T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 4 September 2017

Members

Mr Paul Edbrooke — Chair
Ms Cindy McLeish — Deputy Chair
Ms Roma Britnell
Dr Rachel Carling-Jenkins
Ms Chris Couzens
Ms Maree Edwards
Mr Bernie Finn

Witnesses

Ms Hannah Quanchi, Owner and Director,

Ms Andrea Quanchi, Midwife and Director of Midwives, and

Ms Gabrielle Sammon, Parents Group Representative, My Midwives Melbourne.

The CHAIR — Welcome to My Midwives Melbourne. I welcome to these public hearings Ms Hannah Quanchi, owner and director; Ms Andrea Quanchi, midwife and director of midwives; and Ms Gabrielle Sammon, My Midwives Melbourne parent group. I believe we have in the audience Celeste Morgan as well. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript. I think it is very appropriate that we have babies at this inquiry today. Perhaps if we can start with a 10–15 minute presentation from you about your service and the inquiry.

Ms A. QUANCHI — Hi, I am Andrea. We did have a PowerPoint presentation, but we are just having a few technical difficulties, as you can see. Thank you for asking us to present today. My Midwives is a private midwifery practice that has various locations around Australia. My Midwives originally started in Queensland. That was the first practice in Australia that had visiting access to a hospital, so the midwives had admitting rights. Our practice in Perth was the first practice in Western Australia with visiting access, and we were the first practice with visiting access in Victoria.

My Midwives has won several awards around Australia for innovative partnerships with various health services. What we pride ourselves on is continuity care, and that means one midwife for one woman, so each woman gets allocated her own midwife. They meet several other midwives, but the aim is for each woman to primarily have their care from one midwife throughout the whole continuum of pregnancy.

The Cochrane review, which was done of 17 000-plus women, has shown that this is the best way to ensure women have the best outcomes. Having that model of care, women will have less intervention, they are less likely to have caesarean sections, they are less likely to have perineal tears or episiotomies, they are more likely to have a spontaneous vaginal birth and less likely to have babies that go to a special care nursery, and the neonatal and maternal morbidity for babies is better when women have continuity of care.

The Women's did a large study of continuity of care for the COSMOS program, which has been running for over 10 years now. It has also shown better outcomes for mothers and babies. Despite that, continuity of care is not available for the majority of women in Victorian public hospitals. The programs that are run across the state are limited mostly to low-risk women. They are oversubscribed, in that many, many more women want to get into these programs than are available and the amount of continuity with the same midwife is restricted.

In 2015 the Andrews government made an election commitment to run a pilot program here in Victoria. Northern Health and Monash both put in to be pilot sites for that. Northern Health was selected as a pilot and they commenced with My Midwives in 2016. They chose us to be their partners in running that pilot.

Monash Health liaised with us at the time about getting going, but to date they have not yet credentialed any midwives. So the Northern remains the only hospital in Victoria that currently has credentialed private midwives.

Visual presentation.

Ms H. QUANCHI — The way that we work in conjunction with Northern Health is that the midwife provides all the antenatal care and collaborates with Northern Health where appropriate. We use the midwifery guidelines for consultation and referrals, so if women need a consult with an obstetrician or a referral to an obstetrician, then we can. The premise is that all women have midwifery continuity of care and then some women will have some obstetric care along the way as needed. Intrapartum the woman is admitted under the private midwife into the Northern Hospital as a private patient. Women will either use their private health insurance or be self-funded. During intrapartum care the midwife collaborates with the obstetric team as needed. Even if there is obstetric involvement, the woman remains a private patient and uses the obstetric team of the day.

The women that use this model of care are all risk, and that is a big difference from what we see in some of the public continuity of care models is that they are often low risk. We have found that being an all-risk model means that women to whom typically the continuity of care models have been unavailable, for them to have access to midwifery continuity of care the whole way, we know that that then improves the outcomes for those mothers and babies — just little things in terms of having the same person managing their care and liaising with

the obstetric teams as needed. It is less likely things will be missed in communication if they have got the same person with them the whole time.

As I was just saying about the continuity of care programs that are available in Victoria so far in public hospitals, they are funded by the state government and they are sometimes costly to the state government as well. Part of having midwives on call is that it can then become a more expensive endeavour. It is not available in all hospitals, and they have a limited amount of women that they can take in, so often the waiting lists are phenomenally bigger than the amount of women who are actually getting to the program. And then again women who are low-risk are often the only ones that are allowed in.

After the first year of the pilot program at the Northern Hospital, the Northern reviewed the statistics of the private midwife program compared to the public sector and found that the private patients had a reduced length in hospital stay, reduction in caesarean section, reduction in the use of epidurals for pain relief in labour, reduction in the number of episiotomies and perineal tears, and reduction in instrumental birth by forceps or ventouse. They also did a survey of public patients versus private patients in terms of satisfaction and found higher satisfaction in the private patients.

The way that the private model is funded is that the antenatal care is funded by the woman. We see that women particularly who are going to their public antenatal clinic at the hospital are doing the majority of their antenatal care at the private midwife clinic. The care is funded by the woman, and she receives a Medicare rebate for each appointment that she has. In intrapartum care the woman is admitted as a private patient, either has private health insurance or is self-funded. There is no cost to the hospital for the midwives' wages. Women are also having a shorter length of stay. The postnatal care is then paid for by the woman again, and she has Medicare rebates and private health rebates if she has private health insurance. So the biggest difference is that there is no additional cost to the state government. Because of shifting funding to Medicare, it is shifting to federal funding for antenatal and postnatal care.

The barriers that we see at the moment in Victoria are that there has not been an expansion of the private practice midwife model like we have seen in Queensland. Currently Northern Hospital is the only program in Victoria, and there has not been any other traction in any hospitals in Victoria. At this point we see it as a cultural thing within hospitals, that there seems to be a bit of a fear about what the program will entail and some confusion about the processes of referring to obstetric care, particularly in the intrapartum period, which are not issues that we have seen come to light in our experience in the last year and a half at the Northern. There is a lack of the Australia-wide maternity services action plan. You probably know all about that from recently.

Private midwives also fall outside the state level, and because we are mostly working with Medicare, it is more of a federal level and there does not seem to be much governance in initiating the programs from hospital to hospital. The biggest issue for midwives at the moment is that we cannot insure midwives with less than three years clinical experience and if they are not the director of a company. That is restrictive in the midwives that we can employ as well and for us getting a bigger workforce. And then again with Medicare, midwives with under three years clinical experience cannot access Medicare. The midwifery items were to be reviewed in September, but there has not been any word of it yet and no plan moving forward.

Our recommendations are to do with the redevelopment of the national maternity services plan; Victoria supporting a stakeholder group, including private practice midwives; the MBS task force reviewing midwifery item numbers as committed; and a review of insurance, visiting access and other barriers to utilisation of private practice midwives in Victoria. What we really want to see is the model that we have at the Northern carried out across other hospitals in Victoria. In particular that was why a lot of our mums wanted to come today, because a lot of them have had to travel quite a distance in order to birth at the Northern Hospital, in order to have the care that they wanted to have. For some of them that meant driving past a public hospital that offered maternity services to get to one where they could have continuity of care. For them in particular they wanted to express how important it is to be able to access these services in their local areas, not just at one facility.

Ms A. QUANCHI — That is from the women.

Ms SAMMON — I am just here as a representative of the parents from the My Midwives parents group. We have just made some supplementary submissions for you, because we did not want to take your time up with it today, which are just our stories about why we are such advocates for continuity of care and the experiences that we have had with My Midwives. I will pass those around for you after I am done.

The main point that comes across in all our stories is just the importance of having confidence in your care provider when you are pregnant and going to have a baby, and especially for the first time — it is just essential. Even though a lot of us had different labour experiences and birthing experiences, we all felt empowered by them and that our care providers had made the best decisions for us and our babies, and we really believe that that is because of the continuity of care and the time that we always had with Hannah or Andrea, knowing who our care provider was.

Our main points were that we recommend you replicate this model in other hospitals. Particularly in regional Victoria there are just not the same level or options of perinatal care, and I think that is really important.

Ms H. QUANCHI — And in particular for you, Gabrielle was thinking about moving back to the country but has decided not to because she knows that she will not be able to access continuity of care for the birth of her next baby.

Ms SAMMON — Yes, or if I do, I will have to come to and from Melbourne and Warrnambool, but I think the treatment is of such a standard that I would do that. I think it is also important that often the people that access the best standard of care are people like myself who can afford to and are educated and find out about it, and yes, we really benefited, but the people that probably need that the most, and need more support — and it would really benefit them and their children — cannot afford it and do not know about it, and a lot of them live regionally, so that is really important.

Another issue was that — 2 and 3 are sort of combined — when we all started sharing our stories, we found out about My Midwives and continuity of care by accident or by referrals. I had no idea what continuity of care was. I just shopped at the shopping centre opposite My Midwives, and when I got pregnant I thought, 'The midwives will know what to do; I'll call them'. So I am extremely fortunate that I shop there.

One of our ideas was that if there is a sort of standard booklet or leaflet of information that we can give to GPs that just explains all of the different care options for pregnancy and birth in completely non-biased language — it just has statistics relating to all the different options, of what is public, what is private, what will be out-of-pocket expenses — when women first go to their GP for their pregnancy test, they could be given this information. Because the other thing I certainly came up against was that GPs were quite uncomfortable that I was just seeing a midwife and not an obstetrician, so if it is in more of a written format, they cannot put their bias on the information as well. So those are our recommendations, and our stories are in here just to supplement that as well.

The CHAIR — Do you mind if we ask some questions?

Ms SAMMON — Yes, go for it.

Ms H. QUANCHI — Yes, absolutely.

The CHAIR — This program has been expanded in Queensland and not in Victoria. The data is very compelling. You have got a great opportunity today to advocate very strongly for private midwives and continuative care. You have said it is a cultural issue that we cannot get through. What are the key things that you would tell this committee that we need to do to get more private midwives into hospitals, not just the Northern Hospital?

Ms A. QUANCHI — We have approached nearly every hospital, I would say, in Victoria over time, and the thing that we are coming up against at the moment is this misunderstanding of what happens when a woman is outside the scope of practice of a midwife. When you have got a woman who has been admitted under the private midwife and needs an escalation of care, so needs obstetric input, there is a misunderstanding of what happens to the woman then. A lot of people think the woman then needs to be reverted to a public patient somehow. The trouble with that is that if the woman reverts to a public patient, the midwife then has no insurance. The woman remains a private patient, but then the hospital adds the obstetric team of the day to provide that part of her care. The woman still needs a midwife looking after her — every woman has a midwife looking after her in hospital — but maintains the private midwife doing the midwifery component of care. So the woman remains a private patient — so it is private care in a public hospital — and then the obstetrician of the day, if you like, is able to delegate care to the registrar or whoever in their team, but they still stay a private patient. There seems to be a misunderstanding of the ability of that to happen. When we say it is a cultural thing,

when we go to other hospitals that have tried to have the discussion, they keep coming back to — and this has happened in other states as well — that there is a misunderstanding of how that happens.

Ms H. QUANCHI — They often want a process where there will be private obstetricians, backup private midwives, in a public hospital, which makes the entire thing much more complicated.

The CHAIR — I bet.

Dr CARLING-JENKINS — Thank you very much for your submission, and I look forward to reading more of the personal stories, because they really seem to illustrate and give us that anecdotal evidence to back up a lot of what you have said. I am an academic, so I actually spent some time reading the Cochrane review last night, which was fascinating,

Ms H. QUANCHI — Did you? Good.

Dr CARLING-JENKINS — The evidence base is very clear, isn't it?

Ms H. QUANCHI — Yes.

Dr CARLING-JENKINS — I notice that you talked about New Zealand particularly. You mentioned New Zealand, the Netherlands and Sweden, but New Zealand particularly is our closest neighbour, and they have more of a continuity of care model. I wonder if you could unpack that a little bit for us and explain what we could learn from our closest neighbour.

Ms A. QUANCHI — I guess the difficulty is they have a completely different funding model. In New Zealand the funding follows the woman, so there is funding for antenatal care for a woman regardless of who provides that care, so the women can choose whether to have a private midwife or go to a public hospital or go to an obstetrician. The same amount of money gets allocated for each component of their care, and I think there are three different packages, if you like — so there is an antenatal package, an intrapartum package and a postnatal package — and the women can nominate who will provide that care. Our funding is different because our funding does not work the same way.

Dr CARLING-JENKINS — Because our funding is split between state and federal, and Medicare numbers are a bit —

Ms A. QUANCHI — A lot of people do not understand that. You cannot just say, 'Well, we want the New Zealand model here', because the funding does not work that way. It is well entrenched in New Zealand now that when you are pregnant midwives are legitimate care providers, if you like, whereas it is still very much in Australia seen as that you have to see a doctor, you know what I mean. It is still very much more a thing that women are confronted with a lot. I am not knocking private institutions, do not get me wrong at all.

Dr CARLING-JENKINS — Of course not, but it is that cultural issue that you are talking about.

Ms A. QUANCHI — But there is a cultural thing that a private obstetrician is the gold standard of care kind of thing.

Dr CARLING-JENKINS — And midwives are still seen to be looked down upon.

Ms A. QUANCHI — Well, that we are somehow nurses. Not all midwives are nurses. Some, like me, are trained as a nurse as well, but Hannah trained as a midwife and has not trained as a nurse. So it is just even that conversation — that midwives can look after women having low-risk pregnancies without needing any involvement from a medical colleague. But there are some women who at some stage might need a medical colleague for maybe a small bit of their pregnancy, maybe the whole pregnancy. It might not be an obstetrician they need; it might be an endocrinologist or a physician or something else — a specific add-on to their pregnancy.

Dr CARLING-JENKINS — Sure. So there are still a lot of myths in Australia that we need to —

Ms SAMMON — We think obstetricians are the care providers for pregnancy, and I did not realise until I was pregnant and being treated by my midwives, and then also speaking to medical friends who are doctors,

that obstetricians are specialists in high-risk pregnancies but our society does not think that. We just think, 'You get pregnant; you get an obstetrician'. I had a friend who was doing her obstetrics round, and she said to me, 'I don't want to do it because it's specialising in the worst-case scenario of childbirth'. She understood that, but as a community we do not understand that. We do not see —

Ms H. QUANCHI — I think the difference is that in Victoria most women when they think that they are pregnant will go and see their GP, and the GP will say, 'Do you have private health insurance?' 'Yes'. 'If you do, here's this obstetrician that I recommend', or, 'No, you don't. Here's the public hospital that's closest to you', and send in a referral either way. Whereas in New Zealand the culture appears to be that a woman will find out she is pregnant and just automatically either see the GP or automatically source out the midwife that is closest to her — the similar birth centre that she would want to birth in. So the culture is a little bit different about where women go, and the expectation in New Zealand is that all women will have a midwife.

Dr CARLING-JENKINS — Thank you very much.

Ms H. QUANCHI — Quite a high number of women have midwifery continuity of care — I think above 90 per cent.

Dr CARLING-JENKINS — Above 90 per cent in New Zealand?

Ms H. QUANCHI — Yes.

Dr CARLING-JENKINS — Wow, and what percentage do we have here?

Ms A. QUANCHI — Oh, I could not actually do the —

Dr CARLING-JENKINS — You do not want even want to go there, do you?

Ms A. QUANCHI — It is pretty low.

Ms H. QUANCHI — Pretty low.

Dr CARLING-JENKINS — Fair enough. Okay, thank you very much.

Mr FINN — I would like to wipe out a few myths too. What is the relationship between yourselves and the medical profession? There is a thought process that people have that you two are at war.

Ms A. QUANCHI — It is a myth, but it is also partly a frustration. It depends where you are. If you ask me today, out at the Northern Hospital it is fantastic. Professionally it is the best thing I have ever done because I could pick up the phone today and talk to the obstetric director or go into births wing and talk to any of the obstetric team and have absolutely no problem whatsoever, but at other hospitals it is not the same. There is another big tertiary hospital in Melbourne that is no longer taking referrals from midwives. They will not take backup bookings for home births from midwives. It is very much like this because there is just no mechanism for the conversation to happen. The way Medicare was set up was that midwives have to be able to demonstrate collaboration to access Medicare. It is legislated that we have to have a collaborative arrangement with either a hospital or with an individual doctor, but there is no legislation for doctors to have to collaborate with midwives. I personally do not have any problem at all, but I know there are a lot of my colleagues who do have doctors all the time that refuse to write referrals to them.

Mr FINN — Which hospital were you referring to then?

Ms A. QUANCHI — Sorry?

Mr FINN — The hospital that has bailed out or is refusing to take referrals from midwives — which one is that?

Ms H. QUANCHI — The Royal Women's.

Mr FINN — Royal Women's, okay. Right.

Ms A. QUANCHI — They have decided they will not accept them. If the women turn up, they will treat them, but they do not want the bookings.

Mr FINN — Right. Okay. Apart from the Northern Hospital, which clearly is getting along very nicely, are there any other hospitals in the state that you could comfortably say are happy with dealing with the situation that you are proposing?

Ms A. QUANCHI — No, we have not been able to get a single other hospital to get any traction. We have approached them. I have been doing this since the health thing came in in 2010 and have tried multiple hospitals where I work so I could work in them. They are quite happy for me to look after the women and come in and refer women to the clinic and stuff. But when the women come in in labour I am only allowed to be there as a support person, and that is because the women are admitted publicly because they will not let me admit them privately. Therefore I no longer have insurance. So I am walking a very tenuous line because I am there, my relationship with a woman is as her midwife, but legally I am not practising as a midwife. If I say anything or do anything that could be construed as midwifery care, I am then practising illegally because I do not have insurance.

It is actually a very dangerous situation for us. For that reason we have stopped going to do what a lot of midwives call birth support because professionally it is very dangerous for us to do that when we have such a good thing going at the Northern Hospital. So we are saying to women now, 'If you want us to be with you during your birth, you need to come to the Northern Hospital to do that'.

Ms H. QUANCHI — I am a share care provider with the Royal Women's, Mercy and Sunshine, which means that I can provide antenatal care to low-risk women who choose to see me instead of going to the public antenatal department. Then the women will still have a few visits at the hospital during the pregnancy. But if there are any complications arising in the pregnancy, the woman will no longer be eligible for shared care and should not continue to see me and will go to the hospital antenatal clinic. And from the moment when she goes into labour there is no avenue for me to continue to care for her at all.

The CHAIR — Just to clarify — those complications, could that just be pre-eclampsia?

Ms H. QUANCHI — It could be high blood pressure, it could be thyroid issues — it could be anything that puts the woman from straightforward, low-risk pregnancy to needing further close monitoring.

Ms A. QUANCHI — Gestational diabetes — anything, yes.

Mr FINN — Is there a sufficient safety net, if I can use that term, to protect women from a sudden change in conditions, where they are sailing along nicely and all of a sudden birth is imminent and we have an emergency?

Ms A. QUANCHI — As Hannah said, we use the Australian College of Midwives guidelines for consultation and referral. You may not have seen it, but it is a document that was put out by the Australian College of Midwives and that has been supported by RANZCOG. It sets out every condition that could possibly be feasible during pregnancy. It means (a) talk to one of your colleagues, (b) talk to a doctor, and (c) refer care to an obstetrician. So it is all set out. That is at your first presentation in pregnancy all the way through pregnancy, in the intrapartum period and the postnatal period.

Mr FINN — How quickly could you refer to an obstetrician if indeed the birth process has already started?

Ms A. QUANCHI — Quicker than the woman could do it herself by turning up at the emergency department, because we have access to the team.

Ms H. QUANCHI — Do you mean in hospital — when you are in hospital?

Mr FINN — Once you are in labour, either at home or in hospital. At home it would provide a greater degree of difficulty, I would imagine.

Ms A. QUANCHI — Yes. But we only do low-risk home births — women who are very low risk. That is one of the things we know from this new model of care — that the number of home births that we are doing has dropped drastically because we can offer women the continuity of care for high-risk women in hospital. So, yes,

if we are only doing home births for low-risk women, the incidence of requiring transfer is very, very low. No-one could ever say that it could never happen, but we would ring 000 and get an ambulance and transfer the woman to hospital that way. I have been doing this for over 20 years, and I have had to call an ambulance once in 20 years.

Most of the time when interventions happen and things escalate it is because one intervention leads to another intervention to another. So if you are not doing those interventions at home, then you do not get the same escalation that you would get in hospital. Once we are in the hospital then we have got the whole obstetric team at our disposal right outside the door of the birth suite. They know we are there, and they know what is going on in the birth suite. We communicate with them on a personal level. One of the registrars said to me the other day that she loves working with us because she always knows what is going on with our clients in the department, whereas what she has found at other places is that there seems to be this divide between the midwives and the team. Because we are not worried, if you like, that they are going to take the women off us there is no need to have a divide between us.

Ms H. QUANCHI — So the worry with the low-risk model is that women may not be referred in a timely manner because for whatever reason the midwives might be worried that they are going to lose the women from the program. The women might not report things to the midwives because they are worried that they are going to drop out of the program, whereas with an all-risk model there is no harm in us referring a woman to an obstetrician because she is always going to remain in the program. I think that is why the statistics are better, because there is a more timely referral of the high-risk when needed.

In terms of intrapartum in the hospital, when we arrive with the woman we discuss the woman's history with the obstetric team who are there, and in terms of getting help from obstetricians, all it would take is to yell out or hit the button on the wall in the same way that any midwives would in the public hospital, and they would get the whole team running.

Ms A. QUANCHI — One of the concerns that was raised early in the piece was that there was maybe a disconnect between the midwife thinking that she had handed the patient over and the doctor accepting responsibility for the care. Does that make sense? So you talk to them and you think that they have taken over but they have not. So we devised a system where when we go and chat to the obstetrician and we decide that this woman needs to be on medically led care rather than midwifery-led care we put a sticker on the history and both the doctor and the midwife sign the sticker to say that you have handed over care. After the woman has had the baby if it is appropriate for them to hand the woman back, we both sign the sticker again acknowledging that care has been handed back to the midwife. So there is no ambiguity, if you like, over who is the lead carer for the woman at any one point in the journey.

Mr FINN — So in the case of that situation where there is an emergency you as the midwife have looked after the mother and the baby right through the pregnancy, an emergency has occurred during the birth itself, and you have handed her over to the obstetrician for care. The obstetrician can then hand her back to the midwife afterwards for antenatal care.

Ms A. QUANCHI — Yes, and that might happen if the escalation was to, say, do a forceps or something like that. The whole journey has not become high risk; it is just that one small incident. I can give you another example. Recently I had a woman who was planning to birth at home who rang up to say that she was bleeding, so I said, 'I will meet you at the hospital'. She escalated and had an emergency caesarean very quickly after arrival at the hospital and stayed under medically led care after my initial assessment when I called the obstetric team. We had her in theatre and had the baby born within less than an hour after arriving in hospital.

Mr FINN — Thank you.

Ms A. QUANCHI — Does that answer your question?

Mr FINN — It does, thank you.

Ms EDWARDS — Thank you very much. In relation to the Queensland model, my daughter-in-law and son have just been the beneficiaries of that, and I have a beautiful grandson as a result.

Ms H. QUANCHI — Congratulations.

Ms EDWARDS — Thank you.

The CHAIR — She has told us about 10 times.

Ms EDWARDS — I know.

Ms H. QUANCHI — Have you got photos?

Ms EDWARDS — I was thinking about it. There was a gap. Where they live there were about three midwives that covered quite a big area who attended to her needs, from the time she was pregnant. She actually had to transfer to Townsville to deliver, because she was about an hour and a half outside. When she got to hospital to deliver she had to stay there for two weeks before her due date, so she lost that continuity of care from the local midwives. The midwives who delivered were strangers of course to her. But then on her return home the local midwife then picked up and was there the day after she got home. So there was continuity of care but there was that gap in the middle.

When I am thinking about that, and I am thinking about how we apply this to Victoria, if we were going to do a similar model, how would we actually do that in the sense that the three midwives that were local were public midwives?

Ms H. QUANCHI — That is the difference.

Ms EDWARDS — Yes. So we are currently only operating the system where there are private midwives. Now, back in the old days — and I keep saying this because I am feeling rather old, being a grandma — my last two children were born at home, and under the model that I was able to deliver them at home with, for the midwife I did have to pay a small sum, but the insurance covered her and she worked collaboratively with my GP.

Ms A. QUANCHI — That is the same as what we do.

Ms EDWARDS — It did used to happen, I think, but we have moved somewhat away from that model.

Ms A. QUANCHI — In rural Victoria — because I have lived in Echuca for 25 years — we do not have many places in Victoria where women are forced to relocate for very long periods of time. In most places in Victorian women are within driving distance of their closest maternity service. I guess if you get out in the Mallee, there are probably some women that are further away and stuff like that, but the difference is what they call the midwifery group practices, where there is a group of midwives in the public hospital that provide what they call a continuity of care, which is similar to what your daughter would have had. That is the difference between the things. A lot of them have geographical boundaries, they often only take low-risk women and it is very random whether women get into those programs at all, whereas the advantage, I guess, with what we do is that we are able to travel distances, but also because it is a private model of care women can come to us. I have got a client coming to me in the near future who is coming from regional Victoria but who is going to relocate to Melbourne to have her baby here with us because she cannot access this care in her local community.

Ms EDWARDS — I guess the other question around all of that then is: are there enough midwives to actually be able to do this?

Ms A. QUANCHI — We cannot employ more midwives because we have not got more clients. It is a cat and mouse kind of thing. We have got expressions of interest from midwives who want to come and work for us. There are a lot of midwives that are out there that are not doing midwifery because if you work in a small regional town, the midwives in the hospitals only do the intrapartum care. They do not do the antenatal care because the GPs do it. It is very fragmented. I am being vague. It is a hard question to answer.

We have got a lot of young midwives. A lot of the younger midwives are being trained to do continuity during their training, and then we tell them, 'But now you've finished you can't do it. You have to go and work in a hospital', because we cannot have them come and work with us because of this Medicare thing. If you have got a doctor that goes through medical training, they get to go out and work in a GP clinic under the supervision of another GP who has access to Medicare and accesses Medicare, but we do not have the same thing.

Midwives have to have done 5000 hours in the last six years before they can get access to Medicare. Now if you have got a female workforce, they have been through university, have done maybe nursing, then they have done a grad year and then they have done midwifery, the chances are they are going to be in their early 20s. Ninety-nine per cent of them are female, so they are going to want to have a family. The chances of them being able to get to 5000 hours in the last six years of practical experience across the scope of midwifery to be able to apply for Medicare means that it is going to be very, very difficult for midwives to achieve the standard.

Ms EDWARDS — What is the cost then? What is an average cost of seeing a midwife?

Ms A. QUANCHI — For our care?

Ms EDWARDS — Yes. For the whole time.

Ms A. QUANCHI — The whole package, we are not allowed to charge it as a whole package because of Medicare. Just rounding it out for you, we charge about $6000 for the whole episode of care and women will get a percentage back from Medicare, and then if they have got private health insurance, they will get some back.

Ms COUZENS — Thank you for your presentation and for bringing along the little people today. It is great. I just want to clarify: is it only women with private health insurance that can access it?

Ms H. QUANCHI — No. From our clients it is about 50-50 of women that do have private health and women who are self-funded.

Ms COUZENS — You pay for it yourself basically.

Ms H. QUANCHI — Our fees are the same for all women. The amount that they get back from Medicare differs depending on when they reach the Medicare safety net and when in the year they birth. For women with private health insurance they will get some money back for intrapartum care, but the women who do not have private health insurance acknowledge that they are not going to get that portion back. My estimate is that women get about $2500 to $3500 back from Medicare in the whole episode of care and somewhere between $1000 and $2000 back from their private health insurance.

Ms A. QUANCHI — If women go into a public hospital as a self-funded private patient, there is a set bed fee that the hospitals can charge them. It is up to the hospitals whether they do or not and then waive that.

Ms H. QUANCHI — The agreement that we have with the Northern is that they will waive the bed fee for the birth, and if women stay in the postnatal ward after they have the baby, then they can charge them a private bed fee.

Ms COUZENS — I suppose what you are offering is that continuity of care, obviously. If that was provided in the public system, would that address some of the issues?

Ms A. QUANCHI — Well, no, because there is no Medicare funding for that, so we cannot work in the public hospital.

Ms COUZENS — But other midwives can who are employed in the public system?

Ms A. QUANCHI — But hospitals already do that. It is very expensive for them to do it. You would have to ask them, but they would need a lot more funding to be able to do it that way.

Ms COUZENS — Yes, but that is what I am getting at. If that was provided within the public system, would that meet the requirements?

Ms H. QUANCHI — If it was an all-risk model, I think that it could help definitely, but I think they are already pushed to their limits, and none of the programs are expanding.

Ms A. QUANCHI — And in rural areas. All the women that come to us are coming to us — especially the ones in the city — because (a) they cannot get into a public model, or (b) it does not meet their requirements, or it does not provide them with the continuity that they want.

Ms COUZENS — And in regional and rural communities it is much harder to access those services anyway.

Ms SAMMON — It also removes you a little bit from that hospital environment. I was only in the hospital from 5.00 a.m. until 11.30 a.m. That is all the time, and then Andrea came and visited me at home that afternoon. So (a) you are making more hospital beds available, but also you do not have to stay in hospital as if you were sick. If it was run internally by the hospitals, I do not know.

Ms A. QUANCHI — After they have had their babies public hospitals at the moment give women one or maybe two visits. We can visit women with Medicare rebating it every day or multiple times a day for up to six weeks after they have had their baby.

Ms COUZENS — But that is only women who can afford it, is it not?

Ms H. QUANCHI — Yes, definitely. We acknowledge that it is a private service. In New Zealand it is free for all women to access this service. That would be the ideal thing, but unfortunately we need to get paid.

Ms A. QUANCHI — But you have got to deal with the whole insurance story then. Whereas they are private midwives in New Zealand that are providing the service. They are not publicly employed. They are all private midwives.

Ms H. QUANCHI — The other things that I have heard from women is that if they have gone into a public hospital case load program, they do not get to choose their midwife. They do have a bit more control if they are actually able to choose their own midwife and know that that person is going to do their pregnancy and postnatal care. There is a bit more control.

Ms COUZENS — Are you providing any form of support for women with mental health issues?

Ms A. QUANCHI — Yes, we deal with every factor of the woman's care that they need.

Ms COUZENS — How do you deal with that? Do you refer on?

Ms H. QUANCHI — We refer to the mental health team at the Northern Hospital in the same way that if the woman was public she could go and see the team there.

Ms A. QUANCHI — We do the screening at various stages during the pregnancy and just address each woman's individual issues as they arise for all factors of their care.

Ms H. QUANCHI — Some women will choose to see a private psychologist and others will choose to go to the public team at the hospital.

Ms BRITNELL — I have lots of questions. Just some clarifying questions first: regarding your model of care that is covered, for tests that need to be done antenatally, like the vaginal swab at, I think, 36 weeks, do you do that under Medicare?

Ms A. QUANCHI — Yes.

Ms BRITNELL — The findings from the Cochrane study that say that you are less likely to have an epidural, an episiotomy, an instrumental birth, less likely to have a pre-term birth and less likely to enter the special care nursery — it says here there is no rationale for why that is. Is that because you are picking up earlier?

Ms A. QUANCHI — With continuity of care you are likely to pick things up earlier that you can then prevent.

Ms BRITNELL — Are you familiar with the Austin Hospital's HARP model?

Ms A. QUANCHI — No.

Ms BRITNELL — So it is because you are able to have that one on one, you have got the trust element, and you are picking up more.

Ms A. QUANCHI — Yes.

Ms BRITNELL — I am curious as to how long postnatally you are able to be involved with the client.

Ms A. QUANCHI — Six weeks and six days. That is the scope of practice of a midwife. I am a maternal and child health nurse, so I can keep seeing them ad infinitum, but Medicare will provide rebates to six weeks and six days after they have had the baby.

Ms BRITNELL — When you say you could see them four times a day if they were in some sort of crisis mode, do you have to justify your rationale for that?

Ms A. QUANCHI — You have to put it in your notes, obviously, and then when you do your invoice for Medicare you just put 'not duplicate visit' and Medicare will pay. But if you get audited, it is like anything: you have to be able to justify in your records why you did it. It happens rarely. Because we are so closely in touch with the women you are more likely to get a phone call later in the day to say, 'He's just done a poo that's yellow instead of green' or something like that.

But there have been instances where with feeding it has not been going well or something else where I have visited maybe one or two days three times a day, and then you have been able to nip the thing in the bud. Our breastfeeding rates are far higher than that.

Ms BRITNELL — I am not surprised. Other than cultural — because I can understand the whole change thing from a hospital perspective — is it also financial? If you are trying to run a maternity ward and you have got so many midwives rostered on and so many births that you kind of know are going to happen in your part of the world, and you have got your medical team for back up, how does it fit? If you have got private midwives coming in —

Ms A. QUANCHI — They love it, because they are getting WIES funding. Do you understand the funding? They get the same funding. They are not providing the wages for the midwife looking after the woman, and the women are having a shorter length of stay and less intervention.

Ms BRITNELL — I do not understand why your public hospitals are not embracing it.

Ms A. QUANCHI — Good question.

Ms H. QUANCHI — Neither do we.

Ms BRITNELL — It seems to complement, financially.

Ms A. QUANCHI — We have had the conversation over many years with many hospitals, we have tried to point this out. The big obstruction has come down to the collaboration part of it rather than anything else — 'We don't want to change. At the moment the control of maternity services is one way, and that is the way we would like to keep it'.

Ms BRITNELL — If you are working within the hospital system, you are doing nothing different to the other midwives that have got the same qualification and have the same backup, yes? Nothing else different?

Ms H. QUANCHI — Nothing else different.

Ms A. QUANCHI — The big fear is that it always comes back to defining private midwives as homebirth midwives. What we would like for them to see is that this is not about women choosing their place of birth. In fact the worst thing we can do is say to a woman, 'You have to choose your six-week visit or something early where you are going to have your baby'. My thing has always been that women need to birth in the safest place for them to birth. So if we do their care exactly the same — and I do not want to make this about homebirth, because it is not — the majority of the women will choose the safest place to have their baby if they can maintain the continuity.

So that is the fear, I guess, of some of the hospital team members and stuff like that. Their interaction with private midwives has been negative, so they want to make it about that and they have not grasped the concept that this is actually bringing it all back into a very safe network because we are working within very strict

parameters. When you get credentialed at a hospital, you have to sign an agreement that you will work under that hospital's rules and that you will follow the whole thing or you will not get credentialed again. It is exactly the same process. The Northern was very careful to make the process for us to be credentialed exactly the same as it is for the medical team. There is no difference if a physiotherapist wants to get credentialed or a midwife or a doctor or anybody wants to get credentialed to work at the Northern; the process is exactly the same.

Ms BRITNELL — One last question I have got is about sustainability from the employee's perspective. If you have a midwife and you assign her a client, she is on call for that 10 days pre and 10 days post that she delivers, I imagine, or longer. How do you maintain your roster to make sure they are available and get 10 hours off in between if they have had a long shift where someone has had a long birth?

Ms A. QUANCHI — We work in a small team. There is Hannah and I, but we actually have a midwife that we have employed who is a third member of our team. We limit the workload, if you like, to four women a month, which is the maximum we would ever take on because it is internationally well recognised that that is the number of women that a midwife can do in a sustainable model. So we do not take on more than that.

Ms H. QUANCHI — The plan would be one birth a week, but it never actually happens like that.

Ms BRITNELL — Funny that!

Ms A. QUANCHI — What happens is that you will have three births in four days, and then you will have none for three weeks, but it is a very sustainable —

Ms H. QUANCHI — We back each other up, so the women, when they book, will know that there is a possibility that you may not be available and the other midwife might be stepping in for you.

Ms A. QUANCHI — Our phones are diverted as we speak to the other midwife. You know what I mean, and you do that. If there is something important going on in your life that you really want to go to, you tell your clients, 'Hey, listen. It's my son's 21st on Saturday night. I really would like to do that', and in 20 years I have missed two births.

The CHAIR — Well, we do not want you missing a third today.

Ms H. QUANCHI — I am actually going out to the hospital for an induction in about an hour.

The CHAIR — Fantastic. Thank you for your contribution today.

Witnesses withdrew.