Count of responses | % of respondents |
|---|---|---|
| Complete training offered through professional associations | 58 | 69% |
| Not applicable –privately practising homebirth services not provided | 11 | 13% |

The majority of participants use more than one method of professional development:

| Number of methods of professional development used | Count of participants |
|---|---|
| 1 | 17 |
| 2 | 3 |
| 3 | 6 |
| 4 | 14 |
| 5 | 12 |
| 6 | 15 |
| 7 | 17 |

### *How many privately practising midwives have collaborative arrangements in place, and who are these with?*

**39** participants have collaborative arrangements in place. 75 participants responded to this question.

| Rate of collaboration | Count of responses | % of respondents |
|---|---|---|
| No | 36 | 48% |
| Yes | 39 | 52% |
| *Just GP* | 7 | |
| *Just hospital* | 8 | |
| *Just obstetrician* | 6 | |
| *Collaborative arrangement with more than one type* | 9 | |
| *Yes, with no details given* | 9 | |
| **Total count** | **75** | |

## *What are the biggest factors impacting upon entering into collaborative arrangements?*

Participants were asked to select all the appropriate factors that impact upon their entering into collaborative arrangements. **83** participants responded to this question.

The most frequently cited factors impacting upon entering into collaborative arrangements were:

- Voluntary requirement for health services to support collaborative arrangements (**35%** of respondents)
- Relationship with health professional (**33%** of respondents)
- Legislative requirements around arrangements (**31%** of respondents).

| Factor | Count of responses | % of respondents |
|---|---|---|
| Voluntary requirement for health services to support collaborative arrangements | 29 | 35% |
| Relationship with health professional | 27 | 33% |
| Legislative requirements around arrangements | 26 | 31% |
| Relationship with health services | 24 | 29% |
| Restrictions on care through collaborative arrangements | 23 | 28% |
| Not applicable – privately practising homebirth services not provided | 11 | 13% |
| Other | 8 | 10% |
| Location to health service | 7 | 8% |

## *What proportion of privately practising midwives are eligible midwives?*

Of the 85 survey participants:

- **52** are eligible midwives – 61%
- **24** are not eligible midwives – 28%
- **9** did not respond to this question – 11%.

Of the 81 participants who have practised as a midwife in the last 12 months, 50 (**62%**) are 'eligible midwives'.

Of the 57 participants who are privately practising, 42 (**74%**) are 'eligible midwives'.

## *Why are participants not eligible midwives?*

24 participants identified themselves as not being eligible midwives.

| Reasons provided | Count of responses | % of respondents |
|---|---|---|
| Restrictions through the requirements of being an eligible midwife | 10 | 42% |
| Was not aware of the Medicare Australia arrangement for eligible midwives | 2 | 8% |
| Access to the requirements of being an eligible midwife (eg collaborative arrangements) | 1 | 4% |
| No requirement for additional funding through Medicare Australia | 1 | 4% |
| Additional administrative requirements of being an eligible midwife | 1 | 4% |
| Other | 4 | 17% |
| Not applicable – privately practising homebirth services not provided | 2 | 8% |
| No response | 3 | 13% |
| **Total count** | **24** | **100%** |

## *What factor would improve the practice of privately practising midwives the most?*

Participants were asked to select one factor that, if put in place, would most improve their practice as a privately practising midwife.

The most frequently cited factors to improve practice were:

- Legislative and regulatory supports for your practice (32%)
- Access to health services and admitting rights (24%)
- Understanding of practice by community and health professionals (16%).

| Factors | Count of responses | % of respondents |
|---|---|---|
| Legislative and regulatory supports for your practice | 27 | 32% |
| Access to health services and admitting rights | 20 | 24% |
| Understanding of practice by community and health professionals | 14 | 16% |
| Indemnity insurance arrangements | 9 | 11% |
| Improved funding for services | 4 | 5% |
| Relationship with health practitioners | 2 | 2% |
| Relationship with health services | 1 | 1% |
| Other | 4 | 5% |
| No response | 4 | 5% |
| **Total count** | **85** | **100%** |

### *How many participants have received a notification or a complaint against them in the last 10 years in relation to the practice of midwifery?*

| Response | Count of responses | % of respondents |
|---|---|---|
| Have received a notification or complaint | 7 | 8% |
| Have not received a notification or complaint | 77 | 91% |
| No response | 1 | 1% |
| **Total count** | **85** | **100%** |

### *How many participants have had an insurance claim against them relating to the practice of midwifery within the last 10 years?*

No participants reported having received an insurance claim against them relating to the practice of midwifery within the last 10 years.

## J.2. Statistics on homebirth in Australia

As a part of the report, publicly available statistics were collected to demonstrate the number of homebirths across Australia and the trends seen in homebirth practice were collected. These statistics are recorded in the AIHW, *Women and Babies* report annually. The statistics below show the:

- Number of births in Australia
- Number of homebirths in Australia
- Proportion of births in the home out of all births in Australia.

## Number of births in Australia

Births in Australia are recorded by both the ABS and AIHW. The AIHW data relate to live births but is recorded where the birth is defined as the complete expulsion or extraction from a woman of a baby of at least 20 weeks' gestation or weighing at least 400 grams at birth. The AIHW did not include any births where the gestation and birth weight were not recorded.

**Table 32: Number of births in Australia**

| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|---|---|---|---|
| AIHW | 250,071 | 250,758 | 252,584 | 252,871 | 267,793 | 277,436 | 289,496 | 292,156 | 294,540 | 297,357 |

**Sources:** Australian Bureau of Statistics 2011; Australian Institute of Health and Welfare, 2004b-2013.

A limitation of this data set is that it is unclear as to which date is attributable to the birth registration, (eg the date of occurrence, data of registration with the state or territory, or the date in which the registered event is provided to the AIHW).

## Number of homebirths in Australia

According to AIHW data, actual homebirths accounted for 1,345 births in 2010 as outlined in Table 33.

**Table 33: Number of homebirths in Australia**

| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of homebirths by women | 699 | 637 | 576 | 589 | 601 | 708 | 870 | 1,000 | 863 | 1,345 |
| Total number of births at home: | **nr*** | **639** | **nr*** | **592** | **603** | **711** | **874** | **1,002** | **864** | **1,354** |
| *Live births* | *nr** | *630* | *nr** | *592* | *601* | *711* | *871* | *996* | *862* | *1,350* |
| *Fetal deaths* | *nr** | *9* | *nr** | *0* | *2* | *0* | *3* | *6* | *2* | *4* |

**Key:** 'nr*' – Not reported.

**Sources:** Australian Institute of Health and Welfare, 2004b-2013.

The variation between the number of homebirths by women and the number of total births is that more than one baby may have been delivered (eg twins).

Limitations of the data include the uncertainty around which health practitioner is assisting the birth, if any (eg free birth), and the intent of having a planned homebirth. Also, as demonstrated when looking at state and territory data (see Table 34), the completeness of the data is also compromised as a result of information not being published by a state or territory. These limitations are understandable given the role of AIHW and in response to the level of data collected for births.

### *Number of homebirths by jurisdiction in Australia*

Statistics are also provided by jurisdiction (see Table 34). This represents the number of women who actually gave birth at home within each state or territory.

**Table 34: Number of homebirths by jurisdiction in Australia**

| Year | NSW | Vic. | Qld | WA | SA | Tas. | ACT | NT | Total |
|---|---|---|---|---|---|---|---|---|---|
| 2001 | 144 | 127 | 194 | 144 | 37 | 6 | 16 | 31 | **699** |
| 2002 | 99 | 163 | 154 | 121 | 48 | 4 | 14 | 34 | **637** |
| 2003 | 108 | 153 | 67 | 163 | 62 | nr* | nr* | 14 | **576** |
| 2004 | 93 | 181 | 57 | 150 | 67 | 5 | 25 | 11 | **589** |
| 2005 | 112 | 189 | 42 | 155 | 63 | 21 | 10 | 9 | **601** |
| 2006 | 125 | 197 | 47 | 194 | 86 | 12 | 13 | 34 | **708** |
| 2007 | 144 | 253 | 81 | 200 | 107 | 36 | 10 | 39 | **870** |
| 2008 | 196 | 297 | 111 | 232 | 101 | nr* | 5 | 31 | **1,000** |
| 2009 | 228 | nr* | 123 | 245 | 134 | 85 | 11 | 37 | **863** |
| 2010 | 246 | 567 | 85 | 255 | 142 | 13 | 6 | 31 | **1,345** |
| **Total** | **1,495** | **2,127** | **961** | **1,859** | **847** | **182** | **110** | **271** | |

**Key:** 'nr*' – Not reported.

**Note:** Data limitations include the uncertainty around which health practitioner (if any) is assisting the birth. There are also limitations as to whether the births are by publicly funded midwifery schemes or by PPMs. Also note that due to different data extracts being reviewed, there are variations between the aggregate totals for states and territories.

**Source:** Australian Institute of Health and Welfare, 2004b-2013.

## *Proportion of homebirths in Australia*

The proportion of homebirths in Australia can be calculated in a number of different ways; AIHW data collate homebirth in terms of the proportion of women who give birth at home rather than as a proportion of all live births which occur at home. See Table 35.

**Table 35: Proportion of homebirths in Australia**

| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|---|---|---|---|
| Per cent of actual homebirths (per woman) | 0.28% | 0.25% | 0.23% | 0.23% | 0.23% | 0.27% | 0.31% | 0.34% | 0.29% | 0.45% |

**Note:** Limitations of the data include the uncertainty around which health practitioner is assisting the birth or whether the birth is not attended by the health practitioner. There are also limitations as to whether the births are by publicly funded midwifery schemes or by PPMs.

**Source:** Australian Institute of Health and Welfare, 2004b-2013.

## J.3. Maternal outcome literature findings

## Findings

### Australian studies

Australian studies including Kennare et al, Crotty et al, and Woodcock et al,[327] demonstrate positive maternal outcomes from homebirths. However as a result of data limitations, caution should be applied to these studies. For example, it could not be distinguished in the studies:

- Who provided the service ie PPM, public hospital staff
- Whether anyone attended the birth
- If a woman had complex needs during the pregnancy.

Further, these studies have only been completed on a state and territory basis and not nationally and also may not have been statistically significant.

The most recent study undertaken in Australia looking at maternal morbidities was completed by Kennare et al. Kennare et al found that there were better outcomes (measured by postpartum haemorrhage (PPH) and perineal tears) for planned homebirths, than other settings of care. While these results were not statistically significant for homebirth, the study did include high-risk women.[328]

### International studies

The literature review completed identified that in general, two maternal outcomes were documented within studies and academic journals; PPH and perineal tears. Both PPH and perineal tears are considered to be severe adverse outcomes. Note that there are other conditions which a mother may experience while giving birth that may result in a claim, but we have focussed on those which are the most common in studies.[329]

In most cases, PPH can be managed so that there are no long-term consequences for a mother. However, it is possible that in extreme cases, mismanagement can lead to the need for a hysterectomy. Perineal tears of a certain degree alternatively can lead to long-term damage for a mother. The perineal status, its description and care required are outlined in Table 36.[330] The outcome from a perineal tear of 3rd or 4th degree can lead to long-term damage. Therefore, we have made the assumption that an insurer would be concerned with these types of outcomes from birth.

**Table 36: Descriptions of perineal tears and the level of care and pain after tearing**

| Status | Description | Care required |
|---|---|---|
| Intact | No laceration occurs | No further care required |
| 1st degree laceration/vaginal | Injury to the skin | Few or no stitches may be required. Usually quick to heal |

327 Kennare RM, Keirse MJ, Tucker GR & Chan AC 2010; Crotty M, Ramsay AT, Smart R & Chan A 1990; Woodcock HC, Read AW, Moore DJ, Stanley FJ & Bower C 1990.

328 Kennare RM, Keirse MJ, Tucker GR & Chan AC 2010.

329 Other conditions which could have been assessed are prolapsed cord, uterine rupture, blood transfusions, obstetric shock, manual removal of placenta, uterine prolapsed, infections and other types of tear.

330 Note that episiotomies were not included and combined lacerations and episiotomies were not included.

| Status | Description | Care required |
|---|---|---|
| graze | | and cause little or no discomfort to the woman |
| 2nd degree laceration | Injury that may involve the posterior vaginal wall, subcutaneous fat, perineal skin layer, superficial muscles and deep muscles | Tears need to be stitched closed layer by layer. May take a few weeks to heal. Stiches dissolve on their own |
| 3rd degree laceration | Injury involving the above muscles but also the anal sphincter complex. Three categories include:<br>• 3a: partial tear of the external anal sphincter involving less than 50% thickness<br>• 3b: greater than 50% tear of the external anal sphincter<br>• 3c: internal sphincter is torn. | Can cause considerable pain for several months<br>Increases risk of anal incontinence |
| 4th degree laceration | Involves complete disruption of external and internal anal sphincter complex and the anal epithelium | Can cause considerable pain for several months<br>Increases risk of anal incontinence |

**Sources:** Descriptions of tears found at The Women's 2013; Descriptions of care or treatment found at the Baby Centre 2012.

A review of publicly available literature found that Canadian studies were useful to consider given the level of detail with which the studies looked at homebirth activity. The Canadian studies provided data which demonstrated each different morbidity condition and also identified the practitioners and low-risk women. Canadian studies[331] demonstrate lower rates of maternal morbidity from homebirths than births provided in hospital environments. Studies from England also demonstrated lower rates in maternal outcomes for third or fourth degree perinatal trauma whether for high-risk or low-risk women.[332] These outcomes can be seen in Table 37.

### Table 37: Example of findings from international academic studies on birthing interventions

| Number | Jurisdiction | Finding from homebirths |
|---|---|---|
| 1 | Ontario, Canada | Lower rates of PPH and 3rd and 4th degree perineal tears |
| 2 | British Columbia, Canada | Lower rates of 3rd and 4th degree tears |
| 3 | England | Lower rates of 3rd and 4th degree tears |

Lower rates of maternal morbidity in the form of PPH, perineal tears and retained placentas were also seen in several pieces of literature reviewed, when comparing planned homebirth to planned other birth settings, as seen in Table 38.

331 Hutton EK, Reitsma AH & Kaufman K 2009; Jansssen, PA, Saxell L, Page LA, Klein MC, Liston RM & Lee SK 2009.

332 National Institute for Health Research, 2011.

**Table 38: Rates of maternal morbidity**

| Author, date published | Data | Jurisdiction | Settings of birth | Lower rates of type of maternal morbidity seen in homebirth (✓/×) % differences between models of care | |
|---|---|---|---|---|---|
| | | | | Postpartum haemorrhage (PPH) | Perineal tears (3rd and 4th degree) |
| Hutton, Reitsma & Kaufman 2009 | 2003-2006 | Ontario, Canada | | ✓ (for >1000mL) | ✓ |
| | | | Planned homebirth: 6,692 | 0.8% | 2.1% |
| | | | Planned hospital birth: 6,692 | 1.2% | 1.5% |
| Janssen, Saxell, Page, Klein, Liston & Lee 2009 | 2000-2004 | British Columbia, Canada | | ✓ | ✓ |
| | | | Planned homebirth: 2,889 | 3.8% | 1.2% |
| | | | Planned midwife-led hospital birth: 4,752 | 6.0% | 2.9% |
| | | | Planned physician-led hospital birth: 5,331 | 6.7% | 3.4% |
| National Institute for Health Research, 2011 | 2007 – 2008 | England | | ✓ for low-risk (blood transfusion) | ✓ |
| | | | Planned homebirth: 17,000 | 0.6% (low-risk)<br>1.2% (high-risk) | 1.9% (low-risk)<br>1.8% (high-risk) |
| | | | Freestanding Midwifery Unit: 5,000 | 0.5% (low-risk)<br>0.2% (high-risk) | 2.3% (low-risk)<br>1.5% (high-risk) |
| | | | Obstetric Unit: 30,000 | 1.2% (low-risk)<br>2.0% (high-risk) | 3.2% (low-risk)<br>2.8% (high-risk) |
| Kennare, Keirse, Tucker & Chan 2010. | 1998 – 2006 | South Australia | | ✓* | ✓* |
| | | | Planned homebirths: 1,141 | 4.4% | 1.0% |
| | | | Planned hospital birth: 295,598 | 5.5% | 1.8% |

***Note:** The difference was noted as not statistically significantly different.

**Sources:** Hutton, Reitsma & Kaufman 2009; Janssen, Saxell, Page, Klein, Liston, Lee 2009; National Institute for Health Research 2011, Kennare, Keirse, Tucker & Chan 2010.

While this international evidence given by Canadian and English studies represents the activities of independent midwives who operate within different maternity service environments, it does support homebirth as a safe midwifery model, although limitations were also identified as outlined below.

## *Limitations*

A scan and review of literature on maternal outcomes have identified several limitations that would need to be considered if insurers were to use them as substitutes when trying to understanding the likelihood of the adverse outcomes in Australia.

### *1 Lack of consistency in outcomes considered*

From a review of studies the outcomes relating to PPH and perineal tears, appear inconsistent. This appeared to be related to, for example:

- Definitions for medical conditions
- Practices and protocols for birth
- Outcomes recorded or analysed by journals.

An example of this is outlined in Table 39. In this table we have selected four journals that provided comment on perineal tears and postpartum haemorrhage outcomes.

**Table 39: Inconsistency in outcomes seen in journals for maternal outcomes**

| Outcome | SA, Australia (Kennare, Keirse, Tucker, & Chan, 2010) | Ontario, Canada (Hutton, Reitsma & Kaufman, 2009) | British Columbia, Canada (Janssen, Saxell, Page, Klein, Liston & Lee, 2009) | England (National Institute for Health Research, 2011) |
|---|---|---|---|---|
| Perineal tears | Yes, as a single category of '3rd and 4th degree perineal tears' | Yes, 6 categories of tears assessed which included<br>• 1st degree<br>• 2nd degree<br>• 3rd degree<br>• 4th degree<br>• Labial<br>• Vaginal. | Yes, four categories of tears assessed which included:<br>• None<br>• 1st or 2nd degree<br>• 3rd or 4th degree<br>• Degree or tear unknown. | Yes, single category of '3rd and 4th degree perineal tears' |
| Postpartum haemorrhage | Yes, as a single category | Yes, four different categories which included:<br>• <500 mL<br>• 500-1000 mL<br>• >1000 mL. | Yes, as a single category | No, but blood transfusion was a maternal outcome |
| Other outcomes recorded relating to maternal morbidity | None | None | • Prolapsed cord<br>• Uterine rupture<br>• Blood transfusion<br>• Obstetric shock<br>• Death | Blood transfusion |

| Outcome | SA, Australia (Kennare, Keirse, Tucker, & Chan, 2010) | Ontario, Canada (Hutton, Reitsma & Kaufman, 2009) | British Columbia, Canada (Janssen, Saxell, Page, Klein, Liston & Lee, 2009) | England (National Institute for Health Research, 2011) |
|---|---|---|---|---|
| | | | • Manual removal of placenta<br>• Uterine prolapsed<br>• Infection (4 classes – pyrexia, urinary tract, puerperal fever, wound)<br>• Cervical tear. | |

**Sources:** Kennare, Keirse, Tucker & Chan 2010; Hutton, Reitsma & Kaufman 2009; Janssen, Saxell, Page, Klein, Liston &Lee 2009; National Institute for Health Research, 2011.

Reconciling outcomes across international studies was difficult due to lack of consistency in the research completed. For example, the alternative for PPH is variable across journals, as the level of blood loss considered in each study was not discernible (eg within England there was not a proxy for PPH and therefore blood transfusions has been used as a determinant instead).

Using a substitute data point within the English studies for blood transfusion may not be seen to be a good proxy for an adverse outcome, as it could be perceived to be more of an intervention in the birth. However, it should be noted that it appears that high-risk women in homebirth have the same probability of requiring a blood transfusion as those in an obstetric unit. Other outcomes also noted by Janssen et al showed higher rates of pyrexia infection in planned midwifery-led hospital birth and obstetric units compared to homebirths. All other outcomes did not show statistical significance across practices.

## 2. *Journals and other studies have limitations which make the findings on maternal outcomes inconclusive*

The AIHW has recently started to record perineal status for women who give birth vaginally (total births by all settings). To demonstrate the low significance of the number of women who will one, have a vaginal birth each year in all settings, and also two, will have a 3rd or 4th degree tear, numbers have been recorded in AIHW's *Annual Mother and Babies Report*. The number of these types of tears is low only occurring in 2,713 of births, which accounts for 1.8 per cent of all births as shown in Table 40.

**Table 40: Perineal tears by status for vaginal birth across all settings in Australia 2010**

| | Intact | 1st degree | 2nd degree | 3rd/4th degree | Other* | Total |
|---|---|---|---|---|---|---|
| Number | 42,961 | 34,974 | 39,890 | 2,713 | 31,238 | 151,776 |
| Per cent of vaginal births (women) | 28.3 | 23.0 | 26.3 | 1.8 | 20.6 | 100.0 |

**Note*:** Other includes episiotomies, combined episiotomies and lacerations, other and not stated categories.

**Source:** Australian Institute of Health and Welfare, 2004b-2013.

Additional specificity for maternal morbidity information recorded by AIHW is not included in this as the data is not reconcilable across states and territories: there is variability in definitions, practices and protocols used to assess conditions.[333] Instead, the outcomes documented in journals that were held to be benchmarks for homebirth practice were used.

## J.4 Perinatal outcome literature findings

There is benefit from understanding the variation in perinatal outcomes between planned homebirths and other settings of care. An insurer could then look to adjust premiums according to the risk profile or practice. From research completed adverse perinatal outcomes appear to be uncommon for all births. Therefore when differences between models relating to outcomes are outlined, this should remain a central consideration.

International studies, in line with Australian studies, are inconclusive as a result of the characteristics attributed to women. International studies with the fewest limitations show the difference between settings may not be statistically significant or no worse than hospital settings. These are outlined in further detail below.

## Perinatal mortality

### Australian studies

From reviewing available studies, it is inconclusive whether homebirths lead to greater perinatal mortality than other birthing models of care in Australia[334] as there have been different outcomes presented; both higher rates[335] and no increase in rates.[336] These studies have data limitations, specifically in not drawing out differences in high and low-risk women within the study and in using old data sets (ie data from before 2000) (see Chapter 3, Finding 2).

Challenges were identified with reviewing Australian studies given the quality of data available. It was determined that there are several areas where data is not collated accurately and quickly enough in Australia to determine the number of perinatal deaths from PPM practice. This is due to a context where:

- There are delays in births being registered[337]
- Some deaths may not be notified to the state and territory perinatal data collections but are still registered by the parents as a live birth. This is more likely to occur in remote/regional areas than metropolitan areas
- Births are not differentiated by health practitioner within the AIHW data
- Data on births do not show the transfer rate to other health services when a planned homebirth requires other practitioner attention

333 Australian Institute of Health and Welfare, 2013.

334 Kennare RM, Keirse MJ, Tucker GR & Chan AC 2010.

335 For example, Bastian H, Keirse MJ & Lancaster 1998 demonstrated a higher rate of perinatal mortality for homebirths compared to hospital births (7.1/1000 births). However, by removing high-risk women, there was no variation. Also, the study was completed prior to 2000 falling outside of the review period being analysed.

336 For example Kennare RM, Keirse MJ, Tucker GR & Chan AC 2010 demonstrated that there was not an increase in perinatal mortality for homebirth compared to hospital births (7.9/1,000 vs. 8.2/1,000). However, the study only looked at South Australia and therefore is not representative of Australia.

337 Australian Institute of Health and Welfare, 2013.

- There is variation in data collated across states and territories given that some states record transfer information and publicly report on it on a regular basis (eg South Australia and Western Australia). The AIHW through the NPESU also collate this data.

It is worth noting that a leading cause attributed in an Australian study to perinatal or intrapartum mortality is intrapartum asphyxia.[338] Intrapartum asphyxia is the impairment of the delivery of oxygen to the brain and vital tissues during the progress of labour. However, this outcome may in part be linked to the study's inclusion of a cohort of women who had high-risk factors that developed during the birth. This finding is important for three reasons:

- The finding links closely to significantly lower rates of fetal monitoring in homebirth compared to hospital birth[339, 340]

- Intrapartum asphyxia is associated as one of the causes of cerebral palsy or encephalopathy. The largest ever payout for an obstetric case in Australia was related to cerebral palsy (see *Simpson v Diamond* call out box in Chapter 2)

- Women included in studies (eg high or low-risk) impact upon the study outcome, with the result that their study might be misleading.

## *International studies*

International studies reviewed were not definitive for PPMs with respect to changes in perinatal mortality rates as a result of the inclusion of nulliparous women. Recent evidence has shown perinatal mortality rates can be significantly higher if nulliparous women are analysed. Studies previously have not used nulliparous women to indicate higher risk women (including the ACM *Literature Review on Homebirth*[341] which indicated it excluded an English study), demonstrating a limitation in comparatives between studies.

Studies undertaken in the provinces of Ontario,[342] and British Columbia[343] in Canada, the Netherlands,[344] and Sweden[345] do not demonstrate an increase in perinatal mortality rates between planned homebirth compared to planned hospital birth as shown in Table 42.

338 Kennare RM, Keirse MJ, Tucker GR & Chan AC 2010.

339 Janssen PA, Saxell L, Page LA, Klein MC, Liston RM & Lee SK 2009.

340 Johnson KC & Daviss BA 2005.

341 Australian College of Midwives, 2011.

342 Hutton EK, Reitsma AH & Kaufman K 2009.

343 Janssen PA, Saxell L, Page LA, Klein MC, Liston RM & Lee SK 2009.

344 de Jonge A, van der Goes BY, Ravelli AC, Amelink-Verburg MP, Mol BW, Nijhuis JG, Bennebroek Gravenhorst J & Butiendijk SE 2009.

345 Lindgren HE, Radestad IJ, Christensson K & Hildingsson IM 2008.

**Table 41: Example of findings from international academic studies on birthing interventions**

| Jurisdiction | Finding from homebirths |
|---|---|
| Ontario, Canada | No increase in rates of perinatal mortality for planned homebirths |
| British Columbia, Canada | No increase in rates of perinatal mortality for planned homebirths |
| The Netherlands | No increase in rates of perinatal mortality for planned homebirths |
| Sweden | No increase in rates of perinatal mortality for planned homebirths |
| England | Higher rates for a composite of adverse perinatal outcomes only for nulliparous, low-risk women |

**Sources:** Hutton, Reitsma & Kaufman 2009; Janssen, Saxell, Page, Klein, Liston & Lee 2009; de Jonge, van der Goes, Ravelli, Amelink-Verburg, Mol, Nijhuis, Bennebroek Gravenhorst & Butiendijk 2009; Lindgren, Radestad, Christensson & Hildingsson 2008; National Institute for Health Research, 2011.

Limitations for the use of international studies as applicable to the Australian context are noted in Chapter 3, Finding 2. However, it is particularly worth noting certain limitations for using perinatal mortality including:

- There are different international definitions for perinatal death, and it can be reported as intrapartum mortality, stillbirth and neonatal death. For example, in Australia, perinatal mortality is the death of the fetus from 20 weeks of pregnancy to 28 days after birth. However, this can be classified as different time periods, based on the origin of the study undertaken. The Netherlands, for instance, uses a different definition for perinatal death

- The cause of perinatal death is not always assessed; therefore, it is difficult to link the outcome with a complication by the woman or a fault on the midwife's part.

## *Perinatal morbidity*

### *Australian studies*

Perinatal morbidity is also relevant for an insurer, particularly if it leads to permanent disablement as this could lead to ongoing payments being paid by an insurer to facilitate care during the child's life. In the case of *Simpson v Diamond* (see call out box in Chapter 2), damages were awarded as a result of negligence during the birth that was found to have led to the disability.

Using the literature to assess the prenatal morbidity outcomes from homebirths, issues identified included that:

- AIHW data for perinatal morbidity outcomes were not recorded for homebirths

- Australian studies are not representative of perinatal outcomes for PPM activity (the last study conducted was undertaken in 1994 by Woodcock, Read et al)[346]

346 Woodcock HC, Read AW, Bower C, Stanley FJ & Moore DJ 1994.

- Perinatal morbidity outcomes in journals do not give a full representation of all outcomes on the ACM guidelines or outcomes which an insurer may be interested in for establishing the risk profile of PPMs. The outcomes monitored are often related to APGAR scores and birth weight, or short-term complications with the birth, rather than the impact on a baby's life. For example, a further unconsidered outcome which was identified in consultation was the possibility of a baby suffering from hyperbilirubinemia (ie jaundice) where excess bilirubin in the blood causes its thickening.[347] This adverse outcome is not reported in statistics but is held to be a serious condition as it can be hard to detect and it corrodes neurons in the brain, which may cause long term damage

- Kennare et al considered specialised neonatal care; however, given that this includes high and low-risk women in the cohort studied, it provides little guidance on potential adverse outcomes if insurers are insuring PPMs following ACM guidelines.

## *International studies*

International studies also show similar difficulties as the Australian studies. It may be difficult for insurers to know the long term impact of a neonatal morbidity, as the results are recorded as neonatal outcomes rather than morbidities. The information recorded at birth may not give a clear picture of how much support a baby will need for the rest of their life; therefore, claims for PPMs are likely to be long tail.

Findings from reviewing literature are that there are lower rates of perinatal morbidity where nulliparous low-risk women are excluded, see Table 43.

**Table 42: Example of findings from international academic studies on birthing interventions**

| Jurisdiction | Finding from homebirths |
|---|---|
| British Columbia, Canada | Lower rates of birth trauma from subdural or cerebral haemorrhage, fracture of clavicle, long bones or skull, facial nerve injury, Erb's palsy or unspecified.<br>Lower rates of resuscitation at birth. |
| Ontario, Canada | No increased rate of perinatal morbidity seen for homebirths provided by Ontario midwives. |
| England | Higher rates for a composite of adverse perinatal outcomes for nulliparous, low-risk women. |

**Source:** Janssen, Saxell, Page, Klein, Liston & Lee2009; National Institute for Health Research, 2011.

Consultations indicated that there are other jurisdictions that have more sophisticated databases or research approaches to obtaining information on neonatal outcomes when compared to Australia. Examples internationally where relevant databases have been successfully created are:

- *The England Birthplace Cohort study* has provided a full picture of birth practices and outcomes from those practices in England[348]

- The KNOV in the Netherlands monitors approximately 1,000 indicators for midwives and therefore has a large statistical database upon which to base studies[349]

347 HIROC, Personal Communication, March 2013.

348 National Institute for Health Research, 2011.

- BORN in the province of Ontario records hospital and unit data for outcomes.[350]

More sophisticated database or research approaches may be something that is considered in the future to implement in Australia, not only for the purpose of risk assessment for PPM, but more broadly for maternity service outcomes.

## J.5. Situational influences

As outlined in Chapter 3, four conditions were identified as examples of situational influences that may impact upon the incidence of adverse outcomes:

- **Risk profile of women:** Services provided in the home to a caseload of mixed-risk women, ie both high and low-risk women
- **Proximity to health services:** The location of health services relative to the woman's place of residence
- **Practice of midwifery during homebirths:** The number and types of interventions which occur from PPM activity in homebirths, given that PPMs are only meant to provide services for normal vaginal births
- **Transfers from home to hospital:** The outcomes from transfers to hospitals and the relative number of times where transfers occur.

## Risk profile of women

Currently, data is insufficient in Australia on the risk involved in the birth, for the following reasons:

- **Definitions:** Definitions of high-risk were absent in Australian studies for outcomes from homebirth
- **Availability of data:** There is no publicly available data for outcomes from homebirth by high and low-risk women
- **Substitutes:** International data substituted in the place of Australian data, relate to outcomes based in different operating environments and definitions of high-risk.

### *Definitions*

High-risk is defined in the Department of Health WA guidelines as:

> *"the term used by clinicians to describe women who have a history of problems in a previous pregnancy or have an existing medical condition or have some potential risk of complications that might require speedy or specialist treatment."*[351]

However, not all studies have applied this definition, or studies did not define women as of lower or higher obstetric risk for the purpose of understanding outcomes from homebirth.

### *Availability of data*

Without consistency of definitions, it is difficult to assess the potential for adverse outcomes to result. Currently, information on characteristics of high-risk women and of adverse outcomes is not available.

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349 Personal communication, December 2012.

350 BORN Ontario, 2012.

351 Department of Health WA 2011, p.xi.

Given that publicly available data do not show the outcomes for PPMs providing homebirth to either low or high-risk women, journals were reviewed to understand homebirth outcomes. This review found that Australian journals did not have sufficient data to assess factors that may affect outcomes associated with high and low-risk women. In the ACM report,[352] women having homebirths who were of higher obstetric risk were noted. However in this case, the data sample size was not large enough to be able to reach a conclusion, even if the data were available.

## *Proxies*

Even when high-risk is defined by international studies, there are differences (the impact of was not tested) seen across jurisdictions, including:

- Different gestational ages
- Inclusion of women who were transferred to hospital or health services
- Potential differences between the risks associated with medical conditions or obstetric risk
- Induction or augmentation of the labour
- Medical conditions occurring during labour, ie prolonged rupture of membranes.

As an example, a comparison of definitions of low-risk in the province of British Columbia in Canada, and the Netherlands in a series of cohort studies was completed, as seen in Table 43 below.

**Table 43: Academic literature definitions of low-risk women**

| | Classification | Not included in definition |
|---|---|---|
| British Columbia, Canada | • Gestational age greater than 36 and less than 41 completed weeks of pregnancy<br>• Absence of significant pre-existing disease, including heart disease, hypertensive chronic renal disease or type 1 diabetes<br>• Absence of significant disease arising during pregnancy, including pregnancy-induced hypertension with proteinuria (>0.3 g/L), antepartum haemorrhage after 20 weeks gestation, gestational diabetes requiring insulin, active genital herpes, placenta previa or placental abruption<br>• Singleton fetus<br>• Cephalic presentation<br>• Woman has had no more than one previous caesarean section<br>• Labour is spontaneous or induced on an outpatient basis<br>• Woman has not been from a referring hospital | • Excluded:<br>– Planned homebirths during which the fetal presentation was determined to be breech after the onset of labour<br>• Women who had had a previous caesarean birth, because these women are ineligible for homebirth |

352 Australian College of Midwives, 2011.

| | Classification | Not included in definition |
|---|---|---|
| The Netherlands | • Women who gave birth between 37 and 42 weeks gestation to a single fetus<br>• No medical or obstetric risk factors that were known before labour, such as non-cephalic presentation or a previous caesarean section<br>• Women in study who planned a homebirth who may have ended up giving birth hospital | • Women classified as medium risk, ie to be looked after by secondary care due to previous postpartum haemorrhage<br>• Women who had prolonged rupture of membranes (more than 24 hours) without contractions, intrauterine death before labour started or a child with a congenital abnormality |

**Sources:** Janssen, Saxell, Page, Klein, Liston & Lee 2009; de Jonge, van der Goes, Ravelli, Amelink-Verburg, Mol, Nijhuis, Bennebroek Gravenhorst & Butiendijk 2009.

## *Proximity to health services*

It was indicated in consultations that geographic issues are believed to be strongly associated with the transfer time taken to transport the woman and/or child from home to hospital and the options for referral of care.[353] There was limited data identified in Australia that demonstrated the distance between services provided in the home and options for referred care (eg health services).

From consultations with insurers in the Netherlands, it was identified that homebirth services delivered geographically further from care may have an increased risk profile.[354] With this in mind, data on the distance of homes to alternate referral health services, and on the associated transfer time, as well as the time associated with the birth appear to be insufficiently known for the purposes of establishing a risk profile, as the distance from place of referral is not publicly recorded in Australia.

### *Distance*

Homebirths currently recorded by AIHW outline the ABS remoteness area of woman's usual residence. For the purposes of determining a risk profile, this has limitations as it does not:

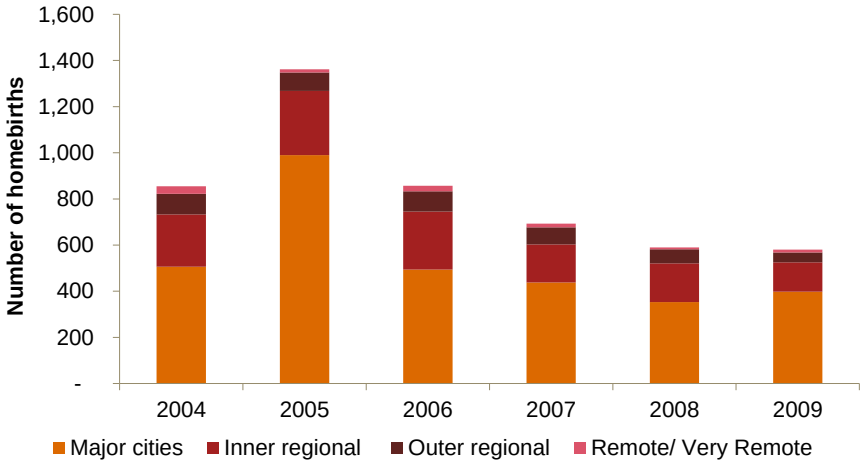
- Show how far away the woman's residence is from referral health practitioners
- Demonstrate how far away a PPM is travelling to the woman's residence.

For example, Figure 17 contains information from the AIHW, showing that most births are in major cities and inner regional areas. However, this does not indicate the timings and distances for those women to be safely transferred to a referral health service (eg health service).

353 Personal communication, November 2012.

354 Ibid.

**Figure 17: Number of homebirths by remoteness area of woman's usual residence**




**Source:** Australian Institute of Health and Welfare, 2006-2011.

## *Practice of midwifery during homebirths*

Research completed highlighted an uncertainty around the number and types of interventions in homebirth provided by PPMs in Australia. There appears to be insufficient data to understand if a PPM is operating within their scope of practice and to understand the causal relationship and likelihood of an incidence occurring where there are a greater number of interventions.

From a review of literature and publicly available data, issues identified with the current data set include a lack of data on:

- **Care outside practice:** Publicly available data on the numbers of PPMs providing care outside of the practice of a normal vaginal birth or why the PPM either provided care in this form or intervened (if appropriate)

- **Medication:** Publicly available data for number of PPMs prescribing drugs to induce or for pain relief during birth.

As with the other situational influences, international and national sustainable data in this area appear insufficient and limited in being able to understand PPM activity.

### *Care outside of practice*

Consultations highlighted that actual interventions used by PPMs are not well known, and therefore do not appear to be documented publicly. AIHW statistics on rates of interventions as shown in Table 44 outline that for homebirths, the majority have no interventions and are normal vaginal births.[355]

355 Australian Institute of Health and Welfare, 2004b-2013.

**Table 44: Number of normal vaginal births**

| Method of birth | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|---|
| Normal vaginal birth | 581 | 592 | 690 | 866 | 990 | 859 | 1,335 |
| Other | 8 | 9 | 10 | 1 | 10 | 4 | 4 |
| **Total** | **589** | **601** | **700** | **867** | **1,000** | **863** | **1,339** |

**Source:** Australian Institute of Health and Welfare, 2006-2012.

However, using this AIHW data has its limitations. It is not known for example:

- The number of PPMs practising or the number of homebirths supported by PPMs; it is possible that the interventions in homebirths were not performed by PPMs
- Why there are still a small proportion of homebirths which do have interventions
- The maternal characteristics of the data set in terms of risk
- Whether an intervention was intended for the homebirth
- Whether the woman refused a transfer to a referred health setting by the PPM.

## *Literature findings*

In line with consultations held, findings from homebirth studies show that there are lower intervention rates for homebirth (see Table 45). Consultations identified that homebirths should be provided to women who are low-risk and therefore should require on average, less intervention than high-risk women.[356]

Literature findings are useful as a guide but again, they are limited in their application as there is no cause provided in relation to interventions made. For example, Kennare et al is the most recent Australian study that has compared intervention rates. The study saw lower rates of caesarean section, instrumental delivery and episiotomy during homebirths. Similarly, the Department of Health, WA assessed the intervention rates found in several international journals and found that rates were lower for homebirth. The findings of the international studies findings for intervention rates are summarised in Table 45.

**Table 45: Example findings from international studies on birthing interventions**

| | Jurisdiction | Finding from homebirths |
|---|---|---|
| 1 | Canada | Lower rates of augmentation in terms of artificial ruptured membranes and use of oxytocin |
| 2 | Canada | Lower rates of analgesia in terms of nitrous oxide, narcotics and epidurals |
| 3 | Canada, Sweden, US | Lower rates of episiotomies, assisted vaginal deliveries and caesarean sections |

356 Personal communication, March 2013.

Table 46 shows that lower rates of augmentation have been documented in Canada for both Artificial Rupture of Membranes and Oxytocin.

**Table 46: Rates of augmentation**

| Author, date published | Data period | Jurisdiction | Settings of birth | Lower rates of type of augmentation seen in homebirth (✓/×) % in study | |
|---|---|---|---|---|---|
| | | | | Artificial Rupture of Membranes (ARM) | Oxytocin |
| Hutton, Reitsma & Kaufman 2009 | 2003 – 2006 | Ontario, Canada | | ✓ | ✓ |
| | | | Planned homebirth: 6,692 | 22.4% | 8.2% |
| | | | Planned hospital birth: 6,692 | 28.2% | 13.1% |
| Janssen, Saxell, Page, Klein, Liston & Lee 2009 | 2000 – 2004 | British Columbia, Canada | | ✓ | ✓ |
| | | | Planned homebirth: 2,889 | 19.3% | 5.9% |
| | | | Planned midwife-led hospital birth: 4,752 | 31.9% | 12.7% |
| | | | Planned physician-led hospital birth: 5,331 | 39.6% | 18.4% |

**Sources:** Hutton, Reitsma & Kaufman 2009; Janssen, Saxell, Page, Klein, Liston & Lee 2009.

Table 47 shows that lower rates of analgesia have been documented in Canada.

**Table 47: Rates of pharmaceutical pain relief**

| Author, date published | Data period | Jurisdiction | Settings of birth | Lower rates of type of analgesia seen in homebirth (✓/×) % in study | | |
|---|---|---|---|---|---|---|
| | | | | Nitrous Oxide | Narcotic | Epidural |
| Hutton, Reitsma & Kaufman 2009 | 2003 – 2006 | Ontario, Canada | | ✓ | ✓ | ✓ |
| | | | Planned homebirth: 6,692 | 3.3% | 1.7% | 9.8% |
| | | | Planned hospital birth: 6,692 | 18.0% | 6.3% | 21.0% |

**Sources:** Hutton, Reitsma & Kaufman 2009.

Table 48 shows that lower rates of episiotomies, assisted vaginal deliveries and caesarean sections.

**Table 48: Rates of episiotomies, assisted vaginal deliveries and caesarean sections**

| Author, date published | Data period | Jurisdiction | Settings of birth | Lower rates of type of intervention seen in homebirth (✓/×) % in study | | |
|---|---|---|---|---|---|---|
| | | | | Episiotomies | Assisted vaginal deliveries | Caesarean sections |
| Hutton, Reitsma & Kaufman 2009 | 2003 – 2006 | Ontario, Canada | | ✓ | ✓ | ✓ |
| | | | Planned homebirth: 6,692 | 4.3% | 2.9% | 5.2% |
| | | | Planned hospital birth: 6,692 | 5.9% | 4.4% | 8.1% |
| Janssen, Saxell, Page, Klein, Liston & Lee 2009* | 2000 – 2004 | British Columbia, Canada | | ✓ | ✓ | ✓ |
| | | | Planned homebirth: 2,889 | 3.1% | 3.0% | 7.2% |
| | | | Planned midwife-led hospital birth: 4,752 | 6.8% | 7.2% | 10.5% |
| | | | Planned physician-led hospital birth: 5,331 | 16.9% | 13.8% | 11.0% |
| Lindgren, Radestad, Christensson & Hildingsson, 2008 | 1992 – 2004 | Sweden | | ✓ | ✓ | ✓ |
| | | | Planned homebirth: 897 | 0.8% | 2.2% | 2.4% |
| | | | Planned hospital birth: 11,341 | 7.2% | 9.6% | 6.8% |
| Johnson & Daviss 2005 | 2000 | USA and Canada | | Not recorded | | |
| | | | Planned homebirth: 5,418 | 2.1% | | 3.7% |

**Note*:** Janssen, Saxell, Page, Klein, Liston & Lee also compared caesarean sections for nulliparous women (13.0% vs. 18.7% vs. 21.8%) with multiparous women (3.0% vs. 1.9% vs. 3.4%).

**Sources:** Hutton, Reitsma & Kaufman 2009; Janssen, Saxell, Page, Klein, Liston & Lee 2009; Lindgren, Radestad, Christensson & Hildingsson 2008; Johnson & Daviss 2005.

Again, it must be noted that in part, similar statistical challenges as seen in Australian studies reviewed were identified and that the outcomes should be considered in light of the environment.

## *Transfers from home to hospitals*

Transfer data on how many mothers and babies are referred from PPMs to other practitioners, and the time taken to transfer from a PPM to a different practitioner, could provide insurers with insight on:

- The operating environment in which PPMs practice
- The amount of risk taken on by a PPM.

It was identified that data for transfers may be insufficient for insurers to use as:

- **Number of transfers:** Data for the number of transfers completed from home to health services are not publicly available
- **Time taken for transfers:** Data for the time taken for transfer are not recorded
- **Persons transferred:** Data for who is transferred are not recorded ie mother, baby or both
- **Meaning of transfers in terms of outcomes:** Data for reasons for referral are not recorded
- **Access arrangements and transfers:** Data on transfer to hospital of choice are not recorded
- **Proxies for transfers:** Proxies for transfers are not always sufficient.

### *Number of transfers*

Publicly available information on the number of transfers could only be obtained through comparing the difference between the AIHW statistics (Table 49) to those who:

- Intended to give birth at home
- Those who actually gave birth at home.

**Table 49: Number of actual and intended homebirths in Australia**

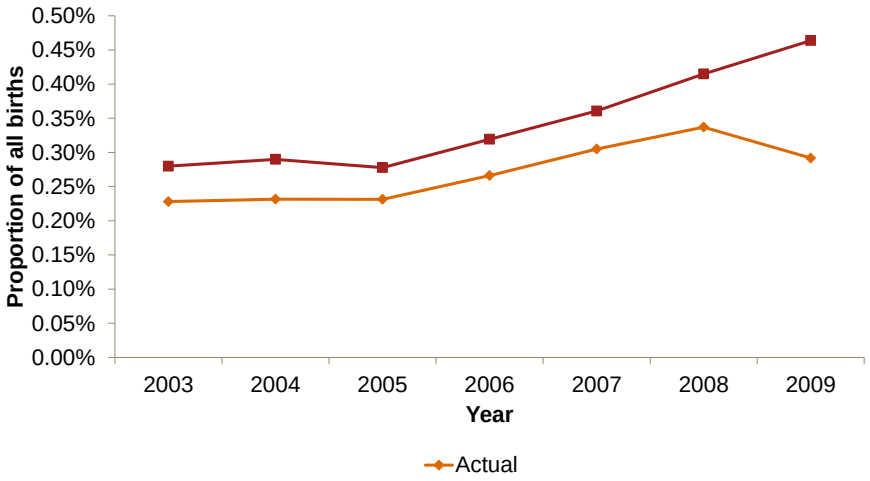
| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of actual homebirths (women) | 699 | 637 | 576 | 589 | 601 | 708 | 870 | 1,000 | 863 | 949 |
| Number of intended homebirths in Australia | - | - | 707 | 733 | 744 | 886 | 1,044 | 1,212 | 1,031 | 1,345 |

**Source:** Australian Institute of Health and Welfare, 2004b-2013.

The AIHW data is limited in that jurisdictions collect the intended place of birth at different times during the pregnancy. As an example, Victoria, South Australia and Tasmania determine the 'intent' of a homebirth at the time of booking the birth location, while the remaining states and territories collect the intended place of birth at the onset of labour.

As shown in Figure 18, the divergence between these two data trends show that marginally more women intend to give birth at home than the number who actually give birth at home.

**Figure 18: Proportion of births intended to be at home compared with those which took place at home**




**Sources:** AIHW, Mother and Babies publications, 2003–2009; Australian Bureau of Statistics 2011.

However, using the difference between these trends to account for transfer rates should be completed with caution. The collection methods used for each data set do not give a clear understanding of when the transfer occurred. For instance, the transfer may have occurred at different stages in the pregnancy.

In addition, there is little indication from the statistics available of those who actually gave birth at home who actually intended to give birth there. Further, while they provide a proxy, these statistics relate to all homebirths, not those supported by PPMs only.

## *Time of transfer*

Information available that relates to the time of transfer to a health service in the provision of maternity services may show that transfer rates are not indicative of adverse outcomes. Instead, the time of transfer could be indicative of transfer being used as a precautionary measure and is appropriate. A recent Australian study by McMurtie et al (2009) saw that the highest proportion of transfers for women planning a birth occurred in the antenatal period. This can be seen in Table 50.

**Table 50: Transfer rates to hospitals**

| Time of transfer | Rates of transfer per jurisdiction | | |
|---|---|---|---|
| | Australia | USA and Canada | UK |
| Antenatal | 30% | nr* | 35.9% |
| Intrapartum | 10.0% | 10.1% | 9.1% |
| Maternal transfer after birth | 2.9% | 1.3% | Nr* |
| Neonatal | 1.4% | 0.7% | Nr* |

**Key:** 'nr*' – Not reported.

**Sources:** McMurtrie, Catling-Paull, Teate, Caplice, Chapman & Homer 2009; Johnson & Davis 2005; National Institute of Health 2011.

A further difficulty identified in the data relates to its completeness, and whether data is representative of all transfers undertaken by homebirths.

## *Meaning of transfers in terms of outcomes*

Studies demonstrate that transfers will need to occur for some women planning to give birth at home. However, this is not unexpected, given that birth is a natural process and complications can occur. A PPM providing the care does not have the scope of practice to provide care for some complications in labour and the mother in these circumstances, may need the attention of other health professionals. Therefore, using transfers as an indication of an adverse outcome may not be accurate if it falls into the category of what some consulted with believe is the natural course of care for low-risk women.

In the UK, a recent study identified the primary reasons for transfer during labour. The most common reasons for transfer in the planned homebirth setting was seen to be failure to progress (18.5%) followed by meconium staining (5.5%) and repair of perineal trauma (4.5%). The most common reasons are shown below in Table 51.

**Table 51: Reasons for transfer to a health service**

| Most common reasons for transfer | From home – % | From freestanding maternity unit– % | From maternity unit – % |
|---|---|---|---|
| Failure to progress | 18.5 | 15.1 | 15.9 |
| Epidural request | 3.0 | 2.7 | 5.4 |
| Fetal distress | 3.1 | 4.0 | 4.3 |
| Meconium staining | 5.5 | 4.8 | 4.8 |
| Pain relief (epidural, not specified or other) | 1.1 | 0.1 | 0.0 |
| Postpartum haemorrhage | 1.2 | 0.7 | 0.7 |
| Repair of perineal trauma | 4.5 | 2.8 | 3.1 |
| Retained placenta | 1.9 | 1.6 | 1.1 |

**Source:** National Institute for Health Research 2011.

It is worth noting that as with pain relief, failure to progress is not held by some stakeholders consulted with for this report as a poor outcome in itself, but it is reflective that as a part of birth, some women will need to be transferred. It is only a poor outcome where transfers are hindered.

## J.6. Literature reviewed, biases and limitations

Table 52 details which studies were considered by key stakeholders when forming their position statements on the topic of homebirth. It can be seen that different documents are used to support their positions. Different biases can be demonstrated, as an example, by analysing the documents used by both RANZCOG[357] and ACM,[358] and how they are used, to support their positions.

Firstly, one bias arises from how interpretations differ regarding the relevance of a journal for supporting their position if high-risk women are included in the sample. The ACM note that the study by Kennare et all concluded that there are similar rates of perinatal mortality but higher rates of intrapartum death (including an increase In rates of intrapartum asphyxia) with homebirths compared to other health settings. However the ACM also note that there were factors identified in the sample that would mean that the women showing these outcomes were of a high-risk. The ACM also use Bastian et al and Parratt & Johnson for their literature review. Both of these documents are noted for including high-risk women. Therefore, the outcomes may not be considered as realistic as if the ACM guidelines for risk were applied to the cohorts chosen.

Secondly, another bias arises when considering how studies are used. As an example Mori et al is used for different arguments by stakeholders. The study is used by RANZCOG to support the position that those identified as low-risk in pregnancy may develop a complication necessitating transfer to care in a conventional birth suite setting – the argument being that in many locations in Australia this cannot be accomplished expeditiously. However, the ACM have used the study to show that unintended homebirths were included in the presented figures for showing that the higher intrapartum-related perinatal mortality rate from those transferred during labour should be treated with caution. The challenges that occur from this are that the documents are being used to support very different arguments and can be interpreted for different purposes.

The documents used by both bodies are predominantly from Australia, however as the scope of this required a focus on studies post 2000, several of studies have not been considered in the body of this report.

357 Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2011b.

358 Australian College of Midwives, 2011.

We have also noted the geographic location of these documents in the table below. We have included whether the WA health network has considered these documents and any others in their report. This is to demonstrate the divergence between positions between State and Clinical organisations.

**Table 52: Documents used by organisations to evidence outcomes from homebirth**

| Document | Jurisdiction | RANZCOG | ACM | WAHS | Chosen for literature review | Limitations for literature review |
|---|---|---|---|---|---|---|
| Wax, Lucas, Lamont, Pinette, Cartin & Blackstone 2010 | Developed western countries | ✓ | × | × | × | • Study data period is from 1976–2006 |
| Chang & Macones 2011 | Missouri, USA | ✓ | × | × | × | • Study is not a country study and falls outside of countries being analysed |
| Kennare, Keirse, Tucker, & Chan 2010 | South Australia, Australia | ✓ | ✓ | ✓ | ✓ | • Study was included but unknown what is included or excluded criteria for planned homebirth or what was high and low-risk<br>• Study data period is from 1991–2006 |
| McMurtrie, Catling-Paul, Teate, Caplice, Chapman & Homer 2009 | St George Hospital, Australia | ✓ | ✓ | ✓ | ✓ | • Study includes NSW, Australia and covers the period 2005–2009 |
| Crotty, Ramsay, Smart, & Chan 1990 | South Australia, Australia | ✓ | ×* | ✓ | × | • Study covers 1976–1987 |
| Woodcock, Read, Moore, Stanley, & Bower 1990 | Western Australia, Australia | ✓ | × | ✓ | × | • Study covers 1981–1987 |
| Bastian & Lancaster 1992 | Australia | ✓ | × | × | × | • Study covers 1988–1990 |

| Document | Jurisdiction | RANZCOG | ACM | WAHS | Chosen for literature review | Limitations for literature review |
|---|---|---|---|---|---|---|
| Woodcock, Read, Bower, Stanley & Moore 1994 | Western Australia, Australia | ✓ | × | ✓ | × | • Study covers 1981–1987 |
| Bastian, Keirse, & Lancaster 1998 | Australia | ✓ | ✓ | ✓ | × | • Study covers 1985–1990 |
| Parratt & Johnston 2002 | Victoria, Australia | ✓ | ✓ | × | × | • Study covers 1995–1998 |
| Hodnett, Downe, Edwards, & Walsh 2005 | Western countries | ✓ | × | × | × | • Study covered 6 different trials but the data from the trials were from prior to 2000. |
| Mori, Dougherty, & Whittle 2008 | England and Wales | ✓ | ✓ | ✓ | × | • Did not exclude women who had unintended homebirths<br>• Recent Birth place cohort study in England uses only planned homebirth data and therefore selected |
| Stern, Permezel, Petterson, Lawson, Eggers & Kloss 1992 | The Royal Women's Hospital Family Birth Centre, Australia | ✓ | × | × | × | • Study was for ten years of data before 1992 |
| Gulbransen, Hilton, McKay & Cox 1997 | New Zealand | ✓ | × | × | × | • Study covers 1973–1993 |

**Note*:** The document is cited in the position statement or literature review but may not contribute to the position of the organisation on the outcomes from homebirth.

Other documents used by ACM to support their position but which were not used by RANZCOG are included in the table below.

**Table 53: Other documents used by the ACM and WA Health networks**

| Document | Jurisdiction | ACM | WAHS | Chosen for literature review | Limitations for literature review |
|---|---|---|---|---|---|
| Ackermann-Liebrich, Voegeli, Gunter-Witt, Kunz, Zullig, Schindler, Maruer 1996 | Switzerland | ✓ | ✓ | × | Study data period is from 1989–1992 |
| Anderson & Murphy 1995 | USA | ✓ | | × | Study data period is from 1987–1991 |
| de Jonge, van der Goes, Ravelli, Amelink-Verburg, Mol, Nijhuis, Bennebroek Gravenhorst & Butiendijk 2009 | Netherlands | ✓ | ✓ | ✓ | |
| Chamberlain & Wraight 1997 | UK | ✓ | × | × | Study data is for 1994 |
| De Reu, Hijuis, Oosterbaan & Eskes 2000 | Netherlands | | | | Study data is for 1994–1995 |
| Hutton, Reitsma & Kaufman 2009 | Canada | ✓ | ✓ | ✓ | |
| Janssen, Lee, Ryan, Etches, Farquharson, Peacock & Klein 2002 | Canada | ✓ | ✓ | | Study data is for 1998–1999 |
| Janssen, Saxell, Page, Klein, Liston & Lee 2009 | Canada | ✓ | ✓ | ✓ | Study data period is from 2000–2004 |
| Johnson & Daviss 2005 | USA and Canada | ✓ | ✓ | ✓ | |
| Lindgren, Radestad, Christensson & Hildingsson 2008 | Sweden | ✓ | ✓ | ✓ | |
| Murphy & Fullerton 1998 | USA | ✓ | ✓ | × | Study data covers 1994–1995 |

| Document | Jurisdiction | ACM | WAHS | Chosen for literature review | Limitations for literature review |
|---|---|---|---|---|---|
| Pang & Heffelfinger 2002 | USA | ✓ | ✓ | × | Study data covers 1989–1996 |
| Wiegers, Keirse & van der Zee 1998 | Netherlands | ✓ | ✓ | × | Study data outside period reviewed |
| Wolleswinkel-van den Bosch, Vredevoogd, Borkent-Polent, van Eyck, Fetter, Lagro-Janssen, Rosink, Treffers, Wierenga, Amelink, Richardus, Verloove-Vanjorick & Mackenbach 2002 | Netherlands | × | ✓ | × | Study data covers 1996–1997 |

# Appendix K Research on PPM practice internationally

For this report, PwC researched the scale of private midwifery practice, regulation and risk management frameworks for four jurisdictions relating to homebirth, insurance products and the types of claims made against PPMs. The four jurisdictions were:

- England (United Kingdom)
- the province of Ontario (Canada)
- the Netherlands
- New Zealand.

The research is presented with regard to:

1. Scale and scope of midwifery practice
2. Payment for midwifery practice
3. Clinical guidelines and the part played by Colleges
4. Regulation and registration
5. Insurance market
6. Legal structures.

## 1. Scale and scope of midwifery practice

Definitions of PPM practice internationally which are equivalent to the Australian PPM demonstrate that there is variance in the size of the cohort which the definition describes. PPM can be defined as different cohorts in different jurisdictions where either:

- All midwives are viewed as independent and able to provide care both inside and outside of a hospital (province of Ontario or New Zealand)
- Midwives are a specified cohort who practises outside of a hospital (Australia, England or the Netherlands).

An example of definitions applied is presented in Table 54.

**Table 54: Definitions of PPM (or equivalent)**

| Jurisdiction | Equivalent to PPM | All or specified cohort of midwives | Description |
|---|---|---|---|
| Australia | Privately Practising Midwife | Specified cohort | A midwife who is working as a sole practitioner in a business owned solely by the midwife, or in a partnership or collective; or where a midwife is employed by a company that is owned solely by the midwife, or that is owned solely by practising midwives, where the only directors of that company are practising midwives. |
| Ontario, Canada | Independent midwife | All | All midwives in the province of Ontario are independent, working within group practices and are not employees of the health service. |
| England | Independent midwife | Specified cohort | Midwives practising alone or in groups but not as an employee of the NHS, other healthcare organisations or local authorities. |
| The Netherlands | Independent midwife | Specified cohort | Midwives who work outside of a hospital as a sole operator, in a group practice or as a locum (temporary or replacement midwife). |
| New Zealand | Independent midwife | All | All midwives in New Zealand can work independently. |

**Sources:** Flaxman Partners 2011; Personal communication, March 2013; KNOV (The Royal Dutch Organisation of Midwives) 2012; NZCOM, Personal Communication 2012, where New Zealand was communicated as not having private practitioners.

## *Scale of practice*

The numbers for scale of practice are recorded differently by jurisdiction and as a result it should be noted that the data presented may have different definitions and represent different practises. However, key findings, as outlined in Table 55 show that:

- England has the largest number of midwives registered but the smallest proportion of independent midwives perceived to be practising
- The Netherlands has the largest proportion of births which are homebirths each year at 23.4%[359] (2010)
- Australia has the lowest proportion of births at home each year, 0.45%[360] (2010)
- Australia also has the least number of births at home each year at 1,354[361] (2010), despite having the second highest number of births each year at 297,357[362] (2010).

359 Statistics Netherlands, 2013.

360 Australian Institute of Health and Welfare, 2004b – 2013.

### Table 55: Summary of scale of practice

| | Australia | England | Ontario, Canada | the Netherlands | New Zealand |
|---|---|---|---|---|---|
| Number of midwives on register | 35,202[363] (2012) | 28,030[364] (2007-2008) | 405[365] (2009-10) | 2,612[366] (2011) | 2,910[367] (2012) |
| Number of practices | *nr | *nr | 76[368] (2010) | 519[369] (2011) | *nr |
| Numbers of PPMs/independent midwives | 57[370] (2013) | 170[371] | 405[372] (2009-10) | 1,907[373] (2011) | 2,910[374] (2012) |
| Proportion of PPMs of all midwives | 0.16% | 0.6% | 100.0% | 73.0% | 100.0% |
| Proportion of births which are homebirths | 0.45%[375] (2010) | 2.40% (2011) | 2.03%[376] (2009-10) | 23.4%[377] (2010) | 7%[378] |
| Proportion of all births by midwives which are homebirths | *nr | *nr | 1.96% (2009-10) [379] | *nr | *nr |
| Proportion of births by PPMs which are homebirths | *nr | *nr | 1.96% (2009-10)[380] | *nr | *nr |

**Key:** 'nr*' – Not reported.

**Sources:** Footnoted by the statistic recorded.

361 Australian Institute of Health and Welfare, 2012.

362 Ibid.

363 Nursing and Midwifery Board of Australia, 2012. Note, this includes both those registered only as midwives as well those that hold dual nursing and midwifery registrations.

364 Nursing and Midwifery Council UK, 2008.

365 HIROC, Personal Communication, February 2013.

366 NIVEL: Netherlands Institute for health services research, 2013.

367 Midwifery Council of New Zealand, 2012.

368 Ontario Hospital Association, 2012

369 NIVEL: Netherlands Institute for health services research

370 Based on the survey completed by PwC as a part of this report.

371 Birthrights, 2013.

372 HIROC, Personal Communications, February 2013.

373 Of the 2,612 midwives KNOV states that 27% work in a hospital therefore 73% is equivalent to 1907 midwives.

374 Midwifery Council of New Zealand, 2012.

375 Australian Institute of Health and Welfare, 2012.

376 Statistics Netherlands, 2013.

377 Ibid.

378 Home Birth Aotearoa, 2013.

379 HIROC, Personal Communications, February 2013.

380 HIROC, Personal Communications, February 2013.

### *Scope of practice*

Scope of practice yielded some insights regarding the PPMs which can provide births within health settings internationally. In general, it was found that only in jurisdictions where all midwives were viewed as independent that the midwife would be able to assist the woman giving birth in the hospital. Further information obtained through consultation included:

- Access rights were viewed as an integral part to a midwife's scope of practice; all jurisdictions gave or tried to enable PPMs to receive access rights
- Only publicly funded schemes found in the province of Ontario and New Zealand allowed for a midwife to be covered for births inside and outside of the hospital environment
- The province of Ontario requires midwives to have at least one access arrangement with a hospital
- The Netherlands make it compulsory for a hospital to accept referrals from midwives
- England has adopted a SOM model to provide an additional person to reach out to for consultation.

| | Australia | England | Ontario, Canada | the Netherlands | New Zealand |
|---|---|---|---|---|---|
| PPMs provide hospital births | No | No | Yes | No | Yes |
| Access rights | Yes, access rights have partially been achieved | Yes, same referral rights as an NHS midwife | Yes, must have at least one | Yes, required to accept referrals from midwives providing homebirth services | Yes |
| SOM model | No | Yes | No | No | No |

**Sources:** Reference Independent Midwives 2013; KNOV (The Royal Dutch Organisation of Midwives) 2012; Association of Ontario Midwives 2013a.

## *2. Payment for midwifery practice*

Cost of services for midwifery practice was benchmarked. Key findings contained within Table 56 show:

- The province of Ontario and New Zealand have both developed a publicly funded system of midwifery service which is supported by each of the respective governments. Australian PPMs can be government supported if they are an eligible midwife
- A potential reason for the lower fee in the Netherlands may be related to the scale of independent midwifery practice increasing competition and reducing fees for service.

**Table 56: Payment for midwifery practice**

| | Australia | England (UK) | Ontario, Canada | the Netherlands | New Zealand |
|---|---|---|---|---|---|
| Cost | PPM will charge a fee based on their services. MBS can provide indicative fees | Independent midwife will charge a fee | Cost of service is not indicated as paid for by the Government under publicly-funded system | Cost is a set fee, which will be yearly adjusted amounts are made by the Dutch Healthcare Authority | Cost of service is not indicated as the Government pays under a publicly-funded system |
| Total cost for woman | Approximately $2,000 (AUD) | Cost of care estimated between £2,000-£4,000 | Free | €1,189.09 | Free but woman will have to pay for ultrasounds, tests and ambulance |
| Antenatal | $32.30 – $319.00(AUD) | - | Free | €441.92 | Free |
| Intrapartum | $753.30 (AUD) | - | Free | €480.33 | Free |
| Postnatal | $53.40 – $78.50(AUD) | - | Free | €266.85 | Free |
| Payment if in hospital | No, not through the MBS schedule but possible if charging woman fixed fee for services | Yes | Yes | Only can claim the amount which the midwife has provided care for, ie will not be reimbursed for a transfer during intrapartum care | Yes |
| How paid | By woman or through MBS | By woman | Funded by the Ministry of Health and Long-Term Care | By woman's health insurance, through the insurance company | LMCs are paid by module of care provided where a module is antenatal, natal and postnatal |
| Publicly-funded | Yes, if an eligible midwife | No | Yes | No | Yes |

**Sources:** DoHA, Medical Benefits Schedule. Independent Midwives 2013; KNOV (The Royal Dutch Organisation of Midwives) 2012; Association of Ontario Midwives 2013a; New Zealand College of Midwives, 2013b.

# 3. Clinical guidelines and the part played by Colleges

## Roles of Colleges in supporting insurance products

Each jurisdiction has individual clinical guidelines recommended by a national College associated with midwives. Jurisdictions have seen different levels of involvement by Colleges in developing an insurance product or ongoing engagement with the insurance products for PPMs or independent midwives. However, all Colleges have a strong role in guidelines for practice or risk frameworks. A comparison is provided in Table 57.

**Table 57: Role of Colleges in supporting insurance products**

| Jurisdiction | College | Involvement in developing insurance product |
|---|---|---|
| Australia | Australian College of Midwives | Manages guidelines for practice<br>Working with regulator to understand how insurance product can be provided |
| | APMA | Actively engaged in developing understanding among PPMs of insurance products currently available |
| England | Royal College of Midwives | Working with insurer to assist independent midwives in developing a product if the EU Directive takes place<br>Manages guidelines for practice |
| | Independent Midwives UK | Actively involved in developing new business model for independent midwives in order to be able to access insurance if EU Directive goes ahead |
| Ontario, Canada | Association of Ontario Midwives | Heavy involvement with HIROC negotiated from 2001<br>Worked together on risk management frameworks<br>Product released in 2003<br>On-going relationship assessing incidents |
| the Netherlands | KNOV | Manages guidelines for practice<br>Little role in assisting midwives in getting insurance given products readily available |
| New Zealand | New Zealand College of Midwives | Negotiates insurance product using insurance broker for midwives |

**Sources:** Personal communication, November 2012, February and March 2013.

## Clinical guidelines

Overview of the clinical guidelines provided by Colleges is outlined in Table 58.

**Table 58: Clinical guidelines by College within each jurisdiction**

| Jurisdiction | College | Clinical Guidelines |
|---|---|---|
| Australia | Australian College of Midwives | ACM, Guidelines for Consultation and Referral, 2008 |
| England | Royal College of Midwives | NICE, 2008, Intrapartum Care |

| Jurisdiction | College | Clinical Guidelines |
|---|---|---|
| Ontario, Canada | College of Midwives of Ontario (COM) | Indications for Mandatory Discussion, Consultation and Transfer of Care, 2000 |
| | Association of Ontario Midwives | Guidelines for Maternal/Neonate Transfers from Home to Hospital |
| | | OMA Joint Statement of Professional Relations Between Obstetricians/Gynaecologists and Registered Midwives in Ontario |
| the Netherlands | KNOV | Verloskundig vandemecum (VIL), 2003 |
| New Zealand | New Zealand College of Midwives | NZCOM, Consensus Statements and Guidelines |

**Sources:** College of Midwives of Ontario 2000; National Institute for Health and Clinical Excellence 2007; KNOV (The Royal Dutch Organisation of Midwives) 2003; New Zealand College of Midwives 2013c; Ontario Hospital Association 2010.

## *4. Regulation and registration*

For each jurisdiction, information was collated on the regulation of midwifery which was supplemented through consultation. Table 59 outlines the regulators of midwifery in each researched.

**Table 59: Regulators of midwifery**

| Jurisdiction | Regulators |
|---|---|
| Australia | Nursing and Midwifery Board of Australia (NMBA) |
| England | Nursing and Midwifery Council UK (NMC-UK) |
| Ontario, Canada | College of Midwives of Ontario (CMO) |
| the Netherlands | The Royal Dutch Organisation of Midwives (KNOV), Health care Inspectorate |
| New Zealand | Midwifery Council of New Zealand |

An overview of the regulation and registration in each jurisdiction is described in Table 60. Registration costs, length of registration and top up requirements can vary across jurisdictions. Key findings show that:

- Registration was significantly more expensive in the province of Ontario than in other jurisdictions at $1,585 (CAD) for registration fees each year
- The province of Ontario also made requirements on registration for liability insurance which is provided through the Association of Ontario Midwives
- The Netherlands only requires registration every five years, however the KNOV have developed an additional quality register which 80 per cent of midwives have signed up to
- Both England and the Netherlands make requirements on the practice of a midwife in terms of hours worked over the past registration period
- None of the jurisdictions make additional requirements for independent or private practice.

**Table 60: Costs, renewal times and additional top-up requirements for registration**

| | Australia | England | Ontario, Canada | the Netherlands | New Zealand |
|---|---|---|---|---|---|
| Registration compulsory | Yes | Yes | Yes | Yes | Yes |
| Number of midwives on register actively practising | 35,202[381] | 28,030[382] | 405[383] | 2,612[384] | 2,910[385] |
| Cost of registration | $160[386] | £100[387] | $50 for application, $1,585 for registration fees[388] (CAD) | €80[389] | Unable to determine |
| Renewed | Every year | Every 3 years | Every year | Every 5 years | Unable to determine |
| Notes about requirements for on-going registration | Must meet registration standards | Must have undertaken 450 hours | Must have membership and liability insurance arranged through AOM | Minimum hours spent working as a midwife of 2080 hours in 5 years | Unable to determine |
| Additional registration requirements for PPMs | No, only as an eligible midwife | No | No | No | No |
| Other optional registers available | No | No | No | Yes, KNOV has a quality register which 80 per cent of midwives are on | No |

**Sources:** Nursing and Midwifery Board of Australia 2013d; Nursing and Midwifery Council UK 2013a; College of Midwives of Ontario 2013c; KNOV (The Royal Dutch Organisation of Midwives) 2012.

A brief overview is provided of each regulator and registration for a midwife for each jurisdiction.

381 Nursing and Midwifery Board of Australia, 2013a. Note, this includes both those registered only as midwives as well those that hold dual nursing and midwifery registrations.

382 Nursing and Midwifery Council UK, 2008.

383 HIROC, Personal Communications, February 2013.

384 NIVEL: Netherlands Institute for health services research, 2013.

385 Midwifery Council of New Zealand, 2012.

386 Nursing and Midwifery Board of Australia, 2013d.

387 Nursing and Midwifery Council UK, 2013a.

388 College of Midwives of Ontario, 2013c.

389 KNOV (The Royal Dutch Organisation of Midwives), 2012.

## *Australia*

### Table 61: Regulation of midwives – Australia

| | Australia |
|---|---|
| Regulator of Midwives | Nursing and Midwifery Board of Australia (NMBA) |
| Number of health professions regulated | 2 – Nurses and Midwives |
| Legislation established by | Supported by National Law, the legislation which governs the NMBA and AHPRA |
| Role of Regulator | • Registering nursing and midwifery practitioners and students<br>• Developing standards, codes and guidelines for the nursing and midwifery profession<br>• Handling notifications, complaints, investigations and disciplinary hearings<br>• Assessing overseas trained practitioners who wish to practise in Australia<br>• Approving accreditation standards and accredited courses of study |
| Registration with regulator | Yes |
| Registration is required to practice as a midwife | Yes |
| Specific registration requirements for private practice | No, but eligible midwife registration category available |
| Number of midwives on register | 35,202 in December 2012 who are practising[390] |
| Other registers available | No |
| Codes of conduct, standards and guidelines | • Code of ethics for midwives in Australia<br>• Code of professional conduct for midwives in Australia<br>• Midwifery Competency Standards, January 2006<br>• Guidelines for Professional Indemnity Insurance Arrangements for Midwives<br>• Nursing and Midwifery Professional Indemnity Insurance Arrangements Registration Standard<br>• Guidelines and Assessment Framework for the registration Standard for Eligible Midwives and Endorsement for Scheduled Medicines<br>• Professional Boundaries for Midwives |

**Sources:** Nursing and Midwifery Board of Australia 2013a, 2013b, 2013c; Australian Health Practitioner Regulation Agency, 2013.

390 Nursing and Midwifery Board of Australia, 2013a. Note, this includes both those registered only as midwives as well those that hold dual nursing and midwifery registrations.

## *England*

### Table 62: Regulation of midwives – England

| | England |
|---|---|
| Regulator of Midwives | Nursing and Midwifery Council UK (NMC-UK) |
| Number of health professions regulated | 2 – Nurses and Midwives |
| Legislation established by | Established by the *Nursing and Midwifery Order 2001* to safeguard the health and wellbeing of the public |
| Role of Regulator | • Keep the register of nurses and midwives who have the skills, knowledge, good health and good character to satisfy our requirements for registration<br>• Setting standards for education and practice<br>• Giving guidance and advice to the professions<br>• Dealing appropriately with nurses and midwives whose fitness to practise is impaired |
| Registration with regulator | Yes |
| Registration is required to practice as a midwife | Yes |
| Specific registration requirements for private practice | No |
| Number of midwives on register | 28,030 in 2008 with the intention to practice (ITP)[391] |
| Other registers available | No |
| Standards of conduct | • The code: Standards of Conduct, performance and ethics for Nurses and Midwives<br>• Standards for medicines management<br>• Midwives rules and standards<br>• Standard to support learning and practice<br>• Standards to support learning and assessment in practice<br>• Standards of proficiency for nurse and midwife prescribers |
| Guidance | • Record keeping: Guidance for nurses and midwives<br>• Raising and escalating concerns: Guidance for nurses and midwives<br>• Guidance on professional conduct for nursing and midwifery students |

**Sources:** Nursing and Midwifery Council UK, 2013b; Nursing and Midwifery Council UK, 2013c; Nursing and Midwifery Council UK, 2013d.

391 Nursing and Midwifery Council UK, 2008.

## *Province of Ontario*

### Table 63: Regulation of midwives – Province of Ontario

| | Province of Ontario |
|---|---|
| Regulator of Midwives | College of Midwives of Ontario (CMO) |
| Number of health professions regulated | 1 – Midwives |
| Legislation established by | Established with the proclamation of the *Regulated Health Professions Act* and the *Midwifery Act* on December 31, 1993 |
| Role of Regulator | • Regulating the practice of the profession and governing members according to legislation, regulations, and by-laws<br>• Setting standards of qualification for persons to be issued certificates of registration<br>• Developing, establishing and maintaining standards of professional ethics for members<br>• Responding to complaints from the public regarding practice |
| Registration with regulator | Yes |
| Registration is required to practice as a midwife | Yes |
| Specific registration requirements for private practice | No |
| Number of midwives on register | 405[392] |
| Other registers available | No |

392 HIROC, Personal Communications, February 2013.

| | Province of Ontario |
|---|---|
| Standards | • Philosophy of Midwifery Care<br>• Code of Ethics<br>• Continuity of Care<br>• Indications for Mandatory Discussion Consultation and Transfer<br>• Essential Equipment Supplies Medication<br>• Number of Midwife Attendants<br>• When Client Chooses Care Outside<br>• Temporary Alternate Practice Arrangements<br>• Standard on Second Birth Attendant<br>• Standard on Shared Primary Care<br>• Supportive Care<br>• Informed Choice Standard<br>• Standard on Prescribing Drugs<br>• Standard on Certification for Prescribing and or Administering Drugs Designated in the Regulation<br>• Record Keeping Standard for Midwives |

**Sources:** College of Midwives of Ontario 2013a; College of Midwives of Ontario 2013d.

## *The Netherlands*

### Table 64: Regulation of midwives – the Netherlands

| | the Netherlands |
|---|---|
| Regulator of Midwives | The Royal Dutch Organisation of Midwives (KNOV),<br>Also monitored externally by the Health Care Inspectorate |
| Number of health professions regulated | 1 – Midwives |
| Legislation established by | Established in 1898 |
| Role of Regulator (KNOV) | • Strengthen the position of midwives in the health care system (union work)<br>• Improving quality of care<br>• Developing standards and guidelines<br>• Representing midwives in official policymaking bodies<br>• Representing midwives in organisations with health care insurances, with other medical professionals and taking care of common interests |
| Registration with regulator | No, through the BIG Register |
| Registration is required to practice as a midwife | Yes |
| Specific registration requirements for private practice | No |

| | the Netherlands |
|---|---|
| Number of midwives on register | 2,612[393] |
| Other registers available | Yes, KNOV has an additional register as a form of quality register since 2006. This is not compulsory. |
| Number of midwives on register | 80% |

**Sources:** KNOV (The Royal Dutch Organisation of Midwives) 2012; NIVEL: Netherlands Institute for health services research, 2013; KNOV (The Royal Dutch Organisation of Midwives) 2013b.

## *New Zealand*

### Table 65: Regulation of midwives – New Zealand

| | New Zealand |
|---|---|
| Regulator of Midwives | Midwifery Council of New Zealand |
| Number of health professions regulated | 1 – Midwives |
| Legislation established by | Set out under section 118 of the *Health Practitioners Competence Assurance Act 2003* |
| Role of Regulator | • Define the Midwifery Scope(s) of Practice and prescribe the qualifications required of registered midwives<br>• Accredit and midwifery educational institutions and programmes<br>• Maintain a public Register of midwives who have the required qualifications and are competent and fit to practise<br>• Issue practising certificates to midwives who maintain their competence<br>• Establish programmes to assess and promote midwives' ongoing competence<br>• Deal with complaints and concerns about midwives' conduct, competence and health<br>• Set the midwifery profession's standards for clinical and cultural competence and ethical conduct<br>• Promote education and training in midwifery<br>• Promote public awareness of the Council's responsibilities |
| Registration with regulator | Yes |
| Registration is required to practice as a midwife | Yes all midwives must have practising certificates |
| Specific registration requirements for private | No |

393 NIVEL: Netherlands Institute for health services research, 2013.

| | New Zealand |
|---|---|
| practice | |
| Number of midwives on register | 2,910 midwives in 2012 with a practising certificate[394] |
| Other registers available | No |
| Code of conduct | Midwifery Council of New Zealand, Code of Conduct |

**Sources:** Midwifery Council of New Zealand, 2012, 2013a, 2013b.

# 5. Insurance market

## Overview of insurance systems

An overview of each insurance system saw that different systems had components which could impact the product offered. Key components outlined in Table 66 include:

- Compulsory social insurance is mandated in the Netherlands as well as a co-payment for insurance. The Netherlands has multiple insurers in the market for intrapartum care
- Publicly funded care operating in the province of Ontario and New Zealand involve an insurer who provides a product. Both products are negotiated through midwifery organisations either through the AOM in the province of Ontario or through NZCOM in New Zealand
- England does not require independent practice to have insurance. Insurance can be provided to independent midwives but under a group practice model rather than as sole operators.

**Table 66: Overview of insurance systems**

| | Australia | England | Ontario, Canada | the Netherlands | New Zealand |
|---|---|---|---|---|---|
| Publicly-funded | If eligible midwife | No | Yes | No | Yes |
| Co-payment for insurance | No | No | No | Yes | No |
| Liability or indemnity insurance required for private or independent midwives providing homebirth | No – current exemption in Law | No | Yes | No but difficult to get registered without insurance | Yes |
| Number of insurers for sole-operators providing intrapartum care | None | None | One | Multiple | One |
| If insurance not provided for sole- | No | Yes | Not | Not applicable | Not |

394 Midwifery Council of New Zealand, 2012.

| | Australia | England | Ontario, Canada | the Netherlands | New Zealand |
|---|---|---|---|---|---|
| operators then provided for group practice providing intrapartum care | | | applicable | | applicable |

A brief overview of the insurance products available for each jurisdiction is outlined below.

## *England*

### Insurance product offered

There is currently no insurance product available currently for midwives practising independently (sole practitioners) in England. One insurer, RK Harris Insurance Limited, offers an insurance product for other midwifery entities, Clinical Negligence Trust Schemes, a Private Midwifery Practice and a Not-for-Profit Midwifery Practice.

**Table 67: Insurance product – RK Harris Insurance Services Limited**

| England | |
|---|---|
| **Insurer** | R K Harris Insurance Services Limited |
| **Insurer information** | Private company that works closely with the NHS<br>Entered in to this area based on being approached by the Government |
| **Product features:** | |
| Premium pool | No<br>Common pool exists to share the risk |
| Run off cover | None provided, NHS is liable for all past claims |
| Quantum of cover | Over £12.5 million |
| Excess | £50,000 |
| Cost | An element is based on the number of midwives in the organisation, the location of births and number of births<br>Based on a minimum deposit that is payable upfront (£25,000-£50,000) and the number of births that are completed which is paid monthly (up to 35 births/year) |
| **Perceived enablers of service by stakeholders:** | |
| Insurance: | Classification of what was 'risk' and could be related to the midwives as part of their duty of care<br>Availability of information from NHS to have comfort over the actuary risk profile and be able to quantify risks<br>Clinical risk and quality framework exists to provide comfort over risk to the underwriters |
| Practising environment: | Independent midwives are insured through either company or social enterprise models<br>Independent midwives operating independently have not been insured since |

| England | |
|---|---|
| | around 1994. With the *EU Directive* imminent PPMs are working to form a social enterprise<br>SOM helps support midwives operating in the community<br>Limited number of independent midwives, but the risk and premium pool assessed support the products being offered |

**Source:** Personal Communication, November 2012, March 2013.

## *Province of Ontario*

### Insurance product offered

The insurance product offered in the province of Ontario is provided through a NFP arrangement between the insurer, HIROC and the Professional association, AMO. Details of the product are provided in Table 68.

### Table 68: Insurance product – HIROC

| Province of Ontario | |
|---|---|
| **Insurer** | Health insurance reciprocal of Canada (HIROC) |
| **Insurer information** | Not for profit<br>An insurance arrangement held between hospitals and now includes independent midwives<br>Entered in to this area based on being approached by the Ontario Midwives Association |
| **Product features:** | |
| Premium pool | No premium pool and therefore risks are spread<br>All monies are shared and provided returned to members at the end of the year when felt that no further claims will occur |
| Run off cover | No. However premiums need to continue to be paid beyond providing cover |
| Quantum of cover | Policy limits are minimum coverage of $15 million and a maximum of $25 – $30 million (CAD) |
| Cost | Premiums range dependent on the province but are set between $16,000-$25,000 (CAD)<br>The premium for an individual are set based on experience and the exposure<br>Because it is a NFP, HIROC seek to make cover affordable |
| **Perceived enablers of service by stakeholders:** | |
| Insurance | Active working relationship between insurer and AMO (including the development of a risk management frameworks) and clear scope of practice developed<br>Premiums are the same<br>Midwives are not seen to practice outside their frameworks – requires a second midwife in attendance at birth<br>Same ethos held between insurer and registration body |

| Province of Ontario | |
|---|---|
| | Had claims data available to assist in setting the first premium. Subsequent premiums driven from past history |
| Practising environment | All midwives are independent (ie there are no public midwives)<br>Visiting rights exist<br>A perception that there is not a respective culture between medical professionals and independent midwives. |

**Source:** Personal communication November 2012, March 2013.

## *The Netherlands*

### Insurance product offered

The Netherlands has compulsory health insurance for residents of the jurisdiction. The health insurance system protects residents of the Netherlands by making it a statutory obligation to take out basic insurance. The relevant legislation is outlined in Table 69.

### Table 69: The Netherlands Health Insurance Legislation

| the Netherlands Health Insurance Legislation | |
|---|---|
| Exceptional Medical Expenses Act (AWBZ) | Publicly provided insurance<br>Mandatory for all legal residents aged 18 years and above<br>Mainly long-term care |
| Health Insurance Act | Quasi-private<br>Mandatory covering all legal residents although under the age of 18 years the premium is not expected to be paid<br>Includes maternity care<br>There is an obligatory excess deductible |

Table 70 and Table 71 outline the insurance products provided in more detail. Note that there are numerous commercial insurers in the market. Table 71 outlines a sample of three products that are offered.

### Table 70: Insurance products – the Netherlands (summary)

| the Netherlands (summary) | |
|---|---|
| **Insurer** | Multiple |
| **Insurer information** | There is a market for PII for independent midwives |
| **Product features:** | |
| Premium pool | Multiple insurers in the market |
| Run off cover | Not applicable |
| Quantum of cover | €1 million – €1.5 million |
| Cost | €350-400 |

| the Netherlands (summary) | |
|---|---|
| **Perceived enablers of service by stakeholders:** | |
| Insurance: | Clear and common risk management frameworks (including when to transfer, how far to be from a health service) exist that decrease risk<br>Mandatory insurance for all citizens of the country is required. Private insurance companies operate with substantial government regulations |
| Practising environment: | While PII is optional, registration requirements encourage it being taken up<br>Culture that birthing is natural and there is a culture that supports women giving birth at home. This coupled with the relationship formed between woman and midwife has been suggested in consultations to have led to low claims (less than 10 known)<br>Visiting rights exist in hospitals<br>National social tax by citizens for long term disability meaning that only 20% of claims are paid by indemnity insurance |

**Table 71: Insurance products – the Netherlands (by product)**

| the Netherlands (by product) | | | |
|---|---|---|---|
| **Insurer** | De Goudse | Meeùs (intermediary for Interpolis) | VVAA |
| **Insurer information** | Profit organisation | Profit organisation | Membership organisation |
| **Product:** | Indemnity insurance for midwives | Indemnity insurance | Indemnity insurance for medical professions, including midwives |
| Premium pool | Yes | N/A | N/A |
| Run off cover | N/A | N/A | Insurance covers indemnity up to 20 years after finishing practice with a condition that the damage is done during the practice. |
| Quantum of cover | • Insures a midwife up to €2.5 million with each claim and €5 million a year<br>• Only for homebirths<br>• Risks during birth-giving in hospitals are covered by hospital policy | • Insures a midwife up to €1.2 million with each claim and €2.5 million a year<br>• Only for homebirths<br>• Risks during birth-giving in hospitals are covered by hospital policy | • Insures a midwife up to €1.25 million with each claim or €2.5 million with each claim (12.5% higher premium)<br>• Only for homebirths<br>• Risks during birth-giving in hospitals are covered by hospital policy |
| Cost | €324 a year.<br>Medical assistants pay | Not able to be ascertained | €349 a year |

| the Netherlands (by product) | | | |
|---|---|---|---|
| | 70%, non-medical assistants 20%. | | |
| **Additional features of the insurance:** | | | |
| Insurance: | • Includes interns<br>• Number of claims: 'very few' | • Basic package and a package where liabilities during prenatal screening are insured.<br>• Temporary practitioners are included into the insurance during actual practising period. | • Temporary practitioners (including interns) are included into the insurance during actual practising period.<br>• Legal aid by VVAA is included in the insurance to the extent that it refers to the claim for which indemnity is made upon. |

**Source:** Personal Communications, March 2013.

## *New Zealand*

### Insurance product offered

New Zealand has an insurance product offered through one insurer, QBE. This product is offered through the New Zealand College of Midwives, who work with the insurer and broker to support the provision of the product to its members. Details of the product are provided in Table 72.

### Table 72: Insurance product – QBE

| New Zealand | |
|---|---|
| **Insurer** | QBE |
| **Insurer information** | QBE is subsidised by the New Zealand College of Midwives (NZCOM) through a risk-cost sharing arrangement<br>QBE profits under the current arrangement<br>NZCOM works as a not for profit and therefore reinvests back into the College activities |
| **Product features:** | |
| Premium pool | Yes |
| Run off cover | Yes when the midwife leaves the profession then covered |
| Quantum of cover | Insures midwife up to $1 million (NZD) with each claim. However, there is no limit on the number of claims per year<br>Also, provides a midwife with $1 million (NZD) public liability cover which is required to access hospitals |
| Excess | None |
| Cost | $100-$110 (NZD) which is included in the membership fee of approximately $800-$900 (NZD) per year |

| New Zealand | |
|---|---|
| **Perceived enablers of service by stakeholders:** | |
| Insurance: | No fault policy under the personal injury compensation system – as this covers future disability, claims are low (because this is the most costly portion of claims)<br>Claims are normally around $1,000-$1,500 (NZD). Consultations identified that there are approximately 30 claims, but the largest claim has been estimated at $300,000 (NZD)[395]<br>The NZCOM filters the cases which are given to QBE through preliminary investigation which assists in the administrative time and costs for QBE, affecting the premium |
| Practising environment: | Woman makes the decision about who is her lead maternity carer<br>PII is not mandatory for midwives, but required by the Ministry of Health for all health practitioners holding an access arrangement with a public health service. |

**Source:** Personal communication November 2012, March 2013.

# 6. Legal structures

## *Overview of litigation culture*

In order to understand the legal systems impacting upon practice and the number of claims that may be raised as a result of the litigious culture of the jurisdiction, information on the court systems for each jurisdiction was collected and supplemented through consultations with insurers, regulators and Colleges. A summary is provided in Table 73.

Key findings about the litigation culture in each jurisdiction include:

- In the province of Ontario, the Netherlands and New Zealand the number of claims was found to be low although evidence from insurers has only been provided for two of the jurisdictions (province of Ontario and New Zealand)
- For Australia and England, the number of claims was difficult to assess given limitations on data quality and neither jurisdiction had offered a relevant insurance product for an extended period of time.

**Table 73: Summary of litigation for each jurisdiction**

| Litigation culture | Australia | England | Ontario, Canada | the Netherlands | New Zealand |
|---|---|---|---|---|---|
| Number of claims | Claims culture unknown due to insurance product being unavailable for long time | Limitations on data quality makes litigation environment difficult to interpret for | Low claims culture seen by HIROC | Low litigious culture as judges are very reluctant to find against midwives in malpractice | Low number of claims seen by insurance broker |

[395] Note that this could not be verified prior to the finalisation of this report.

| Litigation culture | Australia | England | Ontario, Canada | the Netherlands | New Zealand |
|---|---|---|---|---|---|
| | | independent midwives | | claims | |
| Quantum of claims | Perceived to be high but no evidence to support for PPM practice | Perceived to be high but no evidence to support specifically for independent midwives | Courts have seen a cap on claims for non-pecuniary damages for fatalities.<br>Life disabilities known to be high between $2 million – $9 million. | Insurance co-payments reduce pay-out for claims<br>Social insurance reduces pay out for claims. General Tax for Special Illness | No fault system, where regardless of the incidence, a person injured will receive a specific pay-out, reducing claim quantum |

**Sources:** Flaxman Partners 2011; PricewaterhouseCoopers LLP 2010; HIROC, Personal Communication, March 2013; Claims Canada 2013; Government of the Netherlands 2013; KNOV (The Royal Dutch Organisation of Midwives) 2012.

An overview of each court structure within each jurisdiction is provided in Table 74.

**Table 74: Overview of court systems**

| Jurisdiction | Court levels | Description |
|---|---|---|
| Australia | 6 | 1 State Magistrates' Courts – which hear less serious criminal and civil matters<br>2 State County Courts – which hear more serious criminal cases and civil cases involving large amounts of money. Most appeals from the Magistrates' Court will come to the County Court<br>3 State Supreme Courts – which hear the most serious criminal cases and civil cases for unlimited amounts of money. These courts hear a variety of appeals from different courts, including the County Court<br>4 Federal Magistrates Court – which hears less serious matters that would otherwise go to the Federal Court of Australia<br>5 Federal Court of Australia – which hear cases on federal issues<br>6 High Court of Australia – the highest court in Australia which hears complex cases and appeals |
| England | 5 | 1 State Magistrates' Courts – which hear summary criminal cases and simple civil matters<br>2 Crown Court and County Courts– the Crown Court hears indictable criminal cases transferred from Magistrates' Courts whereas the County Courts hear most civil cases<br>3 High Court – that hears appeals from decisions of the County Courts<br>4 Court of Appeal – which consists of two divisions, the Criminal Division and the Civil Division. The Criminal Division hears appeals from the Crown Court. The Civil Division hears appeals concerning civil law from the High Court, Tribunals and certain cases from the County Courts<br>5 UK Supreme Court – this is the highest court in the UK which hears appeals from the Court of Appeal and the High Court |

| Jurisdiction | Court levels | Description |
|---|---|---|
| Ontario, Canada | 4 | 1 Provincial courts – these courts deal with less serious criminal offences and civil matters. Judges generally only have the powers given to them by provincial statute<br>2 Provincial superior courts – these courts try the most serious criminal and civil cases. These judges generally have unlimited jurisdiction<br>3 Federal courts – Judges in this court have a jurisdiction limited to matters involving federal law<br>4 Supreme Court – this is the final court of appeal from all other Canadian courts. This court has jurisdiction over disputes in all areas of law |
| the Netherlands | 3 | 1 District courts – this is where most cases start. Every district court has a limited jurisdiction, which generally hears civil claims of up to €5,000 and minor criminal offences<br>2 Court of Appeal – if one of the parties to a case held in a District court disagrees with the decision made, it may appeal to the Court of Appeal<br>3 Supreme Court – this is the final court of appeal from all other Dutch courts |
| New Zealand | 4 | 1 District Courts – most court business takes place in these courts. Numerous criminal cases and civil cases (issue is less than $20,000(NZD)) are held here<br>2 The High Court – this court hears more serious trials and complex civil cases in addition to appeals from the District Courts and tribunals<br>3 Court of Appeal – this court hears appeals from the Courts below it<br>4 Supreme Court – this is the final court of appeal from all other courts |

# 7. Data: births, outcomes, incidences and claims

This section summarises additional statistics found for each jurisdiction and tries to narrow the scope of insurance data as far as possible from the data collected. A full report on the information collected is found in the *PwC Claims Report, 2013* and the limitations articulated in that report should be considered when analysing information presented here. However, it is worth noting that no jurisdiction had significant numbers of court cases that were identified as a part of the research for this project, associated with practice.

## *Cases or claims recorded for PPMs or independent midwives*

| Jurisdiction | Tribunal cases | Insurance claims | Court cases | Resolved coronial cases |
|---|---|---|---|---|
| Australia | 20 | Information not provided | One | Two |
| England | Information could not be obtained | Information not provided | One | None could be identified |
| New Zealand | Three | Information not provided[396] | None could be identified | None could be identified |
| Ontario, Canada | Four | Two | None could be identified | None could be identified |
| the Netherlands | One | Information not provided | None could be identified | None could be identified |

**Sources:** See *PwC Claims Report 2013* for more detail about data collected.

## *England, United Kingdom*

### Statistics on independent midwives, live births and homebirths

There are approximately 170 independent midwives which have told the Nursing and Midwifery Council (NMC-UK) that they would like to be able to practise in the UK.[397] In the UK, a live birth is a baby that shows signs of life at birth.

### Table 75: Number of live births

| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total number of live births | 594,634 | 596,122 | 621,469 | 639,721 | 645,835 | 669,601 | 690,013 | 708,711 | 706,248 | 723,165 | 723,913 |

**Source:** Office of National Statistics, 2011.

The number of live births is different from the number of women giving birth which could result in one or more children, and includes stillbirths. Furthermore, a maternity in the home denotes a pregnancy leading to birth in the usual place of residence of the woman. See Table 76.

396 Information on insurance claims was still being collected by the insurance broker at the time of finalising this report.

397 Birthrights, 2013.

### Table 76: Number of women giving birth at home

| | 2009 | 2010 | 2011 |
|---|---|---|---|
| Total number of live births | 706,248 | 723,165 | 723,913 |
| Total number of women giving birth | 698,324 | 715,467 | 716,040 |
| Number of women giving birth at home | 19,159 | 18,155 | 17,200 |
| Percentage of women giving birth at home (%) | 2.7 | 2.5 | 2.4 |

**Source:** Office of National Statistics, 2011, 2010, 2009.

The number of homebirths provided by independent midwives in the UK is not known.

### Adverse outcomes

England has recently undertaken a *National Birthplace Cohort Study*. More detailed statistics related to outcomes different practices including planned homebirth for high and low-risk women can be found within the report.

### Insurance claims

The information presented in this report is publicly available and represents obstetrics and midwifery claims for the NHS. This is as presented by the National Health Service Litigation Authority (NHSLA).[398] Information is not available only for midwives, or independent midwives. Therefore, caution should be made in extrapolating these findings to independent midwifery practice.

For the NHS there were 801 obstetric claims notified in 2010/11. These claims are long tail claims, in that the payments for most claims do not occur for between 5-10 years after the birth. The claims have high costs associated with them, and the amounts paid in 2010/11 are shown in Table 77.

### Table 77: Cost of obstetric claims paid in 2010/11

| CNST Damages | CNST Defence Costs | CNST Claimant Costs | CNST Total Paid |
|---|---|---|---|
| £185,578,557 | £14,290,453 | £34,975,081 | £234,844,091 |

**Source:** NHSLA 2011.

### Disciplinary cases

In England, as disciplinary cases relate to fitness to practice, allegations relating to misconduct, lack of competence, character issues and poor health,[399] and do not separate out midwives by type of practice (eg NHS, independent) they shed minimal insight on the practice of independent midwives in homebirth settings.[400] The NMC-UK provides the same process for fitness to practice hearings for all midwives.

398 National Health Service Litigation Authority, 2011.

399 Nursing and Midwifery Council UK, 2010.

400 Nursing and Midwifery Council UK, 2013e.

## *Province of Ontario*

### Statistics on midwives, births and homebirths

There have been a growing number of midwives in the province of Ontario over the past seven years as seen in Table 78. As noted in the body of the report, all midwives can practise independently, and are required to support a number of births within the home as a part of registration.

**Table 78: Number of midwives in the province of Ontario**

| | 2003-04 | 2004-05 | 2005-06 | 2006-07 | 2007-08 | 2008-09 | 2009-10 |
|---|---|---|---|---|---|---|---|
| Number of midwives | 256 | 275 | 302 | 334 | 380 | 369 | 405 |

**Sources:** Personal Communication February 2013.

In 2009–10, there were 2,741 homebirths out of 11,244 births as seen in Table 79. There have been an increasing number of births in Ontario, Canada. The proportion of those which have been homebirths has remained fairly stable at around 20–24%.

**Table 79: Number of homebirths in the province of Ontario**

| | 2003-04 | 2004-05 | 2005-06 | 2006-07 | 2007-08 | 2008-09 | 2009-10 |
|---|---|---|---|---|---|---|---|
| Total births | *nr | *nr | *nr | *nr | 140,547 | 140,326 | 139,771 |
| Number of birth by midwives | 7,766 | 8,629 | 9,568 | 10,395 | 9,420 | 10,570 | 11,244 |
| Number of homebirths | 1,919 | 1,848 | 1,940 | 2,043 | 2,268 | 2,360 | 2,741 |
| Per cent of births at home | 24.7 | 21.4 | 20.3 | 19.7 | 24.1 | 22.3 | 24.4 |

**Sources:** Personal Communication, February 2013; Statistics Canada 2013.

### Adverse outcomes

Hutton et al 2009[401] suggested that previously in the province of Ontario there had not been an increased rate of perinatal and neonatal mortality or serious morbidity in homebirths provided by midwives, between the period of 2003–2006.

BORN is a database which has been put in place to record statistics in the province of Ontario. It records hospital and unit data for outcomes.[402] This database is relatively new and therefore it is anticipated that there will be more perinatal statistics being made publicly available in the future.

### Insurance claims

In consultation with HIROC, it was communicated that there were four common reasons for incidences to be notified.[403] These included:

401 Hutton EK, Reitsma AH & Kaufman K 2009.

402 BORN Ontario, 2012.

1. Failure by the midwife to monitor the fetus

2. Failure to chart or record during the labour

3. Failure to transfer

4. Use of oxytocin or cintocin which lead to adverse outcome.

As part of the research completed, only two actual loss and damages (L&D) claims have been identified over the past seven years for the province of Ontario.

### Table 80: Number of homebirths in the province of Ontario

| | 2003-04 | 2004-05 | 2005-06 | 2006-07 | 2007-08 | 2008-09 | 2009-10 |
|---|---|---|---|---|---|---|---|
| Total Reported Potential L&D Claims | 36 | 61 | 91 | 102 | 114 | 109 | 54 |
| Total Actual L&D Claims | 0 | 0 | 1 | 1 | 0 | 0 | 0 |

**Sources:** Personal Communications, February 2013.[404]

HIROC indicated approximate amounts that are awarded in a case of different types of claim made as shown in Table 81.

### Table 81: Types and quantum of claims seen in the province of Ontario

| Type of claim | Approximate quantum |
|---|---|
| Life disability | $7 million (CAD) |
| Loss of baby | $50,000-$60,000 (CAD) |

**Sources:** HIROC, Personal Communications, February 2013.

### Disciplinary cases

There have been three disciplinary hearings in the province of Ontario405 and there is another hearing currently in progress.406 More information about the nature of the three disciplinary hearings which have been undertaken as well as the disciplinary process in the province of Ontario can be found in the *PwC Claims Report, 2013*.

403 Personal communication, November 2012.

404 Note this data is the property of HIROC and is not to be used for any other purpose than in assisting Australian midwifery research for AHPRA. Data is as close of business on 31 December 2012.

405 College of Midwives of Ontario 2013b.

406 Association of Midwives Ontario, Personal Communications, 2013.

## *The Netherlands*

### Statistics on midwives, live births and homebirths

There has been a decline in the number of homebirths over the last 10 years in the Netherlands. This is despite it having a relatively high proportion of homebirths compare to other jurisdiction researched. See Table 82.

### Table 82: Number of births and homebirths in the Netherlands

| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total number of births | 199,860 | 199,205 | 197,472 | 191,158 | 185,151 | 182,448 | 178,850 | 181,997 | 182,186 | 181,837 |
| Number of homebirths | 63,755 | 63,546 | 62,994 | 60,406 | 58,508 | 57,654 | 52,582 | 51,687 | 43,542 | 42,550 |
| Percentage of births taking place at home | 31.9 | 31.9 | 31.9 | 31.6 | 31.6 | 31.6 | 29.4 | 28.4 | 23.9 | 23.4 |

**Source:** Statistics Netherlands 2013.

### Adverse outcomes

The Netherlands uses a different definition of perinatal mortality compared with international definitions. However, studies of homebirth undertaken in the Netherlands have seen no increased rates of perinatal mortality.[407]

### Insurance claims

Given the commercial nature of insurers, information on claims raised could not be obtained. However consultations with insurers identified that the number was relatively low.

### Disciplinary cases

Our investigations found only one disciplinary hearing for which the details are publicly available. For more information please refer to the *PwC Claims Report, 2013*.

## *New Zealand*

### Statistics on midwives, live births and homebirths

The number of births in New Zealand has remained relatively stable from 2005-2012. As can be noted in Table 83, figures on the number of homebirths were unable to be obtained. Some consumer groups in New Zealand approximate the proportion of homebirths undertaken per year to be 7 per cent.[408] However, statistics are not recorded at this level of detail in New Zealand. There were 3,379 homebirths documented in the 2009-10 New Zealand College of Midwives Clinical database.[409]

407 De Jonge A, van der Goes BY, Ravelli AC, Amelink-Verburg MP, Mol BW, Nijhuis JG, Bennebroek Gravenhorst J & Butiendijk SE 2009.

408 Home Birth Aotearoa, 2013.

409 Guilliland 2011.

### Table 83: Number of births in New Zealand

| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|
| Total number of births | 57,745 | 59,193 | 64,044 | 64,343 | 62,543 | 63,897 | 61,403 | 61,178 |

**Source:** Statistics New Zealand, Births and Deaths: Year ended December 2012, February 2013.

### Insurance claims

The insurance broker indicated that there have never been any compensation awards due to the *Accident Compensation Act 2001 (NZ)*.[410] The *Accident Compensation Act 2001 (NZ)* also limits the quantum of claims. This makes New Zealand data regarding the quantum of claims data a poor substitute for Australian insurers. However, if an insurer were at risk from initial notification and appointed outside counsel for each case, consultations highlighted that the likely claims costs would be 10-20 times greater and outcomes worse. As a result, those consulted believed that if individual midwives had to carry individual policies, the excesses would be prohibitive.[411]

### Disciplinary cases

For more information about the disciplinary cases against midwives providing homebirth services in New Zealand, refer to the *PwC Claims Report, 2013*.

[410] Personal communication, November 2012.

[411] Ibid.

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