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AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

Professor Bruce Robinson
Chair
Medical Benefits Schedule Review Taskforce
Email: mbsreviews@health.gov.au

Dear Professor Robinson

Thank you for the opportunity to provide feedback on the report from the MBS Review Participating Midwife Reference Group.

The AMA supports women's informed choice and believes that a woman has the right to choose and access the model of care that is best for her health needs. The provision of antenatal, intrapartum and postnatal care by trained and qualified registered midwives is an important component of care options for Australian women.

However, the AMA strongly asserts that a medical practitioner should always be involved in antenatal, intrapartum and postnatal care, either in a consultative or supervisory role. This is essential, not only to ensure effective risk assessment and management, but so that if complications do occur, the medical practitioner who is required to step in has prior personal knowledge of the mother and her needs.

The AMA therefore strongly opposes any dilution of the current requirements for midwives to work within a written collaborative agreement with a medical practitioner in order to access MBS midwife items. While accessing collaboration for participating midwives may be difficult in some circumstances and could be improved, the AMA cautions against any measures which would result in reducing formal medical practitioner participation.

The AMA has consulted with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists in developing its submission. The AMA supports the College's submission to this report, and provides the following additional specific comments on certain recommendations as detailed below.

MBS item recommendations

Recommendation 11 – include general practitioners as eligible specialists for existing telehealth items

The AMA supports the recommendation that existing MBS items (items 82151 and 82152) relating to telehealth be expanded to include general practitioners in the list of medical practitioners that can participate in the video consultation. The AMA agrees that expanding this item to support collaboration with general practitioners would better support women being cared for by midwives, especially in rural and remote areas.

General recommendations

Expand MBS items that currently exist for midwives working 'for and on behalf of, and under the supervision of, medical practitioners' to include 'participating midwives'

The AMA opposes this proposal. It would remove the requirement for a direct collaborative relationship between a midwife and a medical practitioners.

Allow midwives to access MBS items if they comply with the Nursing and Midwifery Board's Safety and Quality Framework rather than require a formal collaborative arrangement with a medical practitioner

The AMA opposes any change to the legislation requiring midwives to be in a collaborative arrangement with medical practitioners. The proposal as described would result in loose and difficult to define arrangements and relationships which are open to significant dilution of meaningful medical practitioner oversight. The AMA strongly supports the current requirement for access to MBS items, which is that midwives work within a written collaborative agreement with a named obstetrician or a facility that has a designated obstetric medical team/service. A formal written agreement ensures documented protocols for women's care. This is in the best interests of women's health and is likely to help limit insurance costs for midwives.

Drop the postgraduate prescribing qualification requirement for midwives

The AMA opposes any reduction of the level of education and training currently required before midwives may prescribe Schedule 4 and Schedule 8 medicines. The argument that midwives require less prescribing training than nurse practitioners because midwives prescribe only a limited formulary is weak.

Nurse practitioners are also only endorsed to prescribe by the Nursing and Midwifery Board of Australia in a specific area of practice. This is consistent with State and Territory prescribing legislation which only authorises nurse practitioners to prescribe within their specific specialty area and scope of practice, for example, in diabetes management, or palliative care, or aged care, etc.

Further, the AMA considers that prescribing Schedule 4 and Schedule 8 medicines requires extensive education and training, irrespective of the range of medicines being prescribed. The NPS MedicineWise *Prescribing Competencies Framework*[1] provides the benchmark for safe, appropriate and quality prescribing. The Framework sets high standards of competencies for diagnosis and prescribing and requires that the prescriber is responsible and accountable for their prescribing decision.

Prescribing requires non-medical health practitioners to undertake additional accredited education and training specific to their scope of practice, which ensures practitioners meet consistent and measurable standards and competencies.

[1] NPS MedicineWise, *Prescribing Competencies Framework*, 2012

Expand midwife access to pathology and diagnostic investigations

The AMA opposes midwives accessing the 12 pathology and diagnostic investigation MBS items listed in Appendix G of the report.

The items are significant tests that are not requested routinely in pregnancy. These tests are requested only when clinically indicated. Midwives do not have the training to make that determination.

The focus of the MBS Review is to remove low value medical services, including tests. This proposal would expand access to a group of health practitioners unqualified to request the tests, interpret the results, or act on them.

For example, midwife access to a postnatal abdominal ultrasound for retained products may seem reasonable at first, but if there are retained products, the patient will need a D and C by an appropriately trained medical practitioner. Delaying the referral to a medical practitioner puts the patient at risk as retained products are associated with haemorrage which may be life threatening.

Similarly, a midwife requesting growth and well-being scans adds an unnecessary additional step. If foetal growth retardation is a consideration on clinical assessment such as fundal height, etc, the patient needs to be referred for specialist obstetric care without delay. The obstetric unit has the expertise to determine the best course of action for further management.

It is extremely worrying that a midwife would request non-invasive prenatal testing for major chromosomal abnormalities. These tests require genetic counselling of the parents at the time of requesting, and if there is an abnormality, expert feedback and counselling. There is significant medico-legal risk associated with a consultation around these tests. A midwife is not qualified to manage the patient if a test result is abnormal.

The AMA is available to expand on any aspect of this submission.

Yours sincerely

Dr Tony Bartone
President