Women and Birth xxx (2017) xxx–xxx

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi

Discussion

Regulation of unregistered birth workers in Australia: Homebirth and public safety

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ARTICLE INFO

Article history:
Received 2 December 2016
Received in revised form 28 June 2017
Accepted 30 June 2017
Available online xxx

Keywords:
Home childbirth
Midwifery
Regulation of health professions
Freebirth
Unregistered birth workers

ABSTRACT

Background: Australian midwives are regulated under the National Registration and Accreditation Scheme. Unregistered birth workers may provide midwifery services at homebirths without any regulatory oversight. To address this issue, several states have passed legislation enabling prohibition orders to be made (negative licensing) against unregistered health practitioners who fail to comply with a statutory code of conduct developed for those not covered by the National Scheme.
Aim: To explore the consequences for the availability of birth choices for women that arise from the introduction of negative licensing.
Discussion: An analysis of the regulatory framework and recent cases of unregistered birth workers attending homebirths reveals problems with equitable access to homebirth support, arising from issues with professional indemnity insurance, geography, and poor integration with hospitals and the wider healthcare system. These problems contribute to women choosing to employ the services of unregistered birth workers.
Conclusion: Negative licensing provides a useful additional tool for improving the safety of homebirths for mothers and babies, but it does not address the issues leading expectant parents to choose an unregistered birth worker to attend their births, and may contribute to an increase in high-risk behaviours, such as freebirthing.

Statement of significance

Problem or issue

Recent legislative changes aimed at protecting the public may have consequences for the availability of birth choices for women.

What is already known

Negative licensing provisions have been introduced in some Australian states, and used successfully in regulating some categories of unregistered health practitioners. The utility and consequences of using negative licensing to prevent intrapartum care being provided by unregistered birth workers has not yet been tested.

What this paper adds

An analysis of the regulatory framework and recent cases of unregistered birth workers attending homebirths reveals inequitable access to homebirth support, arising from issues with professional indemnity insurance, geography, and poor integration with hospitals. Negative licensing is a useful tool but cannot address the factors that have created market demand for unregistered birth workers.

1. Introduction

Midwives have been registered under the National Registration and Accreditation Scheme (the National Scheme) since the Health Practitioner Regulation National Law (the National Law) was enacted in each of the states and territories between 2009 and 2011.[1–8] Regulation of the midwifery profession is overseen by the Nursing and Midwifery Board of Australia (NMBA), which aims to protect the public through the establishment and enforcement of professional standards and policies. 'Midwife' and 'midwife

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http://dx.doi.org/10.1016/j.wombi.2017.06.023
1871-5192/

practitioner' are protected titles under the National Law,[1] and all midwives wishing to practice in Australia must be registered with the NMBA and comply with the NMBA's standards and policies.

In recent years, high profile cases have arisen of previously registered midwives continuing to attend homebirths, highlighting a limitation of the current regulatory framework.[9] It is possible for an unregistered, or even entirely unqualified, birth worker to attend a homebirth by using descriptors such as 'doula', 'birth advocate' or other labels for unregistered birth workers, and receive payment for these services, without any regulatory oversight. However, several states passed legislation enabling prohibition orders to be made against unregistered health practitioners who fail to comply with a statutory code of conduct developed for those not covered by the National Scheme.[10–13] Further, a National Code of Conduct has been agreed to by the Council of Australian Governments (COAG) Health Council but not yet enacted in all of the remaining states and territories.[14] This gives rise to a form of 'negative licensing' in which incompetent or unethical health practitioners are removed from practice. Although these developments were not driven specifically by concerns regarding unregistered birth workers, negative licensing has nevertheless been portrayed in the media as a solution to the problem of '[r]enegade midwives and unqualified birth assistants who pose a risk to women and their babies.'[15]

This paper examines the effect of negative licensing on the availability of birth choices for women and the potential consequences for public safety. The negative licensing provisions apply to all unregistered health care workers who provide a health service; in the context of homebirth, it applies to unregistered birth workers. Unregistered birth workers may include 'doulas, birth assistants, lay midwives, childbirth educators, bodywork specialists, Indigenous birth workers, hypnotherapists, nutritionists, naturopaths and ex-registered midwives.'[16] The regulatory framework for midwives who attend homebirths will first be outlined, and then the extent to which unregistered birth workers pose a problem will be assessed. Regulatory and legislative options available for use against unregistered health practitioners, and their limitations, are identified and the utility of negative licensing in this context is evaluated. I argue that while negative licensing provides a useful additional tool for improving the safety of homebirths for mothers and babies, it does not address the issues leading expectant parents to choose an unregistered birth worker to attend their births, and may contribute to an increase in high-risk behaviours, such as freebirthing. Negative licensing therefore contributes to the narrowing of available birth choices for Australian women, and thus provides only a partial solution to the question of how to regulate for the health and safety of women and babies in homebirth.

2. Regulation of homebirth midwives

Under the National Law, the NMBA is responsible for regulating the practice of midwifery through the development of registration requirements and professional codes and guidelines.[1–8] This regulation is undertaken with the aim of protecting the public through maintaining high standards of safe and professional practice. These professional guidelines include specific provisions for midwives attending homebirths, although they comprise only a small proportion of births in Australia. In 2013, 958 women gave birth at home, comprising 0.3% of all Australian births.[17]

Midwives may provide homebirth services through private or publicly funded models. In recent years, publicly funded homebirth programs for low risk pregnancies have been introduced by some Australian hospitals, although none are available in Queensland, the Australian Capital Territory or Tasmania.[18] Midwives are required, under section 129 (1) of the National Law, to hold appropriate professional indemnity insurance (PII). Midwives employed by hospital-affiliated homebirth programs are covered by their employer's indemnity insurance.

However, no insurance providers have offered PII for private midwives providing intrapartum care at a homebirth since 2001.[19] An exemption from the requirement to hold PII for these midwives was due to expire in December 2016, but has been extended by Federal and state and territory health ministers for a further three years in order that a national insurance solution be developed to address this issue.[20] Exemption is subject to requirements outlined in section 284 of the National Law: that a woman must give informed consent, that the midwife must comply with codes or guidelines approved by the Board under section 39 of the National Law, and that the midwife complies with safety and quality practice requirements.[21]

The requirements that private midwives must meet in order to qualify for exemption under section 284 were previously outlined in the *Safety and quality framework for privately practising midwives attending homebirths* (Framework).[22] Following a review of the Framework begun in 2014, the NMBA released the *Safety and quality guidelines for privately practising midwives* (SQG) in February 2016, which replaced the previous Framework when it came into effect on 1 January 2017.[23] Notable changes include requirements for: a risk assessment based on the *National midwifery guidelines for consultation and referral (2013)*; the presence at a homebirth of two registered health practitioners with skills in maternity emergency management and maternal and neonatal resuscitation; regard for travel time and distance to an appropriately staffed hospital; completion of a professional practice review program; and proof of annual competencies in adult basic life support, neonatal resuscitation and training.[23]

Privately practising midwives providing intrapartum care in the home are subject to regular audits of practice, and must provide evidence of compliance with the relevant requirements either every three years, if they are endorsed for scheduled medicines, or annually, if not endorsed for scheduled medicines.[23] The codes and guidelines developed under the National Law are subject to review at least every five years as part of ongoing efforts by the Australian Health Practitioner Regulation Agency (AHPRA) and the NMBA to ensure the adequacy of the regulatory framework for midwives providing homebirth services.

Changes in the SQG represent efforts to address issues that have arisen in cases of unsatisfactory professional conduct and professional misconduct with homebirth midwives. For example, in *Health Care Complaints Commission (HCCC) v Khalsa No 1* [2013] NSWNMT 20, Akal Kaur Khalsa was found to have exercised care significantly below the standard expected of a registered midwife by failing to provide appropriate neonatal care, failing to recognise the need for emergency medical care, and failing to keep proper clinical records. The Tribunal ordered that Ms Khalsa's registration be cancelled and that she be prohibited from reapplying for registration for a period of two years. The increased emphasis within the revised guidelines on documentation, preparedness for emergencies requiring transfer to hospital, and monitoring through audits and review programs goes beyond the deregistration of a single practitioner and demonstrates effort to prevent similar professional misconduct cases in the wider profession.

Interestingly, a recent decision provides evidence of a change in consequences for individuals found guilty of professional misconduct in relation to homebirths, towards more extensive protective orders. In *HCCC v MacGregor* [2016] NSWCATOD 86, Sonja MacGregor was found guilty of unsatisfactory professional conduct and professional misconduct for her care of a woman whose baby had died by the time of presentation to hospital. The woman had planned to have a homebirth, but had an obstetric history of two caesarean births following unsuccessful induction of labour at

Please cite this article in press as: R. McWhirter, Regulation of unregistered birth workers in Australia: Homebirth and public safety, Women Birth (2017), http://dx.doi.org/10.1016/j.wombi.2017.06.023