



Australian Government

Department of Health and Aged Care

Privately Practising Midwives Access to Professional Indemnity and Midwife Professional Indemnity Run-off Cover Schemes

Impact Analysis



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Executive Summary

This Impact Analysis (IA) sets out the reform options for privately practising midwives (PPMs) to deliver:

- i. low risk home births, and
- ii. intrapartum (labour) care services outside a hospital setting prior to a planned hospital birth.

The preferred option would extend the Commonwealth's Midwife Professional Indemnity Scheme (MPIS) and Midwife Professional Run-off Cover Scheme (MPISROCS) (the Midwife Schemes) to cover these products.

- The MPIS provides professional indemnity insurance (PII) to Endorsed Midwives (midwives who have been endorsed by the Nursing and Midwifery Board of Australia (NMBA) to prescribe scheduled medicines). It provides them with the financial assistance for eligible claims arising from their professional negligence. The Australian Government supports the professional indemnity insurance market by subsidising the costs of claims over certain thresholds to facilitate provision of cover. The current insurer is responsible for covering 100% of the cost of the claim up to \$100,000. For claims that exceed \$100,000 up to \$2 million the insurer will cover 20% of any portion of the cost and Government 80%, and for claims over \$2 million the insurer will bear no additional costs, with any amounts beyond these thresholds being 100% covered by the Commonwealth
- The MPISROCS provides secure ongoing insurance for eligible midwives who have ceased private practice because of retirement, disability, maternity leave, death or other reason, with 100% of costs covered by the Commonwealth (funded via a levy on premium income).

This IA has been developed by the Department of Health and Aged Care (Department) in accordance with *The Australian Government Guide to Policy Impact Analysis* and in consultation with the Office of Impact Analysis. The IA will be used to inform government to make a decision on reforming Australia's midwifery indemnity laws.

This document covers the seven standard IA questions:

1. What is the policy problem to be solved?
2. What are the objectives, why is government intervention needed to achieve them, and how will success be measured?
3. What policy options are being considered?
4. What is the likely net benefit of each option?
5. Who was consulted and was their feedback incorporated?
6. What is the best option from those considered?
7. How will the chosen option be evaluated against success metrics?

1. What is the policy problem to be solved?

Overview

Australia is regarded as a safe country in which to have a baby and compares well on a number of accepted measures of safety and quality of care. However, as for all systems of health care and service delivery, there are areas for continued improvement. Across states and territories there are differences in women's access to services, their choice of care and/or carers and the provision of culturally safe care that ensures women are always treated with respect and dignity.

In line with Woman-centred care “Strategic directions for Australian maternity services” (WCC strategy), the Commonwealth is aiming to increase the availability of private midwifery care to the community while at the same time achieving the best outcome in the interest of public health and safety.

The Midwife Schemes currently indemnify midwives for antenatal and postnatal care but not homebirth and intrapartum care outside hospital. Section 284 of the Health Practitioner Regulation National Law (National Law) currently allows an exemption from PII for homebirths and intrapartum care outside hospitals due to the unavailability of suitable insurance products. The exemption was approved through Health Ministers via the Health Ministers Meeting (then COAG Health Council) in 2013, demonstrating recognition of the issue's impact on maternity services. The exemption is currently proposed to end on 30 June 2025.

Jurisdictions have previously opposed making the current National Law insurance exemption permanent. All jurisdictions agreed on the importance of a national solution and supported the development of a PII product through the commercial insurance market. The Commonwealth agreed to explore the possibility of expanding the MPIS to cover low risk homebirth as a solution to removing barriers

for commercial insurers to offer a PII product for low-risk homebirths, contingent on the risk, liability and financial impacts being acceptable to insurers.

The Commonwealth is aiming to make low-risk homebirths an eligible product under the MPIS. The timing is set to coincide with the expiry of the exemption (noting the exemption could be repealed if a low-risk homebirth product is in place by 1 July 2025, which is the intended implementation date for the new product).

The low-risk definition of homebirth has been set by the Commonwealth in collaboration with jurisdictions and stakeholders. The definition has been based on public program definitions for which there have been no claims since the inception of public programs in any state/territory under their insurances.

A low risk birth is defined as:

- single birth
- cephalic presentation (head is down)
- labour is for a term pregnancy between 37-42 weeks
- the home is within a catchment area or is within a 30 minute drive to an obstetric hospital;
- where the mother has Category B conditions listed in the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (ACM Guidelines), there must be evidence the midwife has consulted with a qualified health care provider with the knowledge and skills to make decisions about women's care
- mother is free from all Level C conditions listed in the ACM Guidelines
- mother must attend antenatal screening and appointments in line with Australian Pregnancy Guidelines
- mother has not previously birthed by caesarean section.

Problem 1: No available insured homebirth product

There is demand in the community for PPMs to provide two new midwifery services:

- i. low- risk home birth
- ii. intrapartum (labour) care outside hospital prior to a planned hospital birth.

The existing Midwives Schemes cover antenatal, postnatal and intrapartum care in hospital but do not provide cover for low risk home births or intrapartum care outside of hospital prior to a planned hospital birth.

- antenatal covers the period spanning conception to the beginning of labour

- intrapartum covers the period from onset of labour to delivery of newborn
- postnatal (perinatal) spans from birth of the newborn to 6-8 weeks after delivery.

The Commonwealth has sought to find a lasting market based solution through the recent approach to market for insurers to offer cover for low risk homebirths and intrapartum care outside a hospital, which was not successful.

Currently there is no PII on the market for these services. The lack of insurers willing to provide cover for low risk home births and intrapartum care outside a hospital reflects a view that it is difficult for insurers to accurately quantify risks due to a lack of data, particularly given the small pool of midwives providing such services, and that the nature of services could lead to some significant high cost claims.

The Government recently granted a separate time limited (to June 2025) indemnity to the insurer to cover 100% of the costs for this service. This indemnity addresses a recently identified gap in cover which was threatening delivery of these services, and which was a particular concern for Aboriginal Community Controlled Health Organisations (ACCHOs) delivering BoC midwifery services. The indemnity was granted until 2025 to address the immediate gap in cover while Government considered longer term solutions and the outcomes of the recent market tender for these services.

Problem 2: What women want?

Women are increasingly seeking greater choice in birth place, including options other than hospitals that offer fewer interventions and greater autonomy¹. There is a cohort of women who, given the opportunity, would prefer to labour and birth in their own home. Literature that discusses women's experiences/reasons for choosing to give birth at home suggests that they see it as a choice that promotes a feeling of more control in their birth process and one that allows immediate and better family integration of the new baby².

The Senate 'Child-Birth' report suggests that women resent the way in which childbirth has been taken over by the medical profession rather than treated as a

¹ Vadam, S. et al. 'The Mother's Autonomy in Decision Making (MADAM) scale: Patient-led development and psychometric testing of a new instrument to evaluate experience of maternity care'. PLoS One 2017; 12(2).

²Tarrant, M. et al. 'A pathway to establish a publicly funded home birth program in Australia'. Women and Birth, Volume 33, Issue 5, September 2020, Pages e420-e428.

natural process, with a concomitant increase in the level of interventions and consequent morbidity outcomes (described in the following chapters) and in the disempowerment of the women giving birth. While acknowledging that the medical approach may be necessary in a small number of cases they consider it inappropriate for most women compelled or persuaded to submit to it without any medical justification. They are further alienated by a system which too often fails to provide continuity of carer so that they may be tended during birth by total strangers. The Senate found that dissatisfaction with the medical emphasis of hospital births and with discontinuity of care were major factors driving consumer demand for alternative, more woman centred approaches to birth, with midwives as the primary care givers³.

Currently, there are 15 publicly funded home birth programs in Australia and a further two under development. The increasing number of publicly funded home birth programs in Australia may indicate a growing desire for birth options that better meet the needs of Australian women

The COAG Women Centred Care: Strategic directions for Australian maternity Services 2019 identified that women want:

- to be respected for their choices of models of care that meet their needs, and the right to freedom from coercion about decisions concerning their maternity care
- health professionals to work together respectfully and collaboratively to support them in their choices
- continuity of care and carer
- access to care in their geographic location - as close to home as possible
- access to evidence and information to inform their decisions regarding their care
- consistency in the availability of postnatal care.

In 2023 the Australian Institute of Health and Welfare (AIHW) report on Australia's mothers and babies⁴ reported that in 2021, there were 315,705 babies born to 311,360 mothers in Australia. Of these, 97% of women with both low and high-risk

³https://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/completed_inquiries/1999-02/child_birth/report/c04

⁴ [Australian Institute of Health and Welfare Australia's mothers and babies report 2023](#)

profiles gave birth in public and private hospitals. A small proportion of mothers gave birth elsewhere, including birth centres (2%), at home (0.5%), or in other settings (arrival before hospital) (0.7%).

Dr Davis-Tuck et al in BMC Pregnancy and Childbirth (2018) compared Australia to New Zealand (3.4% homebirths), Canada and United Kingdom (2% homebirths), and the Netherlands (20% homebirths), and attributed Australia's low rate of planned homebirths to the lack of evidence around Australian homebirth outcomes.

As at September 2023, there are 380 midwives insured with the current insurer under the MPIS and 104 PPMs providing private homebirth in Australia. The exact number of women and PPMs impacted by the gap in insurance is still being determined.

The 2018 First Principles Review of the Medical Indemnity Insurance Fund, which provides data on the risk of liability for homebirth reported that:

- between 2010 and 2017 there had only been two claims made against midwives insured under the MPIS. Neither of these reached the \$100,000 threshold for a claim to be made under the MPIS
- over the 2010-2017, there had been 15 legal expense only matters (not reaching the threshold) and 95 incidents reported to the insurer which have not yet to a claim
- no payments have been incurred under the MPIS since the inception of the scheme.

Problem 3: Birthing on Country

ACCHOs have advised they may need to cease provision of BoC services for First National women and women giving birth to a First Nations baby if insurance cover is not available for intrapartum out of hospital services. The cessation of services would adversely impact the progress made towards the implementation of BoC models and leave many First Nations women without access to culturally safe, continuous maternity care. It could also hamper efforts to achieve Closing the Gap Target 2 to increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91%, by 2031 and Target 12, by 2031, reduce the rate of over-representation of Aboriginal and Torres Strait Islander children in out-of-home care by 45 percent. Research shows that BoC models are contributing to better health outcomes for First Nations mothers and babies, including a

50% reduction in preterm birth rates where trialled and a three-fold decrease in the number of children being removed from their family at birth.

If the insurance gap is not resolved, current BoC investments including the construction of a dedicated BoC centre of excellence in Nowra, NSW, and the positive impacts of BoC models are at risk. The cessation of BoC services due to gaps in insurance coverage could lead to increased risks, including women labouring and birthing alone or entering hospitals prematurely, which is shown to increase the risk of birth interventions and trauma. There are currently 3 ACCHOs impacted by the gap in insurance.

[Problem 4: Barriers discouraging insurers from entering the market](#)

Currently, no insurer is prepared to insure PPMs for low-risk home births or intrapartum care outside a hospital setting under the existing Government supports available through the Midwives Schemes. This lack of interest reflects a view that it is difficult for insurers to accurately quantify risks due to a lack of data to form a risk profile of PPMs conducting homebirth intrapartum care services, the nature of services that could lead to significant high cost claims, and lack of assurance that the regulatory framework is sufficient. Insurers risk profiling follows a structured and auditable process, and the market is too small to generate a risk pool specifically for privately practising midwifery services.

Australian medical indemnity Insurers have also advised Government that the lack of coverage for low-risk home birth intrapartum care under the MPIS is a significant barrier to offering an insurance product. A recent approach to market to find an insurer who would cover existing services under the existing MPIS gave insurers the option to propose changes to the Commonwealth contributions and subsidy thresholds for the new products, including the Commonwealth covering most or all risk. This approach revealed a market failure in insurance availability. Only one tenderer responded, who has bid to manage the existing Midwives Scheme from 1 July 2025 when the current contract ends. The insurer will only cover these two new services if the Commonwealth covers 100% of claim costs for low-risk home births and intrapartum care outside a hospital.

[Analysis of international models](#)

In Australia, Medicare provides universal public healthcare. However, medical indemnity arrangements for endorsed midwives practising in Australia differ considerably from insurance arrangements for midwives practising in other countries with universal public healthcare systems.

- Sweden has a universal public healthcare system. Prenatal and postnatal care in Sweden is primarily delivered through midwives. The average pregnant person in Sweden only sees a doctor if there is a complication during pregnancy or if they require anaesthesia during delivery⁵. The Swedish insurance model indemnifies all health professionals, including midwives for all medical injuries. Under this scheme, injuries are compensated by healthcare insurers on the basis of whether or not the harm was considered to have been avoidable rather on the basis of fault⁶.
- New Zealand has a universal public healthcare system. The New Zealand College of Midwives provides professional indemnity insurance, general liability and statutory insurance for self-employed midwives. Entitlement to these insurances is an automatic benefit of membership of the College⁷.
- The National Health Service (NHS) provides universal public healthcare in the United Kingdom, and supports midwives with appropriate indemnity arrangements. Outside the NHS, many employers are likely to have professional indemnity arrangements that will provide appropriate cover for all the relevant risks related to midwifery scope of practice⁸.
- The United States health system is a mix of public and private, for-profit and non-profit insurers and health care providers. Medicare ensures a universal right to health care for persons age 65 and older, and individuals with long-term disabilities or end-stage renal disease⁹. The US sets strict limits on where certain midwives can work and how they obtain insurance¹⁰.

International and Australian longitudinal studies have provided evidence that low-risk homebirth is as safe as hospital birth, as long as low-risk criteria is used when assessing whether a woman is suitable for homebirth, and that the woman is informed that this may change if complications arise.

⁵ <https://www.internationalinsurance.com/health/systems/sweden.php>

⁶ NHS England National Maternity Review Better Births Improving outcomes of maternity services in England 2016 <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

⁷ <https://www.midwife.org.nz/midwives/join-the-college/professional-indemnity-insurance/>

⁸ <https://www.nmc.org.uk/globalassets/sitedocuments/registration/pii/pii-final-guidance.pdf>

⁹ <https://www.commonwealthfund.org/international-health-policy-center/countries/united-states>

¹⁰ Belkin, Z.R. 'The Confluence of Practice, Philosophy, Work Space and Education: A Case Study of Four Contemporary Midwives in Central New York' May 2009.

Zielinski et al reviewed 23 primary quantitative research reports and 9 qualitative research studies related to maternal and neonatal outcomes of planned home birth. The review discussed the strengths, limitations, and opportunities regarding planned home birth in the United Kingdom, Sweden, Finland, Norway, the Netherlands, United States of America, Canada, Japan, Australia, and New Zealand¹¹. Zielinski reported there is evidence that more women would choose the option of home birth if it were readily available. The report highlighted the benefits of planned home birth, including lower rates of maternal morbidity, such as postpartum haemorrhage, and perineal lacerations, and lower rates of interventions such as episiotomy, instrumental vaginal birth, and caesarean birth. Women who have a planned home birth have high rates of satisfaction related to home being a more comfortable environment and feeling more in control of the experience. While maternal outcomes related to planned birth at home have been consistently positive within the literature, reported neonatal outcomes during planned home birth are more variable. While the majority of investigations of planned home birth compared with hospital birth have found no difference in intrapartum foetal deaths, neonatal deaths, low Apgar scores, or admission to the neonatal intensive care unit, there have been reports in the US, as well as a meta-analysis, that indicated more adverse neonatal outcomes associated with home birth.

Tarrant et al concluded that birth at home is a safe option for healthy women with an uncomplicated pregnancy. Data from European countries and to some extent from the United States, suggest home birth is a safe option in selective cases. Studies from the United Kingdom and Australia show less risk of intervention in women opting for home birth without any additional risks to women and their babies in healthy pregnancy¹². It is increasingly recognised that home birth is a safe and appropriate choice for many women, particularly healthy multiparous, and that it is associated with fewer interventions and better maternal satisfaction than hospital-based birth.

Davis et al compared mode of birth and intrapartum intervention rates for low-risk women planning to give birth in home, primary units, and secondary and tertiary level hospitals under the care of midwives in New Zealand. The results of this study

¹¹ Zielinski, R. et al 'Planned home birth: benefits, risks, and opportunities'. International Journal Women's Health Vol 7; 2015.

¹² Dr James Johnston Walker. 'Planned home birth'. Best Practice & Research Clinical Obstetrics & Gynaecology. Vol 43 August 2017, pages 76-86.

found that women planning to give birth in secondary and tertiary hospitals had a higher risk of caesarean section, assisted modes of birth, and intrapartum interventions than similar women planning to give birth at home and in primary units. Newborns of women planning to give birth in secondary and tertiary hospitals also had a higher risk of admission to a neonatal intensive care unit than women planning to give birth in a primary unit. The study concluded that planned place of birth has a significant influence on mode of birth and rates of intrapartum intervention in childbirth¹³.

While the provision of home births is embedded as a core component of national maternity services in several countries, such as the Netherlands, United Kingdom, and New Zealand, it has not been promoted or well integrated in Australia, even in low risk populations. Tarrant identified the main argument used to dissuade women, and government against home birth has been the rare but unpredictable occurrence of serious intrapartum complications and resultant maternal or perinatal harm.

Tarrant identified the key issues underlying the low uptake of home birth by women, which may be influenced by inflexible birthing services with a lack of midwifery led care, out of pocket costs for private midwifery care, and the complicated indemnity landscape of private midwifery care. There is also a lack of support for home birth in the wider community and from leading medical professional bodies. The result is that the rate of home birth in Australia is a tenth of other similar countries such as the UK.

[Why isn't there a market for midwife indemnity insurance in Australia?](#)

Canil used a case study approach to investigate why, when compared with other small business operators, including medical specialists, the economic viability of the businesses of self-employed midwives has not been protected. Canil suggests that in the past, the reluctance of governments to assist self-employed midwives has been underpinned by the medical profession's entrenched "monopoly" over the provision of obstetric services¹⁴.

Up until mid-2001, some 80 of Australia's 200 self-employed midwives purchased their professional indemnity insurance cover from Guild Insurance through an arrangement with the Australian College of Midwives Incorporated (ACMI). The

¹³ Davis et al. 'Planned place of birth in New Zealand: does it affect mode of birth and intervention rates among low-risk women?' Birth June 2011 38(2).

¹⁴ Canil, M. 'Australia's insurance crisis and the inequitable treatment of self-employed midwives'. Aust New Zealand Health Policy. 2008; 5: 6.

option to purchase professional indemnity insurance cover through this arrangement was available for all midwives who were members of ACMI. When Guild Insurance advised ACMI and its members in June 2001 that professional indemnity insurance cover for self-employed midwives would no longer be available after 1 July 2001, it explained that its decision to withdraw from the midwifery insurance market was based upon a review of its portfolio and a re-evaluation of the risks of midwifery. Guild Insurance advised that such cover could be better provided by others in the market. A significant consideration for Guild Insurance was that even though it had not received any claims against an insured midwife, the number of self-employed midwives that it insured was small and the premiums collected were insufficient to cover even a single large damages award.

Subsequently, within a short space of time, professional indemnity cover for those midwives could no longer be purchased from any insurer either in Australia or elsewhere in the world. Faced with the prospect of continuing to operate their businesses uninsured in terms of their professional indemnity risk, the majority of Australia's self-employed midwives eventually stopped providing services. In response to local pressures, some state and territory governments intervened to provide self-employed midwives with varying degrees of assistance¹⁵.

Overcoming market barriers

The Government is taking action to rectify market failure by establishing a regulatory framework to support PPMs to work to their full scope of practice as insured practitioners.

In the future, the Government would reassess risk levels with insurers leading up to 2029-30, potentially paving the way for a more market-driven solution in the future. Option that could be considered include whether:

- i. existing medical indemnity insurers could pool comparable risks and extend PII cover to endorsed midwives. This option would initially require Government funding until the insurer bodies can build up an adequate pool of capital to cover any large damages award
- ii. ACM would consider providing a medical indemnity model based on the New Zealand model, whereby the ACM underwrites the liability of member

¹⁵ <https://www.pc.gov.au/inquiries/completed/national-competition-policy/submissions/dr253/subdr253.pdf>

PPMs. This option would require the development of new legislation to underpin a new role for the ACM, and funding of establishment and administration costs.

Who are the affected stakeholders?

- a. Women who wish to have a low-risk homebirth within the confines of the low-risk definition can have the choice of care and carer, knowing PII coverage would be available in the case of an adverse event.
- b. First Nations women who wish to receive intrapartum care outside of a hospital setting through an ACCHO led BoC model and with access to an insured midwife.
- c. Endorsed midwives, working in private practice, wanting to provide a low-risk homebirth service. Endorsed midwives are those who have been endorsed by the NMBA to prescribe scheduled medicines.
- d. Industry (insurers) providing medical indemnity insurance coverage to PPMs.
- e. Regulator (NMBA) who provides safety and quality guidelines which form the foundation of clinical care guidelines for homebirth.
- f. ACCHOS providing BoC midwifery services for births that occur outside of a registered health facility (i.e. in a birth centre).

2. What are the objectives, why is government intervention needed to achieve them, and how will success be measured?

Rationale for Government involvement

Jurisdictions have been seeking a permanent solution to the lack of PII for PPMs since 2010. On 29 June 2023, COAG Health Ministers agreed they would support removal of the exemption in the National Law.

In previous work conducted by various jurisdictions to find a solution for PII for PPMs since 2010, information was received that insurers were not interested in providing an affordable product for homebirth intrapartum services. Insurers highlighted barriers that precluded risk profiling and understanding the size of the market, and this uncertainty impacts on premium setting. Insurers risk profiling follows a structured and auditable process, and the low numbers of homebirths in Australia may not fit within this profile.

On 10 November 2023, Health Ministers agreed to extend the exemption to hold PII for PPMs providing homebirth services until 1 July 2025. Once the exemption expires, it will become illegal for midwives to offer homebirths without insurance cover, bringing them in line with all other registered health practitioners who must hold insurance cover for all professional services.

To date, no insurer has indicated a willingness to provide the relevant PII cover under existing Government supports for the Midwife Schemes. The failure of the market to respond with a solution can justify Government intervention to address the market failure.

Objectives of Government Involvement

There are several reasons for the Government to provide women with choice in birthing and carer by making low-risk homebirths and intrapartum care outside a hospital eligible products under the MPIS.

Table 1: Identified Problems and Objectives for Government Action

Identified Problems	Objectives for Government Action	Measurement of success and progress against objective
<p>Women are seeking greater choice in birth place and birth carer</p> <p>No available insured homebirth product</p>	<p>To make low-risk homebirths an eligible product under the Midwife Schemes with timing to coincide with the expiry of the exemption</p>	<p>Number of insured midwives offering homebirth services by July 2025.</p> <p>Increase in the proportion of women accessing homebirth services.</p> <p>Exemption successfully removed by July 2025</p>
<p>Birthing on Country programs</p>	<p>To build on momentum towards achieving Closing the Gap Target 2 by improving community access to culturally safe continuity of midwifery services and midwifery care, including expansion of BoC programs by 2031, noting BoC models of care are a major contributor to healthy birth weight</p>	<p>The Department continues to work in partnership with the ACCHO sector and key First Nations maternity health stakeholders to progress the following actions with Commonwealth and state and territory governments through Health Ministers:</p> <ul style="list-style-type: none"> -develop strategies to increase First Nations midwifery workforce; -expand access to culturally safe First Nations-led continuous maternity care programs, with a focus on improved access in remote and very remote locations; -support capacity building for existing and new BoC programs <p>The Department continues to report to Health Ministers annually on progress and seek advice on jurisdictional issues.</p>

<p>Barriers discouraging insurers from entering the market</p> <p>Limited incident and claims data for estimating liability cost estimate for homebirths</p>	<p>To work with state and territory governments to finalise a solution by 2030 to allow PPMs access appropriate PII and work to their full scope of practice</p>	<p>Establishment of data collection and reporting on the two additional services to which the proposal relates.</p> <p>Evidence of insurer engagement or new insurance products offered by 30 June 2029.</p>
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3. What policy options are you considering, and what is their likely net benefit?

In response to the drivers for change outlined above, and consistent with policy objectives for national maternity services, two reform options have been developed for consideration alongside the status quo. These options were developed following significant consultation with a broad range of stakeholders, including state and territory Health Ministers.

This chapter provides:

- an overview of the background and context
- a description of options being considered
- a discussion of the significant changes under the different options
- an analysis of how each option meets the policy objectives.

The impact of specific changes under each option on stakeholders is outlined in appendix 2.

Background and Context

Australian maternity services

Australian maternity services are delivered through a mix of public and private services with planning and delivery predominantly undertaken by the states and territories through publicly funded programs and the Commonwealth providing national direction and supporting efforts to improve care and outcomes.

Access to maternity care is largely determined by Australia’s health system’s structure and funding arrangements, including Medicare, specialist and general practice, private health insurance and other Australian state and territory government health funding models including public hospitals.

Birth on Country (BoC) models support First Nations women (or women pregnant with a First Nations baby) to access to culturally safe, continuous midwifery care with an insured PPM – the lack of insurance cover for these services to date has been a significant concern to ACCHOs developing and supporting BoC models of care.

Midwife Schemes

Under the existing Midwives Schemes the Government supports the PII market by subsidising the costs of claims over certain thresholds to facilitate provision of cover. The current insurer is responsible for covering 100% of the cost of the claim up to \$100,000. For claims that exceed \$100,000 up to \$2 million the insurer will cover 20% of any portion of the cost and the Commonwealth 80%, and for claims over \$2 million the insurer will bear no additional costs, with any amounts beyond these thresholds being 100% covered by the Commonwealth. The current MPIS contract expires on 30 June 2024 with one twelve-month extension option.

The MPISROCS provides secure ongoing insurance for eligible midwives who have ceased private practice because of retirement, disability, maternity leave, death or other reasons, with 100% of costs covered by the Commonwealth (funded via a levy on premium income).

In June 2021, the MPIS was amended to open eligibility to all PPMs irrespective of their employment arrangements. This change was made so that ACCHOs could access the MPIS for their employed midwives to provide intrapartum care.

Health Practitioner Regulation National Law

The National Law is complementary legislation in force in each state and territory reflecting the equal regulatory responsibility between states and territories. Legislative changes and policy responsibility for the National Law is vested in all Health Ministers.

The National Law establishes a national registration and accreditation scheme for the regulation of health practitioners and registration students studying for a qualification or clinical training, in a health profession.

The intent of the National Law when introduced in 2010 was that all registered health practitioners hold professional indemnity insurance. This was put in place for the protection of the public. Section 129 of the National Law, as in force in each state and territory, requires that every health practitioner has professional indemnity insurance (PII) arrangements in place for the practice of their profession.

- PII is a specialised form of cover that provides surety to eligible PPMs, and their patients in the event of an adverse incident caused by the practitioner's negligence.

Section 284 of the National Law provides a temporary exemption that allows PPMs to perform intrapartum homebirth services without the need to hold PII due to the unavailability of suitable insurance products. This exemption is set to expire on 30 June 2025, after which it would become unlawful for PPMs to conduct homebirths and intrapartum care outside hospital without appropriate insurance.

Birth on Country models of care

No insurer has indicated a willingness to provide PII cover for intrapartum care outside a hospital under the existing Government supports available through the Midwives Schemes. This gap in cover was identified late last year and was threatening ACCHOs delivery of critical BoC models of care. The ACCHOs position was that these services would need to cease unless the gap in cover was fixed. ACCHOs have also expressed concern regarding high costs of insurance premiums and run off cover costs, however these concerns, while important, are less immediately critical to service delivery and are being considered separately.

An interim solution was found to this issue through the Department (under authorisation from the Minister for Finance) granting an indemnity under s60 of the PGPA Act for the insurer to cover 100% of the costs of claims arising from these services. The insurer then made cover for these services available to individual midwives. The indemnity was limited to 30 June 2025 to address the immediate threat to service delivery and allow time for Government to consider how best to implement a long term solution to this issue.

Under this option, intrapartum out of hospital services will now be covered by specific legislation, including amendments to the Midwives Schemes legislation. The cover, with Government paying 100% of claims, will be available both to individual midwives directly and to specified entities who employ midwives engaged in delivery of BoC models of care. This responds to concerns from ACCHOs that the entity who employs the midwife (an ACCHO directly or an employer organisation who provides the midwives for the ACCHOs) also needs to have insurance cover available in case the employer was also sued for the actions of the midwives. ACCHOs would need to apply to the Department to be listed as an entity for the purposes of insurance coverage. This would be strictly limited to organisations delivering Birth on Country midwifery services and who employ midwives with the appropriate credentials.

Policy authority

The Medicare Benefits Schedule (MBS) Review Taskforce recommended further investigation of funding models for home birthing for patients with low-risk pregnancies.

The Commonwealth Minister of Health provided the Department with policy authority to explore the expansion of the MPIS to enable endorsed self-employed PPMs obtain insurance to provide low-risk homebirth services (ministerial submission MS20-000467 provides this authority).

The Department received policy authority in the 2023-24 Budget process to explore the possibility of expanding the Midwife Schemes to remove barriers for commercial insurers to offer a professional indemnity insurance for low-risk homebirth and intrapartum (labour) care outside a hospital prior to a planned hospital birth.

Proposed Options

Option 1: Maintain the Status-Quo

The National Law exemption would be retained enabling PPMs to continue to offer services but without insurance, alongside public programs as occurs currently. This option would maintain the status quo.

Under this option, from 1 July 2025 women and families who wish to homebirth outside a public program, or access the intrapartum out of hospital care prior to a planned hospital birth, would continue to have a choice of midwife and choice of birthing where there are midwives who are prepared to provide these services uninsured as long as the National Law is extended.

Australian longitudinal studies have provided evidence that low-risk homebirth is as safe as hospital birth, as long as low-risk criteria is used when assessing whether a woman is suitable for homebirth, and that the woman is informed that this may change if complications arise.

Risks

This option does not uphold the intent of the National Law that all practitioners hold PII. Moreover, PPMs would not be aligned with all other health practitioners under National Law.

While this option provides women with choice, this choice comes with significant risk. Women will have no insurance recourse in the event of an adverse event apart from civil action against the PPM, even though they may consent to proceed without PII for the homebirth.

This option would maintain the current perverse situation where midwives would have no protection from civil litigation. This would likely impact on workforce retention with PPMs forced to enter state and territory funded homebirth programs. As these programs operate through the public hospital system, PPMs scope of practice would be restricted according to hospital governance and clinical guidelines.

Under the status quo, there is limited incident and claims history data with which to base a liability cost estimate for homebirths. The current insurer provides the Department with an annual report and periodically provides Services Australia with claims data as part of the contractual and legislative requirements.

There is also limited claims data to identify the impact of this option on hospital capacity.

Option 2: Expand the Midwife Schemes (preferred option)

Expand the MPIS and MPISROCS to include low-risk home births and intrapartum (labour) care outside a hospital prior to a planned hospital birth, whereby the Government will cover 100% of the costs of claims for these new products if the insurer provides such cover and manages claims.

The Government would offer the insurer 100% of Government coverage of the costs of claims for low- risk home births and intrapartum (labour) care outside a hospital prior to a planned hospital birth. The insurer would provide this cover and manage claims administration, supported by Government payment of settled claims.

The cover for intrapartum care outside hospital would also include coverage for entities engaging midwives in delivery of BoC models of care as well as the midwives themselves.

Under this option the National Law exemption for midwives which enables PPMs to practice without PII would be removed as insurance cover would become available.

The intention is for this insurance coverage to be a long-term solution. The current market failure indicates there is no foreseeable timeline for private insurers to offer these products. This coverage is essential to ensure women's continued access to safe homebirth options and to support culturally-safe maternity care models, particularly BoC services for First Nations communities.

While the Government does not typically provide insurance coverage directly to health entities, this proposal represents a unique and necessary intervention. This intervention is justified by a combination of factors: the specific need to address the insurance gap for PPMs providing low-risk homebirth and BoC services, the lack of willing private insurers demonstrated by the recent tender process, and the importance of ensuring access to essential maternity care services while promoting culturally-safe options for First Nations communities.

The NMBA has well established safety and quality guidelines for PPMs, which form the foundation of clinical care guidelines for homebirth. The guidelines can be refined to include clinical parameters of low risk to which the MPIS would be extended to cover.

The Department would also move to settle arrangements with the current insurer to continue to manage the existing Midwives Schemes from 1 July 2025.

The ongoing need for Government to carry the full risk could be re-considered in 2029-2030 (when the contract for administration of the Schemes will next be put to market) by which time there would be a clearer indication of trends in actual claims and costs to inform insurer interest and risk appetite.

There is an existing precedent for Government to cover 100% of claims:

- i. Under the Medical Indemnity Run-Off Cover schemes (which provide cover once a practitioner retires) the Government accepts 100% liability (although practitioners pay a premium during practice to support provision of this cover).
the Government recently granted a separate time limited (to June 2025) indemnity to the current insurer to cover 100% of the costs of the intrapartum outside of a hospital services to address this recently identified gap in cover which was threatening delivery of these services and had become a particular concern for ACCOs facilitating BoC midwifery care. The indemnity was granted to 2025 to address the immediate gap in cover for

PPMs. It is intended that the cover for intrapartum care outside a hospital would also include coverage for entities engaging midwives in delivery of BoC models of care as well as the midwives themselves.

Legislative change

Authority would be sought to amend the *Midwife Professional Indemnity (Commonwealth Contribution) Act 2010* and any related legislation. These amendments would be specified in the rules or by Determination to stipulate that the Commonwealth would fund 100% of claim costs and remove all monetary thresholds for claims made against eligible midwives providing low-risk homebirth services and intrapartum care outside a hospital.

Under this option, the National Law exemption for midwives would be removed permanently in line with its proposed expiration of 30 June 2025 as indemnity cover would now be available. If the proposal is not accepted, further discussion with states and territories would be required on whether the exemption should be extended or made permanent. States and territories have previously opposed any further extension of the exemption.

Authority would also be sought to make permanent legislative changes to *Midwife Professional Indemnity (Commonwealth Contribution) Act 2010* and any related legislation to ensure employed midwives working in specified ACCHOs are able to access entity insurance. The entity coverage would only apply to employed midwives for services performed by their endorsed midwives in specified ACCHOs.

Capacity for Government involvement

The implementation of this option entails estimated annual costs of \$11.8 million over 4 years commencing from 1 July 2024. These costs primarily cover claims administration, program oversight, and implementation. Potential funding sources to ensure long-term sustainability include Commonwealth budgetary allocation.

The Department and Services Australia currently possesses the in-house expertise required for effective program management. This expertise includes policy analysis, financial management, stakeholder engagement, claims processing and contribution payments. Additional resources may be needed in the following areas such as actuarial.

Risks

Low risk homebirth

Some members of the community and medical profession, homebirth is controversial. Some do not see it as a safe option for women or babies. However,

the MBS Review examined Australian and international longitudinal studies which provided findings that a low-risk homebirth was comparable in risk to a hospital birth.

The risk of not proceeding with this approach is that women who wish to have a low-risk homebirth or intrapartum care outside of hospital prior to a planned hospital birth with a PPM will not be able to access these services from 1 July 2025 (or will only be able to access without any indemnity cover applying).

Lack of data

There is limited incident and claims history data with which to base a liability cost estimate for homebirths. The current insurer provides the Department with an annual report and periodically provides Services Australia with claims data as part of the contractual and legislative requirements.

There is also limited claims data to identify the impact of this option on hospital capacity.

The Department is currently negotiating with the AIHW on the development of a national dataset. The collection of claims data leading up to 2029-30 will allow a much better indication of likely claims profile in 2029-30 and allow the Department to assess the strength of the liability estimate annually. The data will include incident and claims data, and birth data including type of birth escalation rates, outcomes and location etc. Having a better understanding of the risk profile of low risk home births and intrapartum care outside a hospital would enable robust risk analysis for future policy decisions. It may also encourage more insurers to enter the market and reduce the role of the Commonwealth in covering 100% of claims for the low-risk homebirths and intrapartum care outside of a hospital setting.

If the rate and quantum of claims is significantly higher than predicted, the Department would seek advice from the Australian Government Actuary on how to manage risks, including consideration of amendments to the scope of the homebirth services to reduce the risk.

If there are any changes to the number of indemnified entities affecting the Commonwealth's liability, the Department would seek advice from the Australian Government Actuary to reflect changes in the Commonwealth's liability in the event of a claim via an estimates variation process.

Professional indemnity insurance

A market test was undertaken by consulting all known insurers who currently provide medical indemnity insurance to gauge their interest in providing a low-risk

homebirth insurance product. There was only one respondent to the tender, who would only manage the MPIS and cover these new services if the Commonwealth covers 100% of claim costs for low-risk home births and intrapartum care outside a hospital.

There is limited incident and claims history data with which to base a liability cost estimate for homebirths. If the rate and quantum of claims is significantly higher than predicted, further advice would be provided to Government on how to manage risks, including consideration of amendments to the scope of the homebirth services to reduce the risk. The creation of a national dataset, including jurisdictional claims and birth data, would allow Government to assess the strength of the liability estimate annually and inform further consideration of this issue when the Midwives Schemes are next open for tender (2028-2030).

Regional and rural Australia

Some regional and rural Australians will be unable to access the choice for a low risk homebirth with a private midwife as the low-risk criteria requires the woman to reside no more than 30 minutes from a maternity service. This criteria is consistent with public homebirth schemes and exists to ensure a woman and baby can be moved to a hospital quickly as part of the escalation protocol.

Specific challenges for BoC models of care in rural and remote areas exist, including lack of housing for staff and infrastructure. These areas are where BoC models are of greatest need due to the distance to mainstream health services.

Legislative change

If legislative changes to support this option are not passed by 1 July 2025 a further exemption from the National Law may be required until such changes are passed.

Option 3: State and territory homebirth programs

Government commences negotiations with state and territory governments for provision of these services to be facilitated by jurisdictions and covered under their indemnity arrangements.

Under this option Government would commence negotiations with state and territory governments to facilitate provision of these services under public schemes, with insurance coverage under jurisdictional indemnity arrangements for employees. With the exception of Queensland and Tasmania, states and territories already operate public home birth programs.

The goal would be to increase the availability of publicly funded programs for low-risk homebirth and intrapartum care outside a hospital. Midwives working within these expanded programs would gain insurance coverage as state/territory employees through jurisdictional indemnity arrangements.

The Department would also move to settle arrangements with the current insurer to continue to manage the existing Midwives Schemes from 1 July 2025.

Risks

Under this option, women and midwives would be required to operate solely in the public health system. Public homebirth programs have strict eligibility criteria for public safety and limited availability by distance from a maternity services, which is why the majority of women wishing to have a homebirth in Australia turn to PPMs.

Public homebirth is not currently available in all jurisdictions (Queensland and Tasmania) and is only offered in metropolitan centres. PPMs would no longer legally be able to provide privately planned homebirths, which means there would be no service available at all for women in Queensland and Tasmania, where currently PPMs are the only providers of planned homebirth services. Women in states without public homebirth programs would be unable to choose homebirth. Without access to insured midwives, these families are left vulnerable. This option may increase the risk of women using a midwife who is uninsured or choosing to free-birth without a registered health professional. Where an adverse event occurs, these women and families have no recourse except civil action.

A lack of professional indemnity insurance puts midwives at risk of acting outside their registration standards if they choose to provide homebirth services. Where an adverse event occurs, a midwife would have no protection from civil litigation.

There is also a risk that increased demand for public homebirth services could lead to longer waiting lists, potentially restricting access for some women. While jurisdictions have previously opposed making the current insurance exemption permanent, should demand for public homebirth services exceed capacity, it may become necessary to revisit the exemption issue, despite jurisdictional concerns.

The success of this option depends entirely on the willingness of states and territories to cooperate and allocate resources for program expansion.

Option 3(a): Remove the exemption

The National Law exemption could be permanently removed (meaning PPMs could no longer provide these services, effectively rendering homebirth with a PPM illegal).

Under this option, from 1 July 2025 women and families who wish to homebirth, or access the intrapartum out of hospital care prior to a planned hospital birth, outside a public program, would continue to have a choice of midwife where there are midwives who are prepared to provide these services uninsured.

Under this option, further discussion with the states and territories would take place on the implications of removing the National Law exemption.

The Department would also move to settle arrangements with the current insurer to continue to manage the existing Midwives Schemes from 1 July 2025.

Risks

If the National Law exemption is removed in line with its proposed expiration of 30 June 2025, it would become unlawful for PPMs to conduct homebirths without appropriate insurance. A lack of PII puts midwives at risk of acting outside their registration standards if they choose to provide homebirth services. Where an adverse event occurs, these women and families have no recourse (except civil action) and no protection from civil litigation for the midwife.

There would be risks to public safety, especially in the event of free births where the woman gives birth without the assistance of a midwife or health practitioner. Unregistered birth workers can provide midwifery service at homebirths without any regulatory oversight. In these situations, the mothers and families have no recourse against an adverse event (except civil action).

There is also a risk the Government could face criticism for not enabling low-risk homebirths, limiting freedom of choice for women, particularly the opportunity to choose a model of birthing that meets their needs, and to have continuity of care and carer.

This would likely impact on workforce retention with PPMs forced to enter state and territory funded homebirth programs. As these programs operate through the public hospital system, PPMs scope of practice would be restricted according to hospital governance and clinical guidelines.

There is limited claims data to identify the impact of this option on hospital capacity.

4. What is the likely net-benefit of each option?

This section identifies the net benefits of each reform option and seeks stakeholders' views on the assessment presented. In doing so, this section provides:

- an estimate or description of regulatory burden based on options of reform
- an impact analysis on key stakeholders
- a preliminary net benefit assessment of each option.

This analysis indicates that option 2 provides the greatest net benefit for stakeholders. More detailed analysis of the regulatory impacts for each stakeholder group is provided in appendix 2.

Option 1: Status-Quo - Retain the exemption

The National Law exemption would be retained enabling PPMs to continue to offer services but without insurance, alongside public programs as occurs currently. This option would maintain the status quo.

Under this option, from 1 July 2025 women and families who wish to homebirth outside a public program, or access the intrapartum out of hospital care prior to a planned hospital birth, would continue to have a choice of midwives where there are midwives who are prepared to provide these services uninsured as long as the National Law is extended.

Option 2: Expand the Midwife Schemes

Expand the MPIS and MPISROCS to include low-risk home births and intrapartum (labour) care outside hospital prior to a planned hospital birth, whereby the Government will cover 100% of the costs of claims for these new products if an insurer provides such cover and manages claims.

Under this preferred option, women who wish to choose a low-risk homebirth as a birthing option will have this choice, and have choice of midwifery carer including continuity of care. This will be limited to women whose pregnancy is determined to be low-risk according to a nationally consistent definition, to ensure public safety. Community expectations that the public will be protected when a woman chooses to have a homebirth with a PPM attending will be met, by ensuring a robust regulatory framework. PPMs will be able to practice as insured health practitioners, providing recourse to women who wish to homebirth. Insurers will have Government support through the Midwife Schemes to enable them to limit their

liability in providing a commercial indemnity insurance product for PPMs. The intent of the National Law will be maintained by ensuring that all registered health practitioners have appropriate professional indemnity insurance to practise.

Choice for women

This option would be generally welcomed by women seeking greater choice in services and midwives. Women are increasingly seeking greater choice in birth place, including options other than hospitals that offer fewer interventions and greater autonomy¹⁶. There is a cohort of women who, given the opportunity, would prefer to labour and birth in their own home. Literature that discusses women's experiences/reasons for choosing to give birth at home suggests that they see it as a choice that promotes a feeling of more control in their birth process and one that allows immediate and better family integration of the new baby¹⁷.

Queensland Health found that for selected women, there is strong evidence that when homebirth is well integrated into the health service, it is beneficial and safe for mothers and babies¹⁸. Queensland Health drew information from large cohort studies and evaluations of the publicly funded homebirth programs currently operating in Australia. The guidance highlighted that in high-income countries, for selected women at low risk of perinatal complications, planned homebirth at onset of labour is associated with: similar or better outcomes for mothers and babies, higher levels of childbirth satisfaction, reduced healthcare costs, and less iatrogenic events related to overuse of medical interventions. The guidance included support from both the Australian College of Midwives (ACM) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) for women's right to make an informed choice about place of birth. In Queensland, the percentage of women choosing to have a homebirth has increased from 0.09 per cent in 2011 to 0.5 per cent in 2020. In recent years an indication for local demand can be derived through a 30% increase experienced by private practice midwives in Queensland over the last 2 years.

Women within a 30 km radius of an obstetric hospital who wish to have a low-risk homebirth or intrapartum out of hospital care prior to a planned hospital birth will

16 Vedam, S., 'The Mother's Autonomy in Decision Making (MADM) scale: Patient-led development and psychometric testing of a new instrument to evaluate experience of maternity care'. PLoS one 2017; 12(2) e0171804.

17 Tarrant, M. et al. 'A pathway to establish a publicly funded home birth program in Australia' Women and Birth Vol 33, Issue 5 September 2023 Pages e420-e428.

18 State of Queensland (Queensland Health), February 2024. Implementing a publicly funded homebirth program – Guidance for Queensland Hospital and Health Services V1.0.

have choice of care and carer, knowing professional indemnity insurance coverage would be available in case of an adverse event.

Expanding the Midwife Schemes to include low risk homebirth and intrapartum care outside a hospital prior to a planned hospital birth is supported by published evidence that the rate of adverse events is extremely low. Davis-Tuck et al in BMC Pregnancy and Childbirth (2018) studied trends in planned private homebirth in Victoria, Australia from 2000 – 2015, and concluded that “planned homebirth attended by a registered midwife was associated with very low and comparable rates of perinatal death and lower rates of obstetric interventions and other adverse perinatal outcomes compared with planned hospital birth attended by a midwife or physician”.

It will provide broader midwifery coverage and more choice for women, which may in turn decrease the risk of free-births which risk public safety.

PPM scope of practice

The midwifery profession have been advocating for a solution to this issue, lobbying successive governments since 2010 to find a resolution.

PPMs covered by the MPIS hold an endorsement for scheduled medicines, are regulated under the NMBA Safety and Quality Guidelines, and use the ACM Guidelines for Consultation and Referral. Any Midwives found to not be adhering to these regulation and registration standards can be reported to the Nursing & Midwifery Board of Australia and if found in breach may face disciplinary action, including restriction to practice or de-registration.

Under this option, PPMs will have the ability to work to the full scope of their practice and have the comfort they are performing as an insured practitioner. PPMs will be responsible for determining low-risk suitability for homebirth.

Workforce

The availability of an insurance product is expected to address workforce challenges by supporting midwife recruitment, service expansion, and is likely to reduce attrition amongst existing midwives. It is important to note that BoC models of care experience additional workforce challenges due to the rural and remote locations and need to employ First Nations midwives where possible.

Birthing on country models of care

This option holds profound significance for improving maternity care access and outcomes for First Nations communities. BoC models offer culturally safe, community-led maternity services, a crucial need for First Nations women and

babies. The positive health outcomes associated with BoC models for First Nations mothers and babies include reduced preterm birth rates and a decrease in child removal at birth.

This option addresses both individual and entity insurance gaps and ensures a comprehensive and equitable approach to maternity care options, including culturally-safe BoC services for First Nations communities. First Nations women (or women pregnant with a First Nations baby) would have access to culturally safe, continuous midwifery care with an insured PPM. ACCHOS will have the ability to employ midwives to provide intrapartum care outside a hospital, noting that insurers classify any birth outside a hospital as a private planned homebirth service.

ACCHOs

The existing insurance gap poses a significant barrier to the development and expansion of BoC models of care. No insurer has indicated a willingness to provide PII cover for intrapartum care outside a hospital under the existing Government supports available through the Midwives Schemes. This gap in cover was identified late last year and was threatening delivery of these services and was particularly sensitive with ACCHOs providing services under BoC models of care.

An interim solution was found to this issue through the Department (under authorisation from the Minister for Finance) granting an indemnity under s60 of the PGPA Act to the current insurer to cover 100% of the costs of claims arising from these services. The insurer then made cover for these services available to individual midwives. The indemnity was limited to 30 June 2025 to address the immediate threat to service delivery and allow time for Government to consider how best to implement a long term solution to this issue.

Under this option, intrapartum out of hospital services will now be covered by specific legislation, including amendments to the Midwives Schemes legislation. The cover, with Government paying 100% of claims, will be available both to individual midwives directly as well as to certain specified entities who employ midwives engaged in delivery of these services related to BoC models of care. This responds to concerns from the ACCHOs that the entity who employs the midwife (an ACCHO directly or an employer organisation who provides the midwives for the ACCHOs) also needs to have cover available in case the employer was also sued for the actions of the midwives. The ACCHOs position is that unless these entities are also able to access cover then the 'gap' in insurance remains and they would need to cease services. The extension to cover these entities would only apply in relation to organisations specified in sub-delegated legislation such as a Ministerial

determination (these would be ACCHOs or entities employing midwives operating in BoC services).

This option establishes a pathway for ACCHOs to secure insurance for midwives, which directly supports the continuity and expansion of vital BoC services.

Closing the Gap

By facilitating insurance access, this option has the potential to contribute to healthier mothers, babies, and communities, building on momentum towards achieving the National Agreement on Closing the Gap. In particular, Closing the Gap Target 2 which is one of the few targets reported by the Productivity Commission that is now on track to be met by 2031 (progress which is welcomed by the Commonwealth following recent investments in BoC models of care. This option aligns with several Priority Reforms within the Closing the Gap framework. Enabling insurance access fosters genuine partnerships and shared decision-making between ACCHOs and midwives (Priority Reform 1), and it strengthens the First Nations community-controlled sector by supporting sustainable ACCHO-led BoC services (Priority Reform 2). Additionally, this option creates the opportunity for improved data collection and sharing on birthing outcomes, empowering First Nations communities with information for advocacy and effective service planning (Priority Reform 4).

This option also aligns with the Government's election commitment to invest in First Nations health, including \$22.5 million to build a dedicated Birthing on Country Centre of Excellence at the Waminda Health Service in Nowra NSW.

Regional and rural

Currently, the lack of insured homebirth midwives severely limits birthing choices for First Nations women, particularly those in rural or remote areas. This option champions equity and self-determination by increasing access to safe and culturally appropriate birthing options for those who choose them.

Women living in rural and remote areas of Australia, outside of a 30 km obstetric hospital radius, will not have access to a low risk homebirth. However, the creation of a national dataset, including jurisdictional claims and birth data, will provide evidence to support expansion of this program.

This option reflects the Commonwealth's high priority to improve community access to maternity services and culturally safe midwifery and support the ability of Australia's midwives to work to their full scope of practice. It provides a solution to longstanding and entrenched issue PPMs face in accessing appropriate PII.

Commonwealth/state collaboration

Various jurisdictional reviews (including a current review in Queensland) have identified the benefit of introducing or expanding public homebirth programs, under a low-risk model, using existing practice standards and escalation pathway guidelines.

Jurisdictions would support this option given it would see the Commonwealth taking on the insurance risk and costs. With the prospect of a commercial insurance product now available, there would be renewed momentum from all jurisdictions to resolve this issue.

Jurisdictions have also discussed the development of national clinical care guidelines for the provision of low risk homebirths. This would provide restrictions on eligibility to claim under an expanded MPIS.

The recent Independent Review of Overseas Health Practitioner Regulatory Settings (the Kruk Review) endorsed the development of a Maternity Services Strategy¹⁹ This initiative aligns with the current proposal, as addressing insurance gaps for intrapartum care in the home supports women's choices and can positively impact the broader maternity care landscape.

Option 3: State and territory homebirth programs

Government commences negotiations with state and territory governments for provision of these services to be facilitated by jurisdictions and covered under their indemnity arrangements.

Under this option, Government would commence negotiations with state and territory governments to facilitate further provision of these services under public schemes, with insurance coverage under jurisdictional indemnity arrangements for employees. The goal would be to increase the availability of publicly funded programs for low-risk homebirth and intrapartum out-of-hospital services. Midwives working within these expanded programs would gain insurance coverage through jurisdictional indemnity arrangements.

The success of this option depends entirely on the willingness of states and territories to cooperate and allocate resources for program expansion.

¹⁹ https://www.regulatoryreform.gov.au/sites/default/files/Final%20Report%20-%20Overseas%20Health%20Practitioner%20Regulatory%20Settings%20Review%202023%20-%20endorsed%20by%20National%20Cabinet_0.pdf

Various jurisdictional reviews (including a current review in Queensland) have identified the benefit of introducing or expanding public homebirth programs, under a low-risk model, using existing practice standards and escalation pathway guidelines.

In November 2022, the Queensland and Tasmanian Departments of Health were asked if they intended to introduce a public homebirth program in their respective state. Queensland has advised that a low-risk homebirth will be offered at one site in a pilot in Queensland later in 2024. Tasmania has advised that they are unable to consider a public homebirth program at this time.

Under these options, there is opportunity to scope the private hospital sector on their appetite to introduce funded homebirth, although likelihood is considered low given their low uptake of midwifery continuity of care models and a preference for obstetric led models of care.

Option 3(a): Remove exemption under National Law

The National Law exemption could be permanently removed (meaning PPMs could no longer provide these services, effectively rendering homebirth with a PPM illegal).

Continual extension of the exemption has contributed to the rhetoric that PPM attended homebirths are uninsurable and therefore dangerous. While removal of the exemption would allow PPMs to perform to their full scope of practice, this practice would be illegal, and women and families would have no recourse in an adverse event.

Impacts of Options

Financial impacts

Based on estimates provided by the Australian Government Actuary, this proposal will have a cash impact on the Government of \$2.735 million and fiscal impact of \$11.8 million over four years (2024-25 to 2027-28).

The current insurer administers the Midwife Schemes through a contract with the Department. An increase in the administration fee by \$103k, \$105k, \$107 inclusive of Wage Cost Indices-1 for 2024-25 to 2027-28 would account for inflationary pressures and other factors. Average annual inflation rates would account for a significant part of the annual increase in administrative fees, aligned with economic forecasts for the proposed contract term. Moreover, participation in the Midwife

Schemes is expected to increase with an associated growth in the complexity and volume of administration.

Gender Equality

This option meets the criteria for gender equality given the midwifery workforce is highly feminised, and the proposal will have impacts for women's agency in making birthing environment choices. By expanding and supporting home-birth options for low-risk births and intrapartum care outside a hospital, this proposal directly empowers pregnant women by giving them more agency in choosing their birthing environment. This not only aligns with the broader goals of gender equality but also fosters an inclusive healthcare environment where women have access to culturally safe continuity of care and are empowered to make decisions best suited to their individual circumstances. This also aligns to the Woman-centred care: Strategic directions for Australian maternity services (Woman-centred Care Strategy) developed by the Australian Government. The Woman-centred Care Strategy provides national strategic directions to support Australia's high-quality maternity care system and enable improvements in line with contemporary practice, evidence and international developments. Of primary importance is that Australian families have access to safe, high quality, respectful maternity care, recognising that women want to access maternity care in their geographic location and that outreach services and telehealth care enhance maternity care in rural and regional areas.

Impact Analysis

Choice for women

The impact on women is that they will have an increased choice of where to birth and who their carer during birth can be, with the support of recourse in case of an adverse event.

The scope of this insurance coverage will facilitate accurate liability assessments for the Commonwealth and provide women with transparent information about what services are covered and which providers are eligible to offer them.

PPM scope of practice

The impact on PPMs and businesses is that those providing homebirth services can expand their scope of practice to provide intrapartum care as insured services.

This insurance coverage specifically applies to low-risk homebirths as developed in 2021 in conjunction with states and territories, and is in line with current risk profiles of existing publicly funded homebirth and the ACM Guidelines for

Consultation and Referral. Additionally, it covers intrapartum care outside a hospital when provided within the framework of models that adhere to the NMBA's Safety and Quality Framework for PPMs. Only registered midwives holding the appropriate endorsement by the NMBA are eligible for coverage.

Birthing on Country

In recognition of the vital role that BoC services play in improving health outcomes for First Nations women and babies, this option would enable First Nations women (or women pregnant with a First Nations baby) access to culturally safe, continuous midwifery care with an insured PPM. The lack of insurance cover for these services to date has been a significant barrier to ACCHOs developing and delivering BoC models of care.

BoC models of care directly contribute to Closing the Gap Target 2, including a 50% reduction in preterm birth rates where trialled. Emergent evidence also highlights the positive impact BoC models have on reducing the likelihood of child removal at birth, directly contributing to Closing the Gap Target 12. The exact number of women and PPMs impacted by the gap in insurance is still being determined. There are currently 3 ACCHOs impacted by the gap in insurance.

This option aligns with the Government's significant investments in BoC, including support for nine BoC service delivery organisations since late 2022 and a \$22.5 million investment in the BoC Centre of Excellence in Nowra, NSW. The insurance coverage will extend to the following organisations delivering BoC services: South Coast Women's Health and Wellbeing Aboriginal Corporation (Waminda), Central Australian Aboriginal Congress, Institute of Urban Indigenous Health (IUIH) and subcontracted midwives from My Midwives Pty Ltd.

Market risk

The Department recognises the risk of setting a precedent for intervention in other market failures. However, maternity care is an essential health service, and this option directly supports women's choices and access to safe birthing options. Additionally, the lack of insurance disproportionately impacts First Nations communities, hindering progress towards achieving the National Agreement on Closing the Gap targets, including, but not limited to target 2, 4 and 12. Existing research²⁰ supports the safety of low-risk homebirth models, and the recent tender

²⁰ See The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). (2022). Home Births (C-Obs 2).

<https://ranzocg.edu.au/wp-content/uploads/2022/05/Home-Births.pdf>

McLachlan, H. L., Forster, D. A., Davey, M. A., Gold, L., Biro, M. A., & Albers, L. (2022). Ten years of a publicly funded homebirth service in Victoria: Maternal and neonatal outcomes. *Midwifery*, 115. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9790430/>

process clearly demonstrated a market failure, with no private insurers willing to provide coverage.

Constitutional risk

Constitutional risk: medium Amendment to National Law brings little risk as does an amendment to MPIS to effect changes to risk thresholds.

Regional impact

Women would be supported with choice of private midwife if they meet relevant criteria for low risk home births (being within 30 minutes of maternity service) and the eligibility requirements for intrapartum care outside a hospital.

Distributional Impacts

PPMs (inclusive of BoC PPMs) will be able to provide birthing services (under the low risk definition) and intrapartum care outside a hospital. BoC services are critical to First Nation's women living in rural and remote areas, where increased vulnerabilities exist.

Commonwealth-State relations

The Commonwealth has reached agreement with the Jurisdictions on the low risk definition for homebirth and the updated practice standards, since women who require referral for complications would affect public hospital services. If Option 2 is chosen, further negotiations with jurisdictions will be required.

Regulatory impacts

This IA calculates regulatory impacts from the reform options using the Regulatory Burden Measurement framework. Implementation of these options would depend on future data collection, analysis and consultation. This means that it is not possible to completely cost the change in regulatory burden that would flow from the reform option.

The quantifiable changes in regulatory burden that have been identified are outlined in the table below.

Hutton, E.K., Reitsma, A.H., Kaufman, K. (2016). Planned hospital birth versus planned home birth. Cochrane Database of Systematic Reviews, Issue 9. Art. No.: CD000352. DOI: 10.1002/14651858.CD000352.pub3

https://www.cochrane.org/CD000352/PREG_planned-hospital-birth-versus-planned-home-birth

TABLE 2 SUMMARY OF QUANTIFIABLE CHANGES IN REGULATORY BURDEN BY OPTION

<u>Area of regulatory burden</u>	<u>Stakeholders</u>	<u>Option 1</u>	<u>Option 2</u>	<u>Option 3(a)</u>
Compliance costs	Consumers	+\$0.86m	+\$0.61m	+\$0.86
	PPMs	+\$2.60m	+\$0.04m	+\$2.6m
	Industry	\$0.00	+\$0.11m	\$0.0
	Regulator (NMBA)	\$0.00	+\$0.06m	\$0.0
	Business coordinating PPM services	+\$1.50m	-\$1.50m	+\$0.39m
	TOTAL	+\$4.96m	-\$0.68m	+\$3.85

Detailed costings are provided in [Appendix 2](#).

Impacts on Stakeholders

This section provides an overall assessment of impacts on five key stakeholder groups:

- Consumers
- PPMs
- Industry, represented by medical indemnity insurers
- Regulator, represented by the NMBA/Australian Health Practitioner Regulation Agency (Ahpra)
- Business

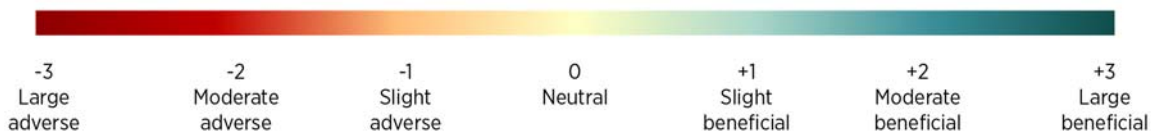
How were impacts assessed?

Feedback from various jurisdictional reviews, the COAG Women Centred Care: Strategic directions for Australian maternity Services 2019 report, and meetings with industry, NMBA, and Health Ministers provided information from which to assess the likely impacts of the options on stakeholders. This included:

1. Assessing how the changes in each reform option may impact key stakeholder groups.
2. Identifying any regulatory burden and whether the impact would increase or decrease.
3. Providing an assessment of the impact, using a common scale for the estimated magnitude.

The assessment uses a 7 point scale, indicating the anticipated impact of changes on particular stakeholder groups relative to the status quo²¹: (representing no change to current arrangements).

Impact Rating Scale



Changes which result in a beneficial impact for stakeholders, or reduce burden, have been rated as positive. Changes which increase operating costs, risk, burden or result in a detrimental impact for stakeholders have been rated as negative. The neutral rating was used to signify minimal impact and that there would be no overall benefit or cost from the option relative to the status quo.

These ratings have been determined as outlined in [Appendix 2](#). While numbers have been applied to this rating scale, these are intended to support accessibility and readability of the ratings rather than representing a precise scale.

Limitations and assumptions

Changes to regulatory burden under each reform option were identified for each stakeholder group but cannot be completely quantified as a dollar cost due to lack of data. Appendix 2 provides some information about specific areas for which there are some regulatory burden costings.

In some areas, subsequent data collection will be used to help identify the risks involved and further consultation will be undertaken to strike an appropriate regulatory balance between the risks to be managed and the level of regulatory burden.

Summary by reform option

Based on the assessment, option 2 provides greatest benefits to consumers, PPMs and business and imposes some administrative burden on industry, the regulator

²¹Australian Government Department of Industry , Science, Energy and Resources: *Reforming Australia's Measurement Legislation 2021* Impact Rating Scale

and business. Table 3 shows how each reform option is likely to impact stakeholders.

Table 3: Overall impact of options on stakeholders

Impact	1	2	3(a)	
Consumers	-7	+6	-7	Option 2 would enable women to have more choice in birthing options and midwifery support and give First Nations Women culturally safe services
PPMs	0	+4	-4	Option 2 allows PPMs to work to the full scope of their practice. Under option 3(a) PPMs are not insured.
Industry	0	-1	0	Option 2 imposes some administrative burden on industry while Options 1 and 3(a) maintain the status quo.
Regulator	-2	-1	-2	Option 2 imposes some administrative burden on regulator while Options 1 and 3(a) require more stringent monitoring of safety and quality of PPM practice.
Business	-3	+2	-3	Option 2 enables commercial viability of First Nations midwifery services while Options 1 and 3(a) could force these businesses to close.
OVERALL	-12	+10	-16	Analysis of stakeholder impacts shows that Option 2 provides the greatest benefits to stakeholders

5. Who did you consult and how did you incorporate their feedback?

Purpose of Consultation

The development and implementation of the proposed new products have been informed by considered and comprehensive stakeholder consultation. Consultation was a key component in developing Option 2. Consultation improved the policy through canvassing varied stakeholder responses to proposed changes and to understand the concerns of business, government and consumers

Who should be consulted?

- Internal areas within Department
- Department of Finance
- Department of the Prime Minister and Cabinet
- The Treasury
- National Indigenous Australians Agency

- Australian College of Midwives
- Medical indemnity insurers
- ACCHOs

When will/were they consulted?

How were they consulted?

Various jurisdictional reviews (including a current review in Queensland) have also identified the benefit of introducing or expanding public homebirth programs, under a low-risk model, using existing practice standards and escalation pathway guidelines.

The midwifery profession has been advocating for a solution to this issue, lobbying successive governments since 2010 to find a resolution.

Stakeholder engagement with NMBA, state and territory governments, health ministers, and other entities has been ongoing. Early engagement with these stakeholders has been supportive of the introduction of a product and amendment to the regulatory framework to support it.

2019

The development of the COAG Women Centred Care: Strategic directions for Australian maternity Services 2019 involved two rounds of public consultations, opportunity for online submissions, attendance at workshops, focus groups and webinars. Across the two round of consultation, over 600 health professionals, service providers, and consumers attended the events. Over 900 organisations and individuals made submissions.

2020

The Department formed an internal working group (PII for PPM Working Group) to address issues, including escalation of care pathways, regulation of a midwife's practise within the low-risk criteria, profitability of providing a product to a very small cohort of practitioners, and costs of development and maintenance of the product and associated reporting under the MPIS. The PII for PPM Working Group has consulted regularly with jurisdictions through the Health Ministers' meetings on the draft definition of low risk for the purposes of homebirth.

October 2022

The Department undertook an industry briefing to foreshadow the Department's intent to expand the MPIS and MPIS ROCS to include a low-risk homebirth intrapartum product provided by PPMs.

November 2022

The Department released a consultation discussion paper and subsequently met with insurers to gauge their interest in offering intrapartum insurance products for low-risk homebirths. Insurers were invited to provide a written Expression of Interest in response to the following questions:

- Would you be open to providing a PII product under the MPIS if this scheme included a low-risk homebirth intrapartum care component?
- If offering such a homebirth PII product was not mandatory for an insurer in order to participate in the MPIS, would you still offer a homebirth PII product?
- Are you satisfied with the proposed definition of a low-risk homebirth for the purposes of the eligibility criteria? If no, what changes would you seek and why?
- Do you have any other questions or feedback about the inclusion of a homebirth PII product? If yes, what are they?
- Would a requirement to enter into a contract with the Commonwealth which included homebirth services deter you from administering the MPIS? If yes, why?
- What is your estimated timeline to develop and rollout a new PII product for low risk births under the MPIS?

November 2023

The Department approached the market to find an insurer who would cover existing services under the existing Midwife Schemes, which subsidises the cost of claims made against PPMs, and these two new services.

November - December 2023

The Department sought input from the ACM, ACCHOs, and the National Indigenous Australians Agency (NIAA) on the design of the preferred option.

February 2024

The Department sought feedback from the Department of Finance, the Department of the Prime Minister and Cabinet, and the Treasury on the viability of the preferred option.

Outcome of Consultation

Consumers, Health Ministers, industry and ACCHOs support implementation of the preferred option. However, the insurer has raised a number of complex issues during consultation that will require further discussion and negotiation. The

Department will undertake further consultation with the expectation of finalising the new contractual arrangements with the insurer in early 2025.

Views of Stakeholders

Consumers

The views of consumers are detailed in responses to several reports and studies outlined in section 1 'What women want' (pages 4, 5, and 6).

As outlined in the Communication Strategy, the Department will seek feedback from consumers on the efficacy of the reform, and whether it meets expectations.

Health Ministers

The views of state and territory government Health Ministers are detailed in section 1 'Overview' (pages 2 and 3).

The Department will continue to report bi-annually to Health Ministers on progress of this reform.

Industry

The ACM has published a position paper that supports the choice of planned, midwife-attended birth at home as a safe option for women with uncomplicated pregnancies. The ACM states that "Midwifery care is woman-centred, and is a partnership between a woman and a midwife. Every woman should have access to midwifery continuity of care"²². The ACM considers that "Women have a right to decide where they wish to give birth to their baby, have access to evidence-based, unbiased information that includes the potential advantages and disadvantages of birth at home" and notes that "Care from a midwife with consultation, referral and transfer mechanisms is key to safety using the ACM National Midwifery Guidelines for Consultation and Referral".

Insurers

Only one insurer responded to the 2022 industry briefing, highlighting several concerns about the introduction of the new products, including:

- the potentially increased risks are appropriately considered and managed to protect both the women and their unborn babies and that the premiums/administration fees are adequate to cover the claims and other additional costs that would be incurred by the insurer

²² https://www.midwives.org.au/common/Uploaded%20files/_ADMIN-ACM/Planned-Birth-at-Home-Position-Statement-2019.pdf

- either a collaborative agreement and/or a care plan in place for the midwife to be insured
- clarity of intent is required in circumstances where a woman plans a homebirth or if a midwife proceeds to provide care in a homebirth not meeting those low risk criteria, or otherwise contrary to the ACM Guidelines
- determining at what point an exclusion to cover applies during a pregnancy or during labour
- how the health and safety of both the woman and the baby can be adequately protected in situations where the midwife is working as a sole practitioner and outside of the established support and clinical governance framework of the public hospital maternity system
- more clarity on the proposed definition for low-risk homebirths
- whether the Commonwealth has considered an alternative approach such as expanding the resources available via the current State based public hospital homebirth programs
- the low number of PPMs means the size of the Scheme and the income pool is very small relative to the claim's exposure and the expectation of the Service and support to be provided and the reporting and monitoring framework.

The Department is continuing to consult with the insurer to ensure they are satisfied that protection of women and their babies underpins the design of the reform.

ACCHOs

The views of ACCHOs are detailed in section 4 'Birthing on Country' (pages 27 and 28).

The Department is continuing to consult with ACCHOs to support the ongoing viability of BoC models.

Impact on Policy Options and/or Impact Analysis

The following table outlines strategies to address issues raised by the insurer during the consultation process.

Issue raised by insurer	Strategies to address the issue
Definition of low-risk homebirth	Health Ministers have agreed this definition
Collaborative arrangements/Care Plans	Government has committed to removing the legislated requirement for collaborative arrangements between PPMs and medical practitioners, to be effected in late 2024. PPMs will continue to adhere to NMBA professional standards to ensure continued inter-professional clinical collaboration
Protection of women and their unborn babies, particularly outside public hospital maternity system	PPMs are required to practice in accordance with NMBA Safety and Quality Guidelines, and use the ACM Guidelines for Consultation and Referral
Ensuring compliance with low risk homebirth criteria	
Determining when exclusion to cover applies during a pregnancy or during labour	
Expanding state based public hospital homebirth programs	The Commonwealth will continue to work with state and territories through Health Ministers to support the expansion of public hospital homebirth programs
Market is too small to generate a risk pool specifically for PPM services	The development of a national dataset will allow a more accurate indication of likely claims profile and annual liability estimate.

6. What the best option from those you have considered and how will it be implemented?

Do the options meet the objectives?

The options outlined in this IA are summarised below. Option 2 has been identified as the preferred option which would deliver on the Government’s objectives of:

1. making low-risk homebirths an eligible product under the Midwife Schemes (which currently indemnifies midwives for homebirth antenatal and postnatal care but not intrapartum care), with the timing to coincide with the expiry of the exemption.
2. improving community access to maternity services and culturally safe midwifery through expansion of the BoC program.

3. working with state and territory governments to finalise a solution by 2030 to a longstanding and entrenched issue PPMs face in accessing appropriate PII to allow PPMs to work to their full scope of practice with professional indemnity insurance coverage.

What is the preferred option?

Analysis confirms that option 2 presents the greatest net benefit. This option is recommended because it:

- Provides the lowest quantifiable impact in annual regulatory burden of -\$0.68 million.
- Offers the greatest alignment with the Commonwealth's priority to improve community access to maternity services and culturally safe midwifery and to support the ability of Australia's midwives to work to their full scope of practice
- Provides the greatest net benefit to stakeholders, as well as:
 - a solution to a longstanding and entrenched issue PPMs face in accessing appropriate PII, giving them comfort they are performing as an insured practitioner and meeting their registration standard.
 - women would have the choice to birth at home and their choice of continuous midwifery care with an insured PPM.
 - First Nations women (or women pregnant with a First Nations baby) would have access to culturally safe, continuous midwifery care with an insured PPM.

How will it be implemented?

A three stage implementation plan demonstrates how the new arrangements will be established and administered.

- i. The department will negotiate and settle details of arrangements with the insurer by the end of 2024 to facilitate development of policies and availability of cover by 1 July 2025.
 - The NMBA will be formally consulted regarding any changes to standards, codes or guidelines that regulate the practice of a PPM conducting homebirth services to effect the reform.
 - Other stakeholder groups such as Homebirth Australia, the Australian College of Midwives, and other advocacy and consumer representative groups will be engaged with information on the proposed product, low risk

definition, and changes to practice standards that no longer include the exemption.

- ii. The exemption in the National Law will be removed by 1 July 2025. From 1 July 2025, all endorsed PPMs should be able to offer insured low risk homebirth and intrapartum services out of hospital if they wish to do so.
- iii. The final stage of implementation (2029-30) will involve evaluation of the ongoing need for Government to carry the full risk (when the contract for administration of the Schemes will next be put to market) by which time there would be a clearer indication of trends in claims and costs to inform insurer interest and risk appetite.

The Department may choose to retest the market prior to the end date of the new contract, which may involve putting the full insurance services out to tender. Given it is a relatively small market, the market is unlikely to support a second provider.

What are the risks of implementation?

While Option 2 has been determined the most suitable from those considered, it is not without challenges and risks. These are outlined below, including an explanation of how they are being monitored and accommodated within the implementation approach.

Option 2 policy objective

Ensure that PPMs can provide low-risk homebirth intrapartum care services with professional indemnity insurance coverage.

There is published evidence to indicate the low rate of adverse events. Davis-Tuck et al in BMC Pregnancy and Childbirth (2018) studied trends in planned private homebirth in Victoria, Australia from 2000 – 2015, and concluded that “planned homebirth attended by a registered midwife was associated with very low and comparable rates of perinatal death and lower rates of obstetric interventions and other adverse perinatal outcomes compared with planned hospital birth attended by a midwife or physician”.

Target

All endorsed PPMs can offer insured low risk homebirth services and intrapartum (labour) care outside a hospital services from 1 July 2025.

Milestones and deliverables

Obtain insurer commitment for a low-risk homebirth and intrapartum (labour) care outside a hospital product by September 2023.

Establish a new contract with the existing insurer to continue the existing services as well as commence new low risk homebirth intrapartum services and intrapartum care outside a hospital services by February 2025.

Insurer commences selling insurance policies for the new products from March 2025, to take effect from 1 July 2025.

Metrics and outcomes

From 1 July 2025, all endorsed PPMs are able to offer insured homebirth intrapartum services if they wish to do so.

The exemption in the National Law is removed which will mean that all registered health professionals hold insurance.

7. How will you evaluate your chosen option?

Purpose

The new services will be independently evaluated prior to 2029-30 (when the contract for administration of the Schemes will next be put to market) to inform ongoing program improvement, assess the effectiveness of the new products, and inform future policy direction. The purpose of the evaluation will be to assess the impact of the regulatory change, whether the benefits have been realised, the impact on key stakeholders, and whether it provides value for money.

To assess the effectiveness of the new products, they will be assessed against whether the objectives outlined in this paper are to be delivered. The independent evaluation will also consider the utility of this option, and whether it needs to be refined to ensure it continues to maximise benefits.

Audience

The evaluation will make recommendations which will be considered by the Australian Government and tabled with Health Ministers. The final report will be circulated to the insurer, the regulator and relevant NACCOs. The evaluation report will also be published on the Department's website, heralded by a media release, to alert consumers, PPMs and interested parties to the findings.

Objectives and principles

The evaluation is designed to assess the impact and outcome of the new insurance products for low-risk intrapartum care services and whether they have been delivered in accordance with the stated objectives of the Midwife Schemes. The evaluation is intended to inform future planning of maternity services and identify opportunities for improvement, including intended and unintended impacts that could be refined to improve the service.

The objectives of the evaluation include:

- a. To assess the program's impact on women's choice of birth
- b. To assess the program's impact on PII scope of practice
- c. To assess the program's impact on public safety within low risk homebirth.
- d. To collect and analyse updated information on implementation of the new insurance product; a baseline for future evaluations
- e. To provide information and analysis on key policy issues
- f. To identify emerging needs, gaps or priorities
- g. To identify opportunities for improvement
- h. To provide accountability and transparency.

Methodology

The evaluation will involve an outcome approach to measure the impact and outcomes, especially long-term implications and possibilities, and to assess whether the low risk homebirth service:

- demonstrates accountability and transparency
- is safe
- the degree to which it meets demand from women
- is efficient and sustainable and has met the objectives.

Decision rule

The preferred option will be the policy approach that delivers the greatest net benefit and corresponds to all three Government reform objectives.

Data Collection

The evaluation will involve the collection and analysis of quantitative through the establishment of a national data set, and qualitative data through face to face meetings and online surveys.

- The qualitative data target women who have used, or wanted to use, the service and PPMs providing the service.
- The quantitative and qualitative data will include:
 - numbers of women seeking low risk homebirth
 - numbers of women accessing low risk homebirth
 - reasons women did not access the service
 - data on the midwives providing homebirths – number, years of experience, meet PPM requirements including annual updates, retention
 - risk management and adverse event reports and actions provided by insurance provider and national dataset.

Data management and analysis

The Australian Government Actuary conducts periodic evaluations of medical indemnity insurance. The qualitative and quantitative data collected will inform these reviews.

Quality and ethical considerations

The evaluation involves human research, and there are ethical considerations, particularly in data collection and analysis activities. Given the potential risk of harm, independent ethic approval by an independent Human Research Ethic Committee (HREC) will be sought.

Ethical consideration	Type of risk	Level of risk	Potential risk management
Psychological harm	Will participants disclose sensitive information?	Medium to high	Participation is voluntary
	How will privacy be protected?		Informed consent
Social harm	Damage to social networks/social stigma		HREC approval is sought
	Could participants' relationships be threatened?		Privacy & confidentiality processes

Evaluation Plan and Strategy

Governance and management

Key governance actions will include:

- i. Alignment of internal review, assurance and evaluation activities with legislative reporting requirements
- ii. The program project manager and director will have responsibility for considering the outcomes of regular performance monitoring activities and the implementation of findings from evaluation reports.

Reporting and communication

The evaluation report will succinctly inform stakeholders about the highlights of the evaluation, including a summary page which may be delivered as a written executive summary, verbal briefing, or short message on the Department of Health and Aged Care internet page. The summary will include a description of the new service and highlight key findings and recommendations from the evaluation.

Table 5 summarises how the evaluation will assess measurements of success against the objectives. Table 6 summarises the evaluation schedule of roles, responsibilities, and timing.

Communication

A tailored stakeholder and communications strategy will be developed and delivered through a range of media to ensure that women and PPMs understand the new low risk homebirth service and its benefits. Guidance and information on the new product will specifically target engagement with First Nations peoples, culturally and linguistically diverse populations, as well as the broad range of maternity services providers.

Stakeholder engagement

The following table identifies the key stakeholders, their interest in the service, and the proposed method of engagement.

Table 4

Stakeholder	Interest in service	Method of engagement
Women desiring homebirth	High	Online surveys
Privately practicing midwives	High	Online surveys
Medical indemnity insurer	High	
Maternity services (ACCHOs)	High	

Nursing and Midwifery Board of Australia/Ahpra	High	Department to meet regularly with stakeholders to discuss and resolve issues arising during implementation.
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Table 5: Evaluating success of policy change

Objectives	Measurement of success		
	Key metrics	Method	Outcome
<p>To assess the program’s impact on women’s choice of birth</p> <p>To assess the program’s impact on public safety within low risk homebirth</p>	<p>Number of:</p> <ul style="list-style-type: none"> -homebirths -escalations to hospital 	<ul style="list-style-type: none"> -Claims data -Online surveys 	<p>Implementation of national dataset and collection of claims data</p>
<p>To assess the program’s impact on PII scope of practice</p> <p>To assess the impact of the new insurance products on growing the midwifery workforce</p>	<p>Number of insured PPMs offering homebirth services</p> <p>Monitoring and reporting on legislative change</p>	<ul style="list-style-type: none"> -Insurer reports (risk management and adverse event reports and actions) -Health workforce data 	<p>Increased rates of compliance with reporting on two additional services</p> <p>Exemption successfully removed by 1 July 2025</p>
<p>To assess the impact of the new insurance products on increasing the availability of BoC models of care.</p>	<p>Number of BoC services operating</p> <p>Number of midwives providing BoC services</p> <p>Closing the Gap Target 2 on First Nations mothers and babies (preterm birth, child removal rates)</p>	<ul style="list-style-type: none"> -ACCHO reports -Closing the Gap Target 2 reports on First Nations mothers and babies 	<p>Increased number of BoC services</p> <p>Increased number of midwives delivering BoC services</p> <p>Decrease in First Nations preterm birth, child removal rates</p>
<p>To provide Government with information and analysis of key policy issues</p> <p>To identify emerging needs, gaps or priorities</p> <p>To identify opportunities for improvement</p> <p>To provide accountability and transparency</p>	<p>All of the above</p>	<p>All of the above</p>	<p>Evidence of insurer engagement or new insurance products offered by June 2029</p>

Table 6: Evaluation roles, responsibilities, timing

Task	Responsible	Activity	Timing
Preliminary phase -Comment on and endorse Terms of Reference -Initial internal consultation	Independent evaluator <i>lead</i> DoHAC <i>support</i>	Draft Terms of Reference Consult with relevant divisions within DoHAC	Feb-March 2028
Draft evaluation plan including: <ul style="list-style-type: none"> ○ Matrix of questions ○ Description of method ○ Data gathering tools ○ Detailed work schedule 	Independent evaluator <i>lead</i> DoHAC <i>support</i>	Analysis of claims data Analysis of insurer reports to DoHAC & Services Australia	April-July 2028
Liaison with partners/stakeholders and target populations	Independent evaluator <i>lead</i> DoHAC <i>support</i>	Online stakeholder surveys: <ul style="list-style-type: none"> -consumers -PPMs Meetings with insurers, NMBA & Ahpra, ACCHOs, NIAA, ACM	Aug-Oct 2028
Draft evaluation report -Prepare document outline -Draft sections of the report -Consolidate sections into draft	Independent evaluator <i>lead</i> DoHAC <i>support</i>	Claims data, survey responses , and feedback from meetings incorporated in draft report Draft report provided to insurer, regulator and ACCHOs for comment	Nov-Dec 2028
Final evaluation report	Independent evaluator <i>lead</i> DoHAC <i>review</i> Health Ministers <i>review</i>	Consolidate stakeholder comments Coordinate input, resolve differences, conduct final edit and submit for endorsement	Feb 2029
Endorsement of report and agreement on release	DoHAC <i>endorse</i> Health Ministers <i>endorse</i>	Final report published on DoHAC website	April 2029

8. Conclusion

This IA has systematically assessed the potential impacts of three options to assist the Government to make an informed decision, mitigate the risks, and successfully implement an option that meets all of the Government's reform objectives. The intent is to highlight the ripple effects of any change, which would enable the Government and stakeholders to plan and prepare for any necessary adjustments.

Option 2 - preferred

Option 2 delivers the greatest net benefit and clearly corresponds with the Government's three reform objectives. This option will:

1. make low-risk homebirths an eligible product under the Midwife Schemes
2. build on momentum towards achieving Closing the Gap Target 2 by improving community access to culturally safe continuity of midwifery services and midwifery care, including expansion of BoC programs by 2031,
3. allow PPMs to access appropriate PII and work to their full scope of practice while allowing time for the Commonwealth to work with state and territory governments to finalise a solution by 2030.

Option 2 has been assessed as delivering the greatest net benefit to stakeholders (consumers, PPMs, industry, the regulator, and business [ACCHOs]), including a net regulatory saving of \$1.043 million per year.

Implementation of this option will involve the establishment of a national dataset that will collect claims data. This data is expected to provide a clearer risk profile of PPM practice and outcomes and enable informed decision-making on a permanent solution for PII for PPMs. Data collected to December 2027 will inform an independent evaluation commencing in February 2027 while data collected to December 2028 will be reflected in the final evaluation report.

Option 1 – retain exemption (status quo)

Option 1 corresponds to the Government's reform objective 3 in that PPMs would continue to provide homebirth and out of hospital intrapartum care services as insured practitioners while the Commonwealth works with state and territory governments to finalise a solution by 2030. This option does not correspond with objectives 1 and 2. It would result in a significant impact on stakeholders, and impose a regulatory burden of +\$5.46 million per year.

Option 3 – remove exemption

Option 3 does not correspond with any of the Government's reform options. It would result in significant impact on stakeholders and impose a negative regulatory burden of +\$3.85 million per year.

Appendix 1: Glossary

ACCHOs are Aboriginal and Community Controlled Health Organisations

ACM is the Australian College of Midwives

Ahpra is the Australian Health Practitioner Regulation Agency

AIHW is the Australian Institute of Health and Welfare

BoC is Birthing on Country

Department is the Department of Health and Aged Care

Government is the Australian Government

MBS is the Medicare Benefits Schedule

Midwife Schemes are:

- **MPIS** - Midwife Professional Indemnity Scheme
- **MPISROCS** - Midwife Professional Run-off Cover Scheme

NIAA is the National Indigenous Australians Agency

National Law is the Health Practitioner Regulation National Law

NMBA is the Nursing and Midwifery Board of Australia

PII is Professional Indemnity Insurance

PPMs are Privately Practising Midwives

WCC is Women Centred Care

Appendix 2: Costing the regulatory burden of changes to midwifery services

This section endeavours to quantify the impacts of the proposed options on Australians overall, above the baseline scenario represented by the status quo. The impact on Australians will be estimated by summing up the impact on Australian consumers, PPMs, industry, regulator, and business.

Option 1 Retain the exemption

Consumer impact

Under this option, freedom of choice for women would be limited, particularly the opportunity to choose a safe model of birthing that meets their needs and to have continuity of care and carer with recourse in the event of an adverse incident.

First Nations women (or women pregnant with a First Nations baby) would not have access to culturally safe, continuous midwifery care with an insured PPM in accord with BoC models of care. This could hamper efforts to achieve Closing the Gap Target 2 to increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91%, by 2031 and Target 12, by 2031, reduce the rate of over-representation of Aboriginal and Torres Strait Islander children in out-of-home care by 45 percent.

The primary cost to the consumer, namely mothers seeking home birth services, is the waiting time (delay) to first see a PPM who will provide the service. The delay cost to consumers are the expenses incurred by an individual due to an approval delay, i.e., the time waited for a first appointment with a PPM multiplied by the number of additional consumers seeking a first appointment.

Table 7 shows the increase in the number of women accessing PPM homebirth services from 2018-2022 - a total of 9,925 homebirths nation-wide²³.

²³ National Health Workforce Dataset 2023

Loss of income incurred through loss of employment

The average based salary for a midwife in Australia is \$42.21 per hour or \$55,093 per year. PPMs typically work 25.1 hours per week²⁵ or 1,305.2 hours per year.

PPM loss of income = (Time required × Labour cost) × (Number of staff)
\$2,589,347 = (1,305.2 hours x \$42.21) x 47

Industry impact

To date, no insurer has indicated a willingness to provide the relevant PII cover for low risk homebirth or intrapartum care outside a hospital under existing Government supports for the Midwife Schemes. Under this option, there would be no regulatory impact on the insurer.

Regulator impact

From a regulator perspective, the status quo is maintained under both options and there is no additional regulatory burden for the regulator.

Business impact

The impact on business is commercial viability of First Nations midwifery services which would otherwise be forced to close. This option will support expansion of their services to provide homebirth and intrapartum (labour) care outside a hospital setting as insured services.

First Nations midwifery services employ approximately 38 midwives, having recently lost midwives due to the uncertainty associated with medical indemnity cover. There is a lack of trend data on the recruitment and retention of PPMs providing BoC services. Any increase in the workforce is based on assumptions, such as additional 8 midwives providing services per year.

	2024-25	2025-26	2026-27	2027-28	Total
Number of midwives	38	46	54	62	
Regulatory cost		+\$500,000	+1,000,000	+\$1,500,000	+\$2,000,000

²⁵ [Midwives Fact Sheet 2017](#)

PPM impact

The primary cost to midwives is administrative. PPMs would be required to spend time learning and complying with the revised NMBA Midwife standards for Practice. Under this reform, it is suggested that PPMs would spend 2 hours per week on additional regulatory administration.

As at September 2023, there were 380 midwives insured with the current insurer under the MPIS and 104 PPMs providing private homebirth in Australia; a total of 484 PPMs.

The average based salary for a midwife in Australia is \$42.21 per hour²⁷.

Eligible midwives will also be required to keep records and provide proof of consulting medical professionals or other health care providers for women with category B conditions.

Assumptions:

- A. Additional administration average 2 hours per week
- B. Average based salary for a midwife in Australia is \$42.21 per hour
- C. Number of midwives in 2023 = 484

Admin cost = (A x B x C) → 2 x \$42.41 x 274 = **\$41,053**.

Industry impact

The primary cost to industry (the insurer) is administrative. The insurer would be required to quantify risks for new services and adjust medical indemnity premiums for midwifery services, and update midwifery policies and IT sys

The insurer has identified additional administrative costs of \$565,000 over 4 years associated with this reform.

	2024-25	2025-26	2026-27	2027-28	Total
Establishment	-\$250,000				-\$250,000
Administration		-\$103,000	-\$105,000	-\$107,000	-\$315,000
					-\$565,000

Regulator impact

The primary cost to the regulator (NMBA/Ahpra) is administrative. The NMBA would be required to spend time updating the NMBA/Ahpra Safety and Quality

²⁷ [Midwife salary in Australia - Indeed](#)

Guidelines to include clinical parameters of low risk homebirth and intrapartum (labour) care outside a hospital setting.

Under this reform, it is suggested the NMBA would spend 37.5 hours per week over a period of 3 months on regulatory administration, which would equate to 450 hours.

This work would be undertaken by 2 staff - APS 6 and Executive Level One with annual salaries of \$114,709 (\$58.83 per hour) and \$142,509 (\$73.08 per hour) respectively (based on the Department of Health and Aged Care Enterprise Agreement 2024-27²⁸), which averages at \$65.96 per hour.

$\text{NMBA administrative cost} = (\text{Time required} \times \text{Labour cost}) \times (\text{Number of staff})$		
$\mathbf{\$59,364} =$	$(450 \text{ hours} \times \$65.96) \times$	2

Business impact

The impact on business is commercial viability of First Nations midwifery services which would otherwise be forced to close. This option will support expansion of their services to provide homebirth and intrapartum (labour) care outside a hospital setting as insured services.

First Nations midwifery services employ approximately 38 midwives, having recently lost midwives due to the uncertainty associated with medical indemnity cover. There is a lack of trend data on the recruitment and retention of PPMs providing BoC services. Any increase in the workforce is based on assumptions, such as additional 8 midwives providing services per year.

	2024-25	2025-26	2026-27	2027-28	Total
Number of midwives	38	46	52	60	
Regulatory cost		+\$500,000	+1,000,000	+\$1,500,000	+\$2,000,000

²⁸ Department of Health and Aged Care Enterprise Agreement 2024-27

Option 3(a)

Consumer impact

Under this option, freedom of choice for women would be limited, particularly the opportunity to choose a model of birthing that meets their needs and to have continuity of care and carer.

There would be no service available at all for women in Queensland and Tasmania, where currently PPMs are the only providers of planned homebirth services.

First Nations women (or women pregnant with a First Nations baby) would not have access to culturally safe, continuous midwifery care with an insured PPM in accord with BoC models of care. This could hamper efforts to achieve Closing the Gap Target 2 to increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91%, by 2031 and Target 12, by 2031, reduce the rate of over-representation of Aboriginal and Torres Strait Islander children in out-of-home care by 45 percent.

The likely increase in demand for public homebirth services could lead to longer waiting lists, potentially restricting access for some women.

Under this option women using a midwife who is uninsured would have no recourse except civil action where an adverse event occurs.

Expected increase in number of women wanting to access PPM homebirth services
2,955 women birthed at home in 2022, up from 2,371 in 2021, an increase of 584 mothers. The regulatory burden this reform imposes on consumers will be based on the additional 584 mothers per year.

Costs of delay in service opportunity

Due to the lack of data around women seeking homebirth services, it is difficult to quantify the regulatory burden incurred. An arbitrary figure of one hour per day over 9 months (40 hours) has been nominated.

The total time impact is converted to a consumer cost per year using a consumer time value of \$37/hr.²⁹ The delay cost per mother is calculated at 40 hours x \$37 = \$1,480.

²⁹ Office of Best Practice Regulation March 2020, [Regulatory Burden Measurement Framework](#).

Regulator impact

The core functions of the NMBA/Ahpra is the regulation of PPM professional standards, registration, notifications, compliance and accreditation in accordance with the 'Safety and quality guidelines for privately practising midwives'³¹.

Under this option, PPMs without PII are at risk of acting outside their registration standards if they choose to provide homebirth services.

Business impact

ACCHOs providing services under BoC models of care have informed the Department that these services would likely cease unless Option 2 was implemented. This could see the loss of 47 midwives currently employed (or contracted to) ACCHOS under BoC models of care.

Loss of income incurred through loss of business opportunity

The cost of recruitment agencies for permanent placements can be significant. On average, businesses can expect to pay between 15-25% of the candidate's annual salary as a placement fee³².

Recruitment agencies providing permanent PPMs for BoC services could charge ACCHOs approximately 15% of a PPM's annual salary for this service. If these businesses are unable to operate, they could incur a loss of \$388,402 per year in lost recruitment fees. A consolidated earning capacity of \$2,589,330 per year, could result in a loss of \$388,402 per year (**15%**) for recruitment agencies.

$\text{Business loss of income} = (\text{Time required} \times \text{Labour cost}) \times (\text{Number of staff})$ $\text{\$388,402} = [(1,305.2 \text{ hours} \times \text{\$42.21}) \times 15\%] \times 47$
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³¹ [NMBA/Ahpra Safety and quality guidelines for privately practising midwives](#)

³² [Pro talent recruitment agencies costs](#)

Appendix 3: Impact on stakeholders

Key impacts on consumers

TABLE 8: SUMMARY OF KEY IMPACTS ON CONSUMERS

Impact	1	2	3(a)	Explanation
Choice	-3	+2	-3	Option 2 would enable women to have more choice in birthing options and midwifery support and give First Nations Women access to culturally safe, continuous midwifery care. Options 1 and 3(a) severely limit choice for First Nations women.
Confidence in birthing support	-2	+2	-2	Option 2 would enable women to have greater confidence in birthing options and midwifery support. Options 1 and 3(a) would give women less confidence due to limited availability of the service and uncertainty if they choose to birth with an uninsured PPM
Compliance	-2	+2	-2	Option 2 is supported by a robust regulatory framework. Options 1 and 3(a) provide a robust regulatory framework within state & territory homebirth programs but women who choose to birth outside these programs and experience an adverse event would have no recourse except civil action.
Total	-7	+6	-7	

Key impacts on PPMs

TABLE 9: SUMMARY OF KEY IMPACTS ON PRIVATELY PRACTISING MIDWIVES

Impact	1	2	3(a)	Explanation
Scope of professional practice	0	+2	-2	Under Option 2 PPMs can work to full scope of their practice and perform as an insured practitioner. Options 1 and 3(a) restrict PPM scope of practice, depending on state and territory regulatory restrictions, option 3(A) would make it be illegal for PPMs to work outside state and territory programs while under Option 1 PPMs can work to the full scope of their practice but with no safety net.
Compliance	-2	+2	-2	Under Options 2 and 3(a) PPMs are supported by a robust regulatory framework. Under Option 3(a), it would be unlawful for a PPM to practice outside of state or territory program, and for both 1 and 3(a) where an adverse event occurs, PPMs could be subject to litigation.
Total	-2	+4	-4	

Key impacts on industry

TABLE 10: SUMMARY OF KEY IMPACTS ON INDUSTRY

Impact		1	2(a)	Explanation
Administrative	0	-1	0	Under Option 2, insurers would need to quantify risks for new services and adjust medical indemnity premiums for midwifery services, and update midwifery policies and IT systems. Options 1 and 3(a)) would maintain the status quo for insurer.
Total	0	-1	0	

Key impacts on regulator

TABLE 11: SUMMARY OF KEY IMPACTS ON REGULATOR

Impact	1	2	3(a)	Explanation
Administrative	-2	-1	-2	Under Option 2, NMBA would be required to update Safety and Quality Guidelines to include clinical parameters of low risk for homebirth. Options 1 and 3(a) would require updates to Guidelines and more stringent monitoring of compliance.
Total	-2	-1	-2	

Key impacts on business

TABLE 12: SUMMARY OF KEY IMPACTS ON BUSINESS

Impact	1	2	3(a)	Explanation
Commercial viability	-3	+2	-3	Under Option 2 ACCHOs will have the ability to employ midwives to provide culturally safe and continuous homebirth services. Under Option 1 and 3(a), ACCHOS will be unable to employ PPMs and midwifery employment agencies may be forced to close.
Total	-3	+2	-3	