Australian College of Midwives

Thursday, 12 January 2012

The Secretary
Senate Community Affairs Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Re: Inquiry into the Personally Controlled Electronic Health Records Bill 2011 and the Personally Controlled Electronic Health Records (Consequential Amendments) Bill 2011

The Australian College of Midwives (ACM) welcomes the opportunity to contribute to the Senate Inquiry into the Personally Controlled Electronic Health Records (PCEHR) Bill and the Personally Controlled Electronic Health Records (Consequential Amendments) Bill 2011. The ACM is the peak midwifery organisation in Australia which exists to provide a unified voice for the midwifery profession and to ensure that all Australian women receive the best possible maternity care.

Midwifery is committed to both woman-held maternity records and the personally controlled electronic health record. This commitment is based on ensuring the protection of the public and on maintaining the highest standards of midwifery care to the Australian community. This includes a commitment to taking the time necessary to ensure that whatever scheme is developed is best practice in terms of the object of the Act.

Personally Controlled Electronic Health Records Bill 2011

1 Object of Act (page 2)

The object of this Act is to enable the establishment and operation of a voluntary national system for the provision of access to health information relating to consumers of healthcare, to:
(a) help overcome the fragmentation of health information; and
(b) improve the availability and quality of health information; and
(c) reduce the occurrence of adverse medical events and the duplication of treatment; and
(d) improve the coordination and quality of healthcare provided to consumers by different healthcare providers.

Recommendation:
The wording of Object (c) should be revised to read 'clinical' incidents rather than medical. This inclusive language should be reflected throughout the Bill.

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Comment:
The object of this Act is supported. However, there are many different clinicians involved in the provision of healthcare. Further, the preferred terminology for adverse events is to use clinical incidents rather than medical.

5 Definitions (page 6)

nominated healthcare provider: *a healthcare provider is the*
nominated healthcare provider *of a consumer if:*
(a) an agreement is in force between the healthcare provider and the consumer that the healthcare provider is the consumer's nominated healthcare provider for the purposes of this Act; and
(b) a healthcare identifier has been assigned to the healthcare provider under paragraph 9(1)(a) of the Healthcare Identifiers Act 2010; and
(c) the healthcare provider is an individual registered by a registration authority as one of the following:

- *(i) a medical practitioner within the meaning of the National Law;*
- *(ii) a registered nurse within the meaning of the National Law;*
- *(iii) an Aboriginal health practitioner, a Torres Strait Islander health practitioner or an Aboriginal and Torres Strait Islander health practitioner within the meaning of the National Law who is included in a class prescribed by the regulations for the purposes of this subparagraph;*
- *(iv) an individual, or an individual included in a class, prescribed by the regulations for the purposes of this subparagraph.*

Recommendation:
That an additional category be assigned in this definition through the addition of 'a midwife within the meaning of the National Law'.

Comment:
The stated objects for the introduction of the Personally Controlled Electronic Health Record (PCEHR) are to improve safety and healthcare through improved access to information for both healthcare providers and consumers.

Maternity care is currently the most fragmented healthcare to be experienced given the multitude of differing healthcare providers across primary, secondary and tertiary care. This fragmentation increases the inherent risk and emphasises the importance of including all maternity care providers as authorised nominated healthcare practitioners under the Act to initiate a shared health summary and participate in the scheme broadly.

Midwives have enduring therapeutic relationships with women as their primary carers for the course of the woman's reproductive life cycle and as such are key maternity care providers and must be included as authorised practitioners in the definitions of the nominated healthcare provider.

This intent is reflected clearly in the National Maternity Services Plan[1], a five year plan endorsed by Australian Health Ministers in November 2010, where mothers and babies are to be given priority for implementation (Actions 4.1.3 and 4.1.4 apply) and where women are provided with increased access to midwives (Actions 1.2.2, 1.2.3, 1.2.4 and 1.2.5 apply).

[1] http://www.health.gov.au/internet/main/publishing nsf/Content/maternityservicesplan

Further, the Australian government introduced rebates under the Medical Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) for women receiving maternity care from eligible midwives.

Not only do the policy directions of the Australian government emphasise the importance of the inclusion of midwives in the PCEHR as health practitioners authorised to initiate a shared health summary but the safety and quality of maternity care for women receiving care from midwives makes it imperative to redress this gross omission.

Division 3—Independent advisory council (page 25)

27 Appointment of members

(1) A member of the independent advisory council is to be appointed by the Minister by written instrument.

Note: The member may be reappointed: see section 33AA of the Acts Interpretation Act 1901.

(2) When appointing members the Minister must ensure that:

(a) at least 3 of the members have significant experience in or knowledge of consumers' receipt of healthcare; and

(b) between them, the members have experience or knowledge of the following matters:

(i) the provision of services as a medical practitioner within the meaning of the National Law;

(ii) the provision of services as a healthcare provider other than a medical practitioner within the meaning of the National Law;

(iii) law and/or privacy;

(iv) health informatics and/or information technology services relating to healthcare;

(v) administration of healthcare;

(vi) healthcare for Aboriginal or Torres Strait Islander people;

(vii) healthcare for people living or working in regional areas.

(3) None of the members referred to in paragraph (2)(a) is to be a healthcare provider.

Membership is part-time

(4) A member of the independent advisory council holds office on a part-time basis.

Term of membership

(5) A member of the independent advisory council holds office for the period specified in the instrument of his or her appointment. The period must not exceed 5 years.

Recommendation:

That the Appointment of Members be amended to reflect the distinctly different services provided by the professions of nursing and midwifery.

Paragraph (2) (b) (ii) should be amended to read 'the provision of services as a registered nurse within the meaning of the National Law'.

Two additional paragraphs should be added 'the provision of services as a midwife within the meaning of the National Law' and 'the provision of services by an Aboriginal health practitioner, a Torres Strait Islander health practitioner or an Aboriginal and Torres Strait Islander health practitioner within the meaning of the National Law who is included in a class prescribed by the regulations for the purposes of this subparagraph'.

Comment:
The PECHR Bill 2011 must be amended to be inclusive of midwives as nominated healthcare providers defined under the Bill and authorised to initiate a shared health summary.

The National Law recognises the distinct differing professional services provided by registered nurses and midwives. One profession is not able to speak for the other on any matters outside their scope of practice for which they have been appropriately prepared and duly recognised within the meaning of the National Law. In addition, the membership of the Independent advisory council must appropriately reflect the clinical groups operating under the Bill.

Personally Controlled Electronic Health Records (Consequential Amendments) Bill 2011

ACM support for this Bill is consequent on the omission of midwives from the Personally Controlled Electronic Health Records Bill 2011 being rectified. This is particularly important for the consequential amendments to the *Health Identifiers Act 2010* as under Section 5, a participant in the PCEHR system has the same meaning as in the Personally Controlled Electronic Health records Act 2011.

This submission from the ACM particularly draws attention to the gross omission of midwives as authorised nominated healthcare practitioners to initiate a shared health summary. Midwives have enduring therapeutic relationships with women as their primary carers for the course of the woman's reproductive life cycle and as such are key maternity care providers and must be included as authorised practitioners in the definitions of the nominated healthcare provider.

It should be noted that both the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and Maternity Coalition, a maternity consumer advocacy organisation, both support this position.

The Senate Community Affairs Committee is asked to redress this gross omission in the interests of safe maternity care and the protection of the public.

Yours sincerely,

Ann Kinnear
Executive Officer

Encl.