



COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

## SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

**Reference: Childbirth procedures**

FRIDAY, 27 AUGUST 1999

CANBERRA

BY AUTHORITY OF THE SENATE

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**SENATE**  
**COMMUNITY AFFAIRS REFERENCES COMMITTEE**  
**Friday, 27 August 1999**

**Members:** Senator Crowley (*Chair*), Senator Knowles (*Deputy Chair*), Senators Bartlett, Evans, Gibbs and Tchen

**Substitute members:**

**Participating members:** Senators Abetz, Brown, Brownhill, Calvert, Chapman, Coonan, Crane, Denman, Eggleston, Faulkner, Ferguson, Ferris, Forshaw, Gibson, Harradine, Lightfoot, Mackay, Mason, McGauran, O'Brien, Parer, Payne, Quirke, Tierney, Watson and West

**Senators in attendance:** Senators Crowley, Gibbs, Knowles and Tchen

**Terms of reference for the inquiry:**

To inquire into and report by 30 December 1999 on childbirth procedures, with particular reference to:

- (a) the range and provision of antenatal care services to ascertain whether interventions can be minimised through the development of best practice in antenatal screening standards;
- (b) the variation in childbirth practices between different hospitals and different States, particularly with respect to the level of interventions such as caesarean birth, episiotomy and epidural anaesthetics;
- (c) the variation in such procedures between public and private patients;
- (d) any variations in clinical outcomes associated with the variation in intervention rates, including perinatal and maternal mortality and morbidity indicators;
- (e) the best practices for safe and effective births being demonstrated in particular locations and models of care and the desirability of more general application;
- (f) early discharge programs, to ensure their appropriateness;
- (g) the adequacy of access, choice, models of care and clinical outcomes for rural and remote Australians, for Aboriginal and Torres Strait Islander women and for women of non-English speaking backgrounds;

- (h) whether best practice guidelines are desirable, and, if so, how they should be developed and implemented;
- (i) the adequacy of information provided to expectant mothers and their families in relation to the choices for safe practice available to them; and
- (j) the impact of the new Medicare rebate provided for complex births, including the use of the term ‘qualified and unqualified neonates’ for funding purposes, and the impact that this has had on improved patient care and reduction of average gap payments.

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**Committee met at 9.02 a.m.**

**DEAN, Dr Margaret Emily, Medical Officer, Department of Health and Aged Care**

**DUNLOP, Ms Marion Helen, Assistant Secretary, Health Strategies and Research Branch, Department of Health and Aged Care**

**MASKELL-KNIGHT, Mr Charles Andrew, Acting First Assistant Secretary, Health Access and Financing Division, Department of Health and Aged Care**

**NICHOL, Dr Bill, Assistant Director, Diagnosis Related Groups Development Section, Acute and Coordinated Care Branch, Health Services Division, Commonwealth Department of Health and Aged Care**

**WELLS, Mr Robert William, First Assistant Secretary, Office of National Health and Medical Research Council, Department of Health and Aged Care**

**LANCASTER, Associate Professor Paul Angus Llewellyn, Director, National Perinatal Statistics Unit, Australian Institute of Health and Welfare**

**CHAIR**—I declare open this inquiry by the Senate Community Affairs References Committee into childbirth procedures. I welcome officers from the Department of Health and Aged Care and from the Australian Institute of Health and Welfare National Perinatal Statistics Unit.

The committee prefers all evidence to be given in public, but should you at any time wish to give your evidence, part of your evidence or answers to specific questions in camera, you may ask to do so and the committee will give consideration to that request. We also point out to the department in particular that you are not required to answer questions on the advice you may have given in the formulation of policy or to express a personal opinion.

I have never presumed to say to witnesses—and I understand you are provided in writing with words that tell you this—that the evidence you give is protected by parliamentary privilege and that if you should give false or misleading evidence to the committee it may constitute a contempt of the Senate. I actually feel like I have to apologise for telling you that. We will see if we can write it in a more positive way. I am not presuming all witnesses arrive here with contempt in their minds. However, I am glad that we now are all clear about that.

What I would like to do is ask representatives of the department and then of the institute to make some opening statements, and then we will field questions.

**Mr Maskell-Knight**—I think it is a reflection of the breadth of the topic that you have before you here representatives of all the health divisions of the Department of Health and Aged Care. There are not many topics that bring us all together from these different areas.

Having a baby in Australia by any standards is a safe event. Maternal deaths are rare. Maternal and perinatal mortality compares favourably with other developed nations.

However, indigenous Australian women, women of culturally and linguistically diverse backgrounds, adolescent women, those living in rural and remote locations and those of low socioeconomic status are more likely to experience poorer outcomes than the community generally.

While Australia has a high rate of obstetric intervention, the association between the high rate of interventions and the excellent pregnancy outcomes is not clear and may be a source of dissatisfaction for some women and health professionals. The reasons for the high intervention rates are complex. Some of the explanations offered are based on informed opinion and are difficult to subject to the rigours of carefully controlled clinical trials. Some of the factors that have been identified include the increased age at which Australian women are having their first children, women's choice, practice of specialist obstetricians who supervise delivery and fear of litigation.

Many of the issues to be addressed by the inquiry are matters relating to medical and midwifery practices which are regulated by state and territory health authorities. The Commonwealth, through the funding of birthing services that are least likely to result in interventions and by encouraging health professionals to involve women in decision making about their care, plays a role in providing women with more choice in maternity services without compromising safety. Government funding of studies into the effectiveness of obstetric interventions, supporting the development of best practice guidelines by the NHMRC and the cosponsorship of the Australasian Cochrane Centre will further increase knowledge and improve the basis for decision making.

I will now briefly summarise the key points of the submission in relation to each of the terms of reference. In relation to term of reference (a) about the range and provision of antenatal services, the range of antenatal services available in Australia is extensive and Australian women have generally enjoyed access to a high standard of antenatal care. However, public patients are less likely to have the same continuity of care as others. Antenatal clinics do not generally offer continuity of care. Many may have long waiting times and many women receive different advice from various care providers.

Antenatal screening is frequently performed to assist the status of the foetus. A number of bodies, including the Australian Association of Paediatric Teaching Hospitals, have expressed the view that established routine antenatal screening and an array of newly introduced screening procedures should be examined for evidence that they do result in improved outcomes, that the benefits of detection outweigh the possible adverse effects of intra-uterine diagnosis and the burgeoning cost can be justified in relation to other health priorities. It is likely that this task will be addressed by the NHMRC.

In relation to term of reference (b), the variation in childbirth practices between different hospitals and different states, data on variations between different states is most readily available for caesarean section rates, which is included in the published data from the AIHW perinatal data set published in 1996. Data by state on other interventions is available through the national hospital morbidity database, or the casemix data set, which allows analysis of recent intervention factors by hospital type, insurance status and other demographic data. Although this data will be used in the Commonwealth's submission, it has not yet been subjected to the extensive analysis that has been applied to the data from the institute.

Although this data will be used in the Commonwealth's submission, it has not yet been subjected to the extensive analysis that has been applied to the data from the institute. There has been a gradual rise in caesarean section rates over the years and Australia now has one of the highest rates in the world. In 1997-98, the national rate was 21 per cent of all births. South Australia, at 23 per cent, had the highest rate, and New South Wales, at 18.6 per cent, the lowest.

The rise in the caesarean section rate has been accompanied by a significant decrease in forceps delivery, from 14.9 per cent in 1985 to 7.4 per cent in 1996. Breech vaginal deliveries have not increased over the years, indicating that health professionals, and possibly informed women, have not opted for trial of breech delivery over caesarean section. Maternal age, private status in hospital and previous caesarean section births were independently associated with higher rates of caesarean section in the study in 1996. Indigenous Australian mothers generally experience less interventions at birth than non-indigenous Australian mothers, although they have a consistently higher caesarean section rate at all ages than non-indigenous Australians. Rates for induction of labour, epidural anaesthesia and episiotomy also vary substantially between states.

On term of reference (c), the variation in procedures between public and private patients, the proportion of mothers who elect private status on admission to hospital has declined in line with the fall in the private health insurance participation rate and does not vary greatly from state to state. For example, in New South Wales the percentage of deliveries with private accommodation status fell from 38 per cent to 28 per cent between 1993-94 and 1997-98. Private accommodation status is more common in women who have their first baby over the age of 35.

Caesarean section rates differ significantly between patients with public and private admission status. This cannot be entirely explained by the fact that older mothers who are more likely to have an operative intervention are also the most likely to have private health insurance. In 1997-98, 18 per cent of public patient admissions were delivered by caesarean section against 27 per cent for women with private status. It is perhaps worth noting that states with a higher caesarean section rate overall tend to have high rates of both public and private.

Episiotomy and epidural rates also varied markedly by accommodation status. A woman who elects private status on admission is almost twice as likely to receive either intervention as a woman with public status. The higher rate of interventions during childbirth for women with private health insurance cannot readily be explained.

I now turn to term of reference (d), variations in clinical outcomes associated with variations in intervention. Inevitably, high risk pregnancies associated with possible perinatal and maternal mortality will, because of their risk factors, be associated with a higher degree of intervention. The intervention is appropriate and likely to improve the outcome. Of more importance is the lack of evidence that a number of interventions actually improve perinatal and maternal outcomes. The NHMRC 1996 publication, *Options for effective care in childbirth*, highlights the need to obtain this evidence and communicate it. Recommendation 15 from that report, made under 'Research requirements', states that funds should be available for evaluation and research into recent initiatives and new strategies for care in

childbirth and that these funds should be used to evaluate, by randomised control trials and other forms of research, new options for care in childbirth to assist the effectiveness of these options.

Since the publication of the NHMRC report a number of studies that assess the value of a number of obstetric interventions have been funded and completed and the results of some of those are referred to in the Commonwealth's submission.

Turning to term of reference (e) about best practices for safe and effective childbirth, the NHMRC report, *Options for effective care in childbirth*, provides an overview of current practices and issues in childbirth care in Australia, patterns of intervention in labour and the puerperium and current knowledge about clinical and social outcomes.

Term of reference (e) relating to early discharge programs, planned early discharge from hospital—that is, a decision made by the woman in consultation with health care providers before the birth of the child, based on the availability of support outside the hospital and the experience of the mother, on her length of stay in hospital and the arrangements for follow-up—has been accepted as an important advance for maternity services.

The postnatal stay is an important time for the establishment of breastfeeding, a recognition of women at risk for postnatal depression and the organisation of intensive home support for those women with ongoing problems such as perineal lacerations or episiotomy or special challenges such as twins or low birth weight babies. Women should not be discharged with unresolved problems unless intensive support is arranged.

While it is possible that in some cases women may be discharged from a hospital as a cost-saving or cost-shifting measure rather than on a basis of a decision made about optimal health and wellbeing, it may be that argument over the optimal length of stay after childbirth is not particularly productive. More attention might usefully be focused on the needs of individual women following childbirth, with particular focus on the establishment of breastfeeding and the follow-up of women experiencing operative delivery. Whether this is achieved by a longer postnatal stay or attention to intensive support systems following discharge may not be important.

For Aboriginal and Torres Strait Islander women, supporting good nutrition in pregnancy, breastfeeding and good food choices for infants is critical. All the evidence supports the premise that the early months and years of life set the scene for health and wellbeing throughout life. Work within the Department of Family and Community Services relates to improving support for young families through programs like Good Beginnings. The work is also being undertaken by the Office of Aboriginal and Torres Strait Islander Health with Aboriginal and Torres Strait Islander families. The Prime Minister's recent announcement on initiatives for families adds further support for this approach.

In relation to the term of reference (g) relating to adequacy of access, choice and models of care, while there were generally high levels of access and choice of models of care, there are particular difficulties for the groups identified in the terms of reference; that is, for rural and remote Australians, Aboriginal and Torres Strait Islander women and women of non-

English-speaking background. The Commonwealth has introduced a range of programs detailed in the submission to address the particular needs of these groups.

Term of reference (h) addresses whether best practice guidelines are desirable. The primary purpose of clinical guidelines is to arrange knowledge in a way that is accessible, logical and based on the best available evidence. A secondary, but important, possible outcome is reduction in interpractioner variance in clinical decisions. However, the development of clinical practice guidelines is hampered by the paucity of evidence in many clinical areas. The departmental submission concludes that clinical practice guidelines are a useful way of collating evidence into a form that assists clinical decision making. Guidelines development should be subject to the same rigour that is applied to the evidence they relate to. Guidelines may require local adaptation and the interpretation of a guideline in relation to an individual patient must be made by the treating clinician.

Locally or regionally developed guidelines become more important in the rural and remote context. A good example of regionally developed guidelines is the manual of the Central Australian Rural Practitioners Association which includes a section specifically dealing with labour and delivery.

The Office of Aboriginal and Torres Strait Islander Health is undertaking work in association with the Research Agenda Working Group of the NHMRC on strategies to support primary health care providers to develop regional or local guidelines based on systematic reviews and other available evidence. The NHMRC has also developed clinical practice guidelines in relation to care around pre-term delivery, and these are attached.

Term of reference (i) refers to the adequacy of information provided to expectant mothers. Access to adequate and appropriate information is undoubtedly one of the key factors contributing to women's satisfaction with their care. Individual communication and access to information are key concerns for women faced with a variety of options. Informed decision making requires the existence of reliable information, particularly in relation to the possible consequences for them of the choices that women may make.

It is clear that information on birth and pregnancy has been the subject of a major effort by service deliverers over many years. Undoubtedly, also, there have been multiple associated evaluations of the usefulness and adequacy of this information. This is likely to be localised and specific and it is unlikely that any generalised national information could be drawn from this. The Commonwealth is therefore unable to comment directly on the adequacy of the information that is provided to expectant mothers.

Term of reference (j) addresses the impact of the new Medicare rebate and the use of the term 'qualified and unqualified neonates'. There is now eight months of information since the introduction of the item for complex delivery. As there is a lag in the take-up of the item, it is not possible to say with any certainty what the impact will be in the medium term. However, since its introduction, almost 43 per cent of services under the new item have been billed at or below the scheduled fee, as against 29.5 per cent of services under the pre-existing item.

Patients receiving services under the new item have benefited by a total \$3.6 million compared to the benefits they would have received under the old item. Over a full year the benefit is estimated to be \$6.7 million. Assuming all the patients have private health insurance, the combined Medicare and fund benefit will amount to about \$9 million. It is worth noting that the Medicare data captured by the Health Insurance Commission for patients obtaining a 'pay doctor' cheque reflects the initial fee charged by the obstetrician. In many cases, doctors will accept a lesser payment if the account is paid within a set period. This makes it hard to reach definitive conclusions about what the level of gap actually is.

The department understands that the National Australian Society of Obstetricians and Gynaecologists has conducted a survey of members to show that patients have received most of the benefit from the higher benefits paid under the new item. We understand the society has made a submission to this inquiry. As far as the distinction between qualified and unqualified neonates is concerned, this did not change on introduction of the new item. Thank you.

**CHAIR**—Professor Lancaster, would you care to make an opening comment at this time?

**Prof. Lancaster**—We appreciate the opportunity to participate in today's proceedings. In our submission, we have given a brief summary of available population data on childbirth in Australia, with particular emphasis on caesarean section and also early discharge from hospital after childbirth. The primary data sources on which this information is based are what is called the perinatal data collection forms and, increasingly in recent years, direct computer entry by midwives. These forms, or the computer entry, are completed for all births in Australia. The information that is recorded includes the demographic characteristics of the mothers, history of their previous pregnancies, whether or not they have had complications in the current pregnancy, information about the type of birth, duration of hospitalisation and also a brief summary on any morbidity or health problems that the mothers or the babies have in the immediate postpartum period.

**CHAIR**—Might I interrupt with one small question here? I do not want to interrupt on the way through. You said the computer entry is by midwives?

**Prof. Lancaster**—Yes.

**CHAIR**—Does this include all the matrons, ward assistants and nurses doing the delivery?

**Prof. Lancaster**—It varies in different hospital settings. Some hospitals for decades have been recording this information in computer systems, hopefully so that it is also consistent with the data collected across the state or territory. In recent years there has certainly been a move to increase the use of personal computers to enter the data within the hospital.

**CHAIR**—I am appreciating that. My concern is: who puts in the data? You have called them midwives. The data is entered by 'midwives'. In that sentence, what does 'midwives' mean?

**Prof. Lancaster**—Within hospitals there may be different groups responsible for the different stages of care. In the labour ward it may be midwives; after the discharge of mother and baby from the hospital it may be the hospital record staff or, indeed, sometimes obstetricians and paediatricians.

**CHAIR**—That's okay. So there is data entered into the computer about the birth process and it contains all that information. It is done by possibly a number of different people who have been associated with that particular patient in hospital. Is that correct?

**Prof. Lancaster**—Certainly, but the main responsibility for these collections has been the midwives, they have had the major responsibility.

The data then are sent from the hospitals of birth, or indeed from home births. The forms are also completed. They go to the state and territory health departments. The states and territories put out their own annual reports based on this data and we in the national Perinatal Statistics Unit receive annual electronic transfer of data from the states and territories.

As well as this perinatal collection there are other major data systems that provide information about childbirth. The Australian Bureau of Statistics publishes annual data on perinatal deaths based on deaths registrations. There is also information on live births from the births registration system where the parents are responsible for completing the information. That does not have the same depth of information about their clinical history as the hospital based records.

The NHMRC has published triennial reports on maternal deaths, although our unit is taking over that responsibility from now on. As well as that, there is additional data that comes from the hospital morbidity data system where records are completed by hospital staff following discharge of patients from hospital.

In our submission we have given brief information about induction of labour, epidural anaesthesia and episiotomy. There is more detailed data on caesarean births to illustrate the patterns of what I think everybody regards as a much more significant intervention in childbirth. And to reiterate some of the comments from my colleague from the department, Australia does have a high caesarean rate compared to many other countries with comparable standards of health care in the world. In 1996, 19.5 per cent, or one in five mothers, had their baby by caesarean section and, as the more recent figures indicate, it has now actually gone above 20 per cent.

This increasing trend has been apparent over a period of more than three decades. As has been noted, caesareans increase with maternal age. There is a higher rate for first birth. We know that there are higher rates for women who are admitted to hospital as private patients compared to those who are admitted as public patients. If we look at indigenous mothers, they are usually admitted as hospital patients and when you compare that category of hospital patients with non-indigenous mothers in all age groups, the caesarean rates are slightly higher in the indigenous population.

There are also variations that we mentioned in our submission by the mothers' country of birth. Filipino mothers, for example, have the highest caesarean rate, whereas Lebanese and Vietnamese born mothers living in Australia have the lowest caesarean rates by country of birth.

When we look at regional comparisons within Australia, South Australia has consistently had the highest caesarean rates in the 1990s, and in earlier periods as well. There are also considerable variations by the size of maternity units. In general, there is a low caesarean rate in the very small hospitals where there are fewer than 100 births a year. In all other categories they have similar caesarean rates across the board. But when we look at individual hospitals—for example, hospitals with more than 2,000 births a year, in other words, big maternity units—the caesarean rates range from about 10 per cent to more than 30 per cent. So there is a lot of variation there.

We do not have current information on practitioner variations in caesarean rates. Unfortunately, the item on caesarean section was taken out of the medical benefits schedule in the late 1980s. I was chair of an NHMRC working party in the mid-1980s on variations in caesarean section rates and we actually had access to health insurance data for individual practitioners. And, irrespective of the size of the obstetrician's practice, there were rather large variations in individual caesarean rates, a sixfold variation, say, from six per cent to 35 per cent or 40 per cent.

If I could move briefly to mothers' length of stay in hospital, again, we are seeing a trend towards shorter stays. This really reflects what is happening in hospitalisation for many other reasons that people are hospitalised for in Australia. During the 1990s, the proportion of mothers staying less than four days has doubled from 20 per cent to 40 per cent. Shorter hospital stays are associated with a mother being younger and with uncomplicated births. They are shorter for public patients than for those who are admitted as private patients, and indigenous mothers generally have shorter stays in hospital as well.

As my colleagues from the Department of Health and Aged Care have mentioned, clearly there have been very major changes in models of care available to pregnant women in Australia in recent years. Women now have, fortunately, more choice and options about how they are cared for during pregnancy and for the birth itself, and then postnatally. But, as we have just said, they are also more likely to be discharged earlier after childbirth.

While there have been some studies that have addressed these issues, we generally lack adequate evidence about the effect of what I would say are large uncontrolled experiments in health care. Particularly with early discharge, this is affecting not just a few mothers, it is affecting tens of thousands of mothers across Australia. It is not clear whether these trends in health care are actually beneficial for the women and their families, or whether there may be some adverse effects from these policies, the different models available for antenatal care, and also particularly for the early discharge after hospitalisation for childbirth.

The population data give us a general perspective, but they need to be complemented, I think, by specific studies that focus on some of these particular issues that are of concern. I am sure they will be raised by other people or other groups during hearings of this committee.

For those of us responsible for the perinatal data collections, we need to improve the quality of data on the models of care at present. I am told that in Victoria there are up to 18 different models of antenatal care in that state, but we do not have good information about these varying models of care in the perinatal collections. So we need to improve the quality of data in those collections.

I think we also could analyse in a lot more depth the patterns of health services available to mainly insured women through the Medicare data because we have an opportunity there to look at the patterns of care by individual practitioner, for specialists, and for general practitioners, and to compare regions and hospitals in a lot more depth than has been done to date. I would just like to reiterate the point that I would like very much to see a specific item on caesarean section go into the Medicare benefits schedule.

As well as that, we need surveys of pregnant women and women who have recently given birth, and we need clinical studies to evaluate the caesarean sections and why they are performed. We also need to evaluate in more depth the outcomes for both the mothers and their babies after early discharge. Some studies have been done to look at whether these mothers are more or less likely to have postnatal depression and whether they perceive the experience of early discharge as being beneficial or otherwise. These studies are very patchy across Australia, and I do not think we can readily generalise from one community whether there are adequate support services for postnatal care in other areas of Australia.

Finally, I think we need also to conduct the types of surveys that have been done in several states—notably in Victoria—in conjunction with reviews of maternity services. I should not single out just Victoria. They have done several of these surveys but, in the last decade or so, surveys have also been done in Western Australia and in New South Wales. I will conclude my comments at this stage. Thank you, Madam Chair.

**CHAIR**—Would any other witness at the table like to make a comment at this time, or shall we go to questions? I would like to ask a couple of questions to start with because I would like to be a bit clearer about it. I thank you all for what you have told me, but I am a little overwhelmed as to where the data comes from. I just wonder whether I could have it for a simple person—grade 1, I am. What data does the department get? List it all for me.

**Mr Maskell-Knight**—I might make a general comment but Bill Nichol will be able to provide more detail. Under the Medicare agreements and the health care agreements, the Commonwealth receives what is known as the state hospital morbidity data set, which is a data set on every hospital separation both public and private. Sorry, I should not use the word ‘separation’, Senator—you chastised me last Senate estimates for using that word—I should say for every hospital episode, both public and private. It includes a range of information about the primary and secondary diagnoses, about procedures that are undertaken during the episode and about the age, gender and insurance status of the person. I do not know whether Bill would like to elaborate on that.

**CHAIR**—Is it given to you in terms of public hospital A in the downtown heart of Adelaide? Can you tell whether it is that hospital, can you tell how many people went into maternity and can you tell who the practitioners were?

**Mr Maskell-Knight**—We cannot tell who the practitioners were, Senator, no.

**CHAIR**—But can you tell me on a hospital by hospital basis how many people went in and how many came out, and in what state their separation was?

**Mr Maskell-Knight**—For certain states we receive data that would allow us to identify individual hospitals, but different states are more forthcoming when it comes to identifying individual hospitals. Generally, most states are willing to identify public hospitals, but very few would identify private hospitals because of their own confidentiality arrangements with the hospitals in question. However, the Commonwealth does maintain two national hospital morbidity databases. One is held by the department—as pointed out by Charles—and we refer to that as the ‘National Hospital Morbidity (Casemix) Database’. The other national hospital morbidity database is that held by the Australian Institute of Health and Welfare. Both databases consist of unit record data—as Charles pointed out—covering both public hospitals and private hospitals. The institute and the department use the same specifications—

**CHAIR**—Stop now, Mr Maskell-Knight. Already I am out of grade 1; I am floundering in grade 6. I now have two databases that do and do not. Can I just get a list. First of all, you are telling me that there is a state hospitals database under the Medicare agreements that provides data of all sorts from all the hospitals in the state. Have I got that right?

**Mr Maskell-Knight**—Yes, Senator. They provide it to us, and they provide the same data to the institute.

**CHAIR**—So you have the same data going in two directions?

**Prof. Lancaster**—No, there are several sets of data that are held by the institute.

**CHAIR**—I do appreciate that, and you actually wrote them down, so I can tick off on them. I have not quite got such a clear ticking list from the department. Dr Nichols went on to say that the state hospitals data can give you a ball by ball description of the public hospitals, including how many public hospitals are listed there and their names and addresses, but not for the private hospitals. Is that true across the country?

**Dr Nichol**—We receive details of individual public hospitals from certain states, namely the ACT, New South Wales, Tasmania and the Northern Territory, but for no other state. The other states will give us identification numbers, but not the names that go with the numbers.

**CHAIR**—What is an identification number?

**Dr Nichol**—It could be any number. If we do find problems with data, it is basically to allow us to identify an individual record, an individual hospital, so that if, for example, the data is showing that men are having babies, we can get back to the states and say, ‘These particular records appear to be problematic’, and it allows them to—

**CHAIR**—Is that the sort of level of difficulty you have, Dr Nichol, before you contact the states?

**Dr Nichol**—Not normally, but records can be flawed.

**CHAIR**—I am chuffed to hear it. We can spend a lot of time going around this, but I have to tell you that I am not leaving this inquiry until I am satisfied, and I am feeling particularly dissatisfied at the moment. I do not want a brawl, and I would certainly like you to know that. But I am aware that it is extremely difficult for a person like me to know exactly what data you are working on.

I have a particular interest in my own state of South Australia because we have got the guernsey. More caesarean sections are done in South Australia than anywhere else, and that is a big worry. I do not know what it is about the women in South Australia, although lots of people ascribe things to the water. Are you telling me that, on the data that is provided to you, I cannot actually break down the difference between the caesarean section rate at the Queen Elizabeth Hospital as compared with the Women's and Children's Hospital?

**Mr Maskell-Knight**—That may very well be so. I should point out that the reason we are provided with this data under the Medicare agreements is to assist in casemix development purposes and, for casemix development purposes, the identity of the hospital providing the service does not matter. So, while some states, out of the goodness of their hearts, have provided us with the names of the hospitals concerned, there was absolutely no need for them to do so for the purpose for which the data was given.

**CHAIR**—I might well appreciate that. I may well agree that, if you are trying to get the going rate for an appendicectomy across the nation, it does not matter much what the name of the hospital is. But, if one of those hospitals was actually doing three times as many appendicectomies as anybody else, it is a different kind of question—but terribly interesting—from the question we are supposed to be talking about here, and then I think it does matter. Is there any way in which the department can tell me which public hospital in South Australia has the highest number of caesarean sections?

**Mr Maskell-Knight**—No, Senator.

**Dr Nichol**—Could I qualify that?

**Mr Maskell-Knight**—Generally speaking, no.

**Dr Nichol**—We could not, except by contacting the Australian Institute of Health and Welfare. As I said, there are two national databases. While all states do not supply the department with identifying details of individual hospitals, they do supply that data to the institute in order that the morbidity data may be matched with the establishment data and in order that epidemiological studies and other research may be conducted.

**CHAIR**—Where does the department get its data from? I appreciate that you do have some, but I appreciate that the AIHW is presumably entirely available—before analysis, or only after analysis to the department?

**Prof. Lancaster**—These are actually different data sets. The hospital morbidity discharge data is obtained in the way that has been outlined by the department. The data in the so-called perinatal collections, or midwives collections, come in a completely different way.

Under the terms of the national health information agreement, to which the states and territories, the Commonwealth, the Australian Bureau of Statistics and the Australian Institute of Health and Welfare are all signatories, the states provide the perinatal data directly to our unit. It differs from the hospital morbidity data that has previously been discussed in that there is information about both the mother and the baby on the same record that is completed by the midwives, as we have already discussed.

**CHAIR**—Does it also name hospitals?

**Prof. Lancaster**—It does not name hospitals. It has a code for hospitals, but one state does not provide us with the code numbers for individual hospitals because of concerns about privacy.

**CHAIR**—Which state?

**Prof. Lancaster**—Your state of South Australia, Senator. Another state, New South Wales, actually publishes in its annual reports the outcomes, including caesarean sections, not only for regions within the state but also for individual hospitals. On the other hand, I think we have to be very careful about doing that because, as has been indicated and as I am sure you well know, there are so many complex factors contributing to variations in caesarean rates that if you are going to make those direct comparisons between hospitals you certainly have to take account of the differences in maternal age and parity and health insurance status as several key variables.

**CHAIR**—I think that is absolutely right and I think one of the things that the community is screaming for is that kind of understanding. It may well be that some newspaper will publish an article of shock and horror about more caesarean sections in the Outer Hebrides than this world could dream of, but the majority of women approaching motherhood have a very good idea of the range of complications. It has taken about 1,000 years for doctors to actually treat them seriously and give them that information. We could be less rude and say that the last 100 years have seen extremely significant increases in the amount of data that is provided to mother and/or to mother and father—in fact, to the point where both your submissions illustrate that one of the critical factors in the variations of outcome might indeed be the decisions made by the parent or the parents.

That is to go a little sideways, but I do think most citizens in this country cope with factual information much better than they cope with myth and legend and obfuscation. I am not sure that I want to blame the citizenry yet, but I am appreciative of your comments.

I am still trying to pursue this data. I might have to ask you to make a list and take it on notice for me, but I think it is better if we talk it through here for a little longer because, if I am confused, I am now of the view that there might be one or two other people who are confused too. So, for South Australia, neither you nor the department would necessarily know which hospital was doing what?

**Mr Maskell-Knight**—I understood Dr Nichol to say that, in the hospital morbidity data set the institute holds, the identification numbers of the hospitals are given and also data about hospitals as establishments is given. So they may well be in a position to link up the two of them. But I suspect that Professor Lancaster is not the person to ask that question of.

**CHAIR**—I see. So there is another group of people called the morbidity keepers. What is the name of this one again, exactly?

**Mr Maskell-Knight**—I do not know what the name of the data set in the Institute of Health and Welfare is—Bill may know—but the Institute of Health and Welfare in Canberra essentially obtains the same data from the states as we do and subject it to the same editing process of weeding out men having children and all that stuff. They are also in the fortunate position of having hospital establishment data provided from the states. So they can link up the two of them and may very well be in a position to tell you what the differences are between hospitals.

**CHAIR**—We have some difficulty too. One of the good things about having an inquiry like this is that all sorts of curious information arrives for the secretariat under the heading ‘please keep this confidential’. Maybe I should ring the AIHW and ask, ‘Is this the data that you have been getting too?’ I find it a bit sad that people are still feeling as though something terrible will happen to them if they make public data that is well known about the practices in a certain hospital. So we have the AIHW and the department. Can I just get further clarification about the casemix data: how far along is this; are you actually getting casemix data from every hospital?

**Mr Maskell-Knight**—Bill can answer more about that. In general, in the first few years of the collection it was incomplete. I understand that in the first years, 1991-92 and 1992-93, we did not necessarily get every private hospital in some states. But I believe it is a very comprehensive collection now. Dr Nichol might like to confirm that.

**Dr Nichol**—Yes. It covers the entire public sector and the private sector, including freestanding day private hospital facilities. The only hospitals not included in the collection are the one private hospital in the Northern Territory and a few freestanding day facilities in Canberra.

**CHAIR**—Can you identify that data from hospital to hospital—public to private patient?

**Dr Nichol**—We can identify for both the public sector and the private sector the patient’s accommodation status. So it is possible to identify, for example, eligible private patients in public hospitals and eligible public patients in private hospitals.

**CHAIR**—You said that the state hospitals data had all the public hospital data as identifiable but not the private hospital data. Did I get that right?

**Mr Maskell-Knight**—In some cases we know the name and address of the hospital. In other cases we know that all the data relate to a hospital, but we do not know which one. So we can go through the data and say that hospital 9953 has this number of patients and these

characteristics and that all the patients have been treated in the same place, but we do not know the name and address of the hospital.

**CHAIR**—Can you find it out?

**Mr Maskell-Knight**—We would have to go back to the states and ask them. I suspect the reason they have not provided that information to us is that in some cases they do not want us to receive it because their own state legislation does not allow them to provide information that might identify individuals—and not only individuals but also individual businesses.

**CHAIR**—Are you suggesting that some of this might be protected under what is called commercial-in-confidence?

**Mr Maskell-Knight**—I am suggesting it might be protected by privacy laws.

**CHAIR**—State privacy laws might be denying the Commonwealth access to reasonable data?

**Mr Maskell-Knight**—We approached the states to ask them to provide data under the Medicare agreements for casemix development purposes, and for the purposes for which the data is provided it is perfectly adequate. We did not have an agreement with the states to provide us with data for research into other things, particularly into differences between hospitals in different areas. Had we done so then they would have had to consider that requirement in the light of their privacy laws.

**CHAIR**—If the institute are able to conclude different things about the source of the data, are they able to provide that to you without contravening the agreements?

**Mr Maskell-Knight**—I do not know the answer to that.

**CHAIR**—I might have to ask you if you can provide us with that.

**Mr Maskell-Knight**—Whether we can get access to known hospital data?

**CHAIR**—I do not mean that you are going behind the states' backs at all. But, over and over again, the challenge we have is that health is paid for by the Commonwealth in large part and provided by the states, who, under a different source of money, sometimes put in what is called their own state money, but that citizens often find it extremely difficult to get access to decent, reliable information about this institution or that institution. I am interested to know a million things, but one thing I am very concerned that this committee finds out, or is provided with, is information that makes it clear to us what data is available to the Commonwealth and what data is then available to the citizens without the citizens having to sneak round or put in submissions about confidentiality.

I find it quite interesting, too, because we have two themes in this area. On the one hand, there are those people who would like to see any necessary intervention done to make sure that a couple are delivered safely of an alive baby, so they will say there should be

intervention to do what is necessary. There is another group of people who say that we need less intervention because the outcomes are clearly better if there is less intervention. That is one of the essential questions we have to look at—and to do that we need good data.

I need to tell you that some people are telling me that in hospital X, which is under threat of closure, the caesarean rate is half that of a hospital up the road. I want to know whether I can deal with this data through you, on the public record, or whether I am going to have to do something else to deal with it. I think it is a very important question for this committee to deal with. I would like to ask you, therefore, how the Commonwealth satisfies itself that the dollars it is spending under the Medicare agreements are actually being spent in a way that satisfies the federal government's policies on health?

**Mr Maskell-Knight**—The federal government's policy on hospitals is that the eligible person should be able to receive free public hospital services. We pay the states about half the cost of running public hospitals; they put in the other half. There is no doubt in our minds that every dollar we put in is spent on public hospitals and that it is indeed matched by roughly an equivalent dollar from state own source revenue.

In terms of providing access to free public hospital services, we receive data from the states about the length of time people wait to receive urgent, semi-urgent and non-urgent elective surgery, and we receive data from the states about waiting times for accident and emergency treatment in different categories. I think it fair to say that were states to start charging fees for hospital treatment to patients who wanted to be treated publicly, we would find out very quickly about that as well, and we have not done so far. So I suspect that, from the point of view of the main objective of the policy, which is to ensure free public hospital services for eligible persons, we can be fairly well assured that that is, in fact, what is going on.

**CHAIR**—That is a very useful comment, thank you. I would now like you to layer on top of that the evidence provided today by yourself, but also by Professor Lancaster, that says that a lot of the things that are going down as hospital practice are like—as you called them—large uncontrolled experiments. And to what extent does the federal government, in spending its dollars, concern itself about the quality of the health practice within those institutions? I know you are doing a lot of fantastic work about casemix, and I appreciate a lot of that. But if it came to your attention that there was something going on in some area of health service delivery in hospitals that was causing major concern in the community, when would this become a matter of concern? When do the dollars you spend on hospitals get you concerned in the actual practice of what is going on in those hospitals in terms of quality of the service delivered?

**Mr Maskell-Knight**—There is a whole range of issues around quality. The Commonwealth is clearly concerned about the quality of the services that we help fund and we are taking various steps to try to improve that. In terms of the specific, I guess it is a hypothetical question: what would we do if we found out that hospital X was doing things that are clearly detrimental to best practice?

**CHAIR**—As in South Australia a few years ago having twice as many tonsillectomies as anywhere else in the country, for example. One could presume that not every child in South

Australia was desperately worse off in terms of health care. Is it a matter of concern when something like that emerges?

**Mr Maskell-Knight**—I suppose it is a matter of concern at a very high level. In terms of what the Commonwealth can do about it, it is very difficult. One has to presume that clinicians are making those judgments in relation to the individual circumstances of the cases in front of them.

**CHAIR**—How long do you go on presuming that?

**Mr Maskell-Knight**—In the case of tonsillectomies in South Australia, it may well be that there are factors about the South Australian climate and environment that make it more appropriate for tonsillectomies to be carried out there.

**CHAIR**—I can see you are a man of controlled curiosity, not at all like me. I would like to find out why it was that tonsillectomies were so different in South Australia. I would like to also point out that, as far as I know from any recent data, that phase has passed. But I am interested in what the department does. Do you actually look to the NHMRC, for example, to discuss things like best practice? Is that how you interface with the professional decisions? I do appreciate this is a tough area we are talking about here, but it is presumably a concern to you that lots and lots of precious dollars are being spent on what the citizens might say are curious differences in practice across the nation. How does the department get interested in this, or aren't you?

**Mr Maskell-Knight**—I find it hard to distinguish my natural curiosity from my official curiosity.

**CHAIR**—You could take that on notice.

**Mr Maskell-Knight**—It is certainly true that we look to the NHMRC to conduct research as to what is effective and what is not, and to disseminate that information across the profession, and that we expect that in the fullness of time the profession will take notice of the research that has been carried out.

**CHAIR**—If I was a mother about to have a baby, the fullness of time would be a big worry—I could not wait; I would like to know that the fullness of time meant that my baby was going to be delivered in three months time in the best kind of way. What does fullness of time mean—how many months?

**Mr Maskell-Knight**—In terms of your child being delivered in the best possible way, the evidence says that we have outstanding results. One can quibble about what the process that leads to them is, but, at the end of the day, we have an excellent maternal death rate and an excellent perinatal one.

**CHAIR**—This is absolutely true, though I appreciate the differences between subgroups within the Australian motherhood range, particularly Aboriginal people. I presume the federal department is concerned about how those dollars are best spent. Is it a matter of interest to you that there is such a difference from one state to another?

**Mr Maskell-Knight**—I come back to the distinction between my professional and my personal curiosity. At a very high level we are concerned that there appear to be differences in practice and we would certainly like to understand them better. That is partly why we fund the NHMRC to conduct research into what drives clinical practice and what best clinical practice is.

**CHAIR**—Professor Lancaster, do you wish to comment on that?

**Prof. Lancaster**—Let us take early discharge of mothers after childbirth as an example. Back in 1991, the National Health and Medical Research Council published guidelines about that. They pointed out that early discharge should be voluntary, that there should be antenatal preparation of the women who were going to be discharged early, that there should be effective liaison between hospitals and community care of those women and babies. In fact, going back some decades, there was often a big gap in the continuity of care between hospitals and community services, but I think that has improved substantially. The NHMRC recommended that there should be adequate support services, usually from midwives, if mothers were discharged early and that there should also be adequate social support.

These policies have been implemented over a period of a decade or so but, from my perspective not only as an epidemiologist but as a paediatrician who used to work in newborn care, the guidelines for clinical practice and best practice have been developed and are clearly there, but there are not earmarked funds to evaluate the implementation of those changes in policy. Certainly, researchers can apply to the NHMRC using the usual applications for research grants, but in general this area has probably not received the priority that it should have in research funding.

**CHAIR**—It seemed to me that you meant something by antenatal screening that seemed to be different from what I meant. Can I please understand what you mean by antenatal screening? First, the department.

**Dr Dean**—When we looked at the terms of reference there was some discussion about what was meant by antenatal screening. For us, we thought about antenatal screening relating more to the status of the foetus. When we thought about that we realised that there is a great deal of discussion in this area and that it is very likely that this will be taken up by NHMRC. The Australian Association of Paediatric Teaching Hospitals has expressed a great interest in this area, and a number of other people have said the time is right to look at antenatal screening, particularly as it relates to the foetus. I apologise if you wished us to talk more about that, but that was our decision at the time.

**CHAIR**—Not at all. People must not feel badly, we are here to discover further. It is just that I would like to be clear what antenatal screening means. Does it mean a monthly visit in the beginning of pregnancy, then weekly visits in the last month? Does it mean a blood pressure check, a weight check, a blood iron level check, or does it actually just refer to ultrasound?

**Dr Dean**—I believe that we took the view that antenatal screening did not really mean the routine surveillance, if you like, of a mother during pregnancy.

**CHAIR**—That is called antenatal care?

**Dr Dean**—I would call it antenatal care. Again, I apologise if we have misinterpreted the term of reference.

**CHAIR**—I think it is more important that we get it clear. So you are saying it actually refers to whatever is done to keep a check on the foetus.

**Dr Dean**—You could extend that to screening procedures of the mother. We did mention screening for gestational diabetes and ultrasound during pregnancy as being two screening procedures which have resulted in a bit of discussion of late.

**CHAIR**—Maybe we will come back to the nature of that bit of discussion later. I have got Mr Maskell-Knight marked under the heading of ‘Keeper of the Commonwealth dollars’, and I would have thought that at least ultrasound would have been ringing bells for him in terms of Commonwealth dollars.

Professor Lancaster, I think you said in your statement that this is another area where antenatal screening is a bit up for grabs. Was that you or the department?

**Prof. Lancaster**—I did not put it quite in those terms. Certainly, the regular antenatal visits of women during pregnancy can be regarded as one form of screening. But, as Dr Dean indicated, I think most of us these days use that term to refer to more technological interventions such as ultrasound or amniocentesis or a chorionic villus sampling.

I mentioned the Medicare data held by the department and the Health Insurance Commission. I think this is one area where there is tremendous scope for having a look at what is going on and looking not only at the patterns of care but looking at the variations in those antenatal screening procedures, as well as other services, say, to do with treatment of infertile couples and assisted conception and so on.

**CHAIR**—Absolutely.

**Senator TCHEN**—As I pointed out to you before, Madam Chair, I am extremely disadvantaged in the childbirth department. My only interest will be if our statistics show that there is danger in childbirth.

**Senator GIBBS**—I have a quick question in relation to this data. I notice in both submissions, which are quite lengthy and very detailed, that you start talking about the processing of data around 1991 and no earlier. Were statistics kept on caesareans and all sorts of things, and everything you have spoken about in here, before then? How far back would they go?

**Prof. Lancaster**—It depends on the individual states, Senator. Certainly, as far as bringing the national data together, that began in 1991. But some states—notably Tasmania and Western Australia—started these so-called midwives collections back in the mid-1970s. Other states gradually introduced them during the 1980s.

The NHMRC working party on caesarean section that I mentioned previously was held in the mid-1980s. We had data on trends on caesarean section from several states but certainly not a national picture. We brought together national data on caesarean sections for 1985 to 1990 that were published in a separate report by our unit which, by the way, I neglected to include in the list of references. I have a copy of it here, and I will make it available to the committee.

**Senator GIBBS**—So we do not know for, say, back in the 1960s when I became a mother, how many caesareans were carried out then?

**Prof. Lancaster**—Not nationally, but there were surveys done at intervals during that period in some states. For example, we know that in the early to mid 1960s it was less than five per cent, that it rose to more than 10 per cent in the 1970s, to 15 per cent in the 1980s, and so on.

**Senator GIBBS**—Okay, so they are general sorts of things. Has this massive increase in caesareans basically taken place in the last eight to 10 years?

**Prof. Lancaster**—No. In fact, the rate of increase has actually slowed down, if I can put it that way, in the 1990s. I would need to refer to the tables but it was about 16 per cent or 17 per cent in 1991, and it is now 19.5 per cent. The preliminary data that we have heard about from the department for the financial year 1997-98 suggests it has reached 21 per cent. In fact, we have now achieved—if that is the correct term to use—a caesarean rate that is higher than the caesarean rate in the United States.

**Senator GIBBS**—Do we have more caesareans here per head of population than they do in the United States?

**Prof. Lancaster**—On the most recent figures I have seen from the United States, they were very concerned nationally about caesarean rates of 24 or 25 per cent a decade or so ago. In the period since then the caesarean rate has declined to a level of 20.7 per cent, with the latest figures I saw for 1996 of 19 per cent and then slightly up again to 20.8 per cent in 1997 in the United States. But, as I say, on our preliminary figures, we have gone to 21 per cent.

**Senator GIBBS**—Thank you. I am very interested in indigenous mothers. I know in both submissions you say that non-indigenous women have a higher percentage of caesarean section births than indigenous women, but—

**Mr Maskell-Knight**—I am sorry to interrupt, Senator, it is the other way around.

**Senator GIBBS**—Indigenous women have a higher percentage of caesareans. I am sorry, I read it wrongly.

**Prof. Lancaster**—Within specific age groups. When you compare the global rate for indigenous mothers with non-indigenous mothers, I think it is 19 point something per cent for the non-indigenous mothers and 17 per cent for the indigenous mothers. But, as I mentioned in my presentation, nearly all indigenous mothers are admitted to hospital as

public patients so it is more reasonable to compare the indigenous with the non-indigenous rates within that particular category. Also, because indigenous mothers are much more likely to have their babies when they are younger than the non-indigenous mothers and because caesarean rates go up with age, it is necessary to compare the indigenous and non-indigenous caesareans for public patients within five-year age groups. When we do that the indigenous mothers have a slightly higher caesarean rate within each age rate than the non-indigenous mothers.

**Senator GIBBS**—Thank you for that. That is interesting. That comes to the question that I wanted to ask because in your submission on page 5 of 10 you say:

Four ATSI regions had overall caesarean rates of 23 per cent. These regions also had high caesarean rates between 19.3 per cent and 31.3 per cent among teenage mothers.

In both of these submissions you have said that the reasons for caesarean section is complicated and that one of the reasons is because mothers now are older—not all mothers are older but a percentage of women giving birth are older. But why would so many teenage mothers have caesarean operations? Surely aren't your teenage years biologically the best age to actually give birth?

**Prof. Lancaster**—I think this is really an issue that needs much closer attention. When we look at the rates by state or territory where the indigenous mothers live, we note that South Australia and the Northern Territory tend to have high caesarean rates for all age indigenous mothers. The data that you were just quoting about the teenage mothers is for specific ATSI regions. This is the first time—in the recent report on indigenous mothers and babies for 1994-96—that we have actually looked at any of the data for ATSI regions.

We have to be cautious in the interpretation, of course, because they are based on relatively small numbers of births in any ATSI region. We aggregated the data for caesarean sections over a six-year period and not just a three-year period to make sure that the random fluctuations that occur when you analyse population groups is not just a question of small sample size. I think this information on those high caesarean rates, whether it is in the state and territory that I mentioned particularly or within regions, should go back to people providing care in those regions. It is then up to the researchers and the people providing the services to look in more depth at why those caesareans are being done.

If you ask obstetricians—and I am certainly not a spokesman for my colleagues the obstetricians—they might suggest that these high caesarean rates are because indigenous women generally have poorer health and that the caesarean section is an indication of good care to meet their poorer health needs. On the other hand, I do not think it readily explains the differences between states and it does not explain why the rates are particularly high in some of those teenage groups. Perhaps it has more to do with the models of care that have been set up. One can envisage a scenario that might be contributing to caesarean rates because of the way that care has been organised, in some of the northern and remote areas of Australia particularly.

**Senator GIBBS**—I find it very disturbing because my home state is Queensland. Obviously, in the ATSI regions, I take it that Queensland would have been part of that. We

have a large indigenous population in Queensland as does Western Australia and the Northern Territory. We have communities. I find this rather extraordinary. Is there any way we can find out further details of this?

**Prof. Lancaster**—The Queensland health department, of course, provide their data to us in the national unit. They would be able to provide data for Queensland for the different regions and for the ATSI groups, hopefully, as well.

**Senator GIBBS**—It seems strange to me. I know in some areas that a lot of the excuses or reasons given for caesarean rates they include poor health, alcoholism and all that sort of thing but that does not apply to all communities and that does not apply to all Aboriginal people. I know in Queensland and the Northern Territory they talk about smoking, drinking, alcoholism and that sort of thing. My experience with Aboriginal women is that the majority of them are teetotallers, basically because of what alcohol actually does to their community and families. I find this extremely disturbing.

There was also something on page 33 in the department's submission about indigenous women having to travel long distances to give birth resulting in costs and the need for accommodation. I take it that these women have to provide their own travel costs and accommodation, or is this supplied to them? Is there a service set up? I see there is one in Cairns. Is this the only one in Queensland? Are these services available to most community women?

**Ms Dunlop**—The one in Cairns is the only one that I am aware of that has Commonwealth funding that we are providing. Queensland health may well have other facilities. Travel to hospitals and accommodation are issues for state government and each state and territory has a patient assistance travel scheme. There is currently a national review of that under way.

**Senator GIBBS**—In Queensland it is not that far from the communities. They can go from Woorabinda to Rockhampton and Oakvale to Cooktown. It is a problem and I would imagine probably the Northern Territory would be a greater problem because there is more spread out community living, I would imagine. That would be a problem there. Do we know of the services in other states?

**Ms Dunlop**—There are other services in other states. One of the particular things that we funded commencing in 1996 is a specialist Outreach program, whereby the specialist gynaecologists and obstetricians go out as part of a team to remote areas. There are 37 rural and remote areas that the specialists have been going out to. There are some figures provided on the number of visits. Since it started there have been, I think the figure was, 185 visits in the Northern Territory out to these remote locations. That is proving to be very successful. They are providing training to local health workers and GPs as well as part of that process. It is clinical care and treatment as well as training and education.

**Senator GIBBS**—I noticed in your submission that a lot of country GPs have training in childbirth because of people in the more remote areas. Is there an adequate number of doctors who service these remote areas—all women, of course—or do we need to attract

more doctors to those areas where women cannot readily access hospitals or clinics to give birth?

**Ms Dunlop**—Yes. That shortage of doctors and nurses is problematic for us.

**Senator GIBBS**—So is the department doing anything to attract doctors to these areas? I see in your submission that most of the specialist doctors would prefer to be in the large cities. Money is the evil within all of us, I suppose. We all strive to earn a decent living. Is the department doing anything to attract doctors to those areas?

**Mr Wells**—The department has a range of schemes to provide incentives, particularly to attract general practitioners to work in rural and remote areas. I have some figures on the general practitioners who have the College of Obstetrics and Gynaecology diploma. It is a sort of inverse ratio to where the specialist obstetricians and gynaecologists are. They tend to be clustered in the cities in the larger rural centres, whereas the GPs with the diploma tend to be the other way around—they tend to be in the less densely populated areas or out into the remote. I guess that reflects the fact that specialists, to maintain a professional level of expertise in their speciality, need to be in a centre where they can get, to put it crudely, the patient throughput—the numbers of births—that their college requires of them to maintain their standard. The further out you go the more difficult it is to get that. There are fewer births there. That is why you tend to find the distribution is that way.

**Senator GIBBS**—The increase in the number of caesareans is disturbing. Has there been any evidence to verify the fact that a lot of caesarean sections are simply convenience—either convenient for the doctor because he wants the weekend off or convenient for the woman because she might be a professional person who has geared her life around having a child on a certain date so she can organise her holidays, then nip off and do that and get back to work? This has been suggested to me by quite a few people. I can understand when they are necessary—when there is a danger and things are going wrong. But many people have suggested to me that a lot of caesarean sections are simply a matter of convenience on the part of the doctor or the mother.

**Dr Dean**—I do not think we have that evidence and it is highly unlikely that we would ever be able to obtain that evidence. Many things that are suggested by anecdote would be extremely difficult to follow up. As we have said in our submission, the reasons for intervention rates in general are extremely complex and are really only partly explained by the sorts of things we can look at. We know about the increasing age when women are having their first child. We know, if we can return to Aboriginal women, that teenage women, although they may be healthy themselves—there is some debate about that in some Aboriginal communities—tend to have low birth weight babies and deliveries which are pre-term. Obstetricians believe, although there is some doubt about the evidence, that small babies have a greater chance of survival if they are delivered by caesarean section. That is debatable, but it is a possible reason for the high caesarean section rate in teenage Aboriginal women.

To be able to draw conclusions about a matter of convenience would be very difficult. It might be suggested that induction of labour is a matter of convenience. One could understand that obstetricians, who are very busy people who have other patients to see and

who also need to have a life of their own, may sometimes wish to induce a pregnancy. Again, we do not have evidence that this is so. We do have evidence, however, that if an induction takes place there is a slightly increased risk that it may result in caesarean section. That is a long answer. I think the answer is that we do not know the answer to your question.

**Senator GIBBS**—I can understand that you would not know. Let us face it—small babies have been born for years the normal way and have survived. Believe it or not, I was only five pounds when I was born. I think that is quite small, considering the size of my daughter, who was nine pounds two ounces. I am a pretty healthy, strapping person. None of my sisters nor my brother were over five pounds and we all survived. My mother did it the normal way. I find it strange that we have this increase in caesarean sections. I can understand if something is going wrong, but it just seems to be the norm.

Before I was in this life, in my previous life I worked with a young girl. She was 21, married, giving birth and very healthy. She came in one day and announced that the baby would be born on a certain date. I said, ‘You can’t always be sure.’ She said: ‘Yes, you can. We have booked in for the caesarean.’ There was nothing wrong with this woman. She was very healthy. She never smoked, did not drink and did all the right things. On this particular date she just went in, had the caesarean and that was it. I found this extraordinary, yet I believe it happens quite a lot. Obviously we cannot get the proof for or the evidence of this, but it seems to happen quite a lot. I know of another woman who booked herself in, had the make-up artist there a few hours later and looked absolutely gorgeous to receive all her friends. This is the most extraordinary way of having a child, I would think.

I know we cannot get evidence of this but we all know it happens. I think it is bad practice. It is my understanding—and I am not a medical person, as Senator Crowley is—that if you want to have more than one child, if you have the first by caesarean and then a second caesarean, it is a danger to your life. Isn’t it risky to have caesarean after caesarean? Don’t they limit this?

**Dr Dean**—Certainly having one caesarean section does place a woman at risk of having further caesarean sections, although that is not necessarily so. But certainly this is one of the factors which must be taken into account in the decision for a woman to have a caesarean section. Yes, there is a possibility that further children will also be born by caesarean section.

**Senator GIBBS**—I will get off this subject now, but it is interesting. In the cases I know of they had private health insurance. If you have private health insurance you just do the deal and go in.

**CHAIR**—I want to pick up on a couple of those points because they are terribly interesting. Could you provide for us any of the evidence that says smaller babies have a better outcome if they are delivered by caesarean section?

**Dr Dean**—There is not a great deal of evidence to back that up. When I am talking about small babies I am talking about very small babies, of course. They would probably be less than five pounds. The study that was done by Judith Lumley’s group suggests that, for

very small babies delivered by vertex delivery, there is no advantage for those to be delivered by a caesarean section. There may be some advantage for very small babies who are breech presentation to be delivered by caesarean section. But this is just one study and there is no agreement about that across the board. No doubt for every study you can find showing one thing we will find many more showing other points of view.

**CHAIR**—The main concern I have about this goes back to the point made by Professor Lancaster. A lot of this is being done without ever being rigorously researched or pursued in a defined kind of, ‘Let’s test it and see’ way—I guess, a research project. In regard to your comment that there is some evidence perhaps that induction leads to a higher caesarean rate, it is also interesting to look at the increased number of inductions, which is some evidence for the point that my colleague Senator Gibbs was making. I am not so sure about people who pop in with the attitude, ‘Why don’t we just have it by caesar,’ but there are lots of people who pop in with, ‘Why don’t we just have it on Friday between nine and five, by induction’. If that does lead to caesarean I would welcome some information on that too, please. On page 8 I am introduced to the terms ‘antenatal’, ‘perinatal’ and ‘prenatal’. What is the difference between ‘antenatal’ and ‘prenatal’?

**Dr Dean**—I think that is an editorial problem. I think it should be postnatal. I remember seeing an error there.

**CHAIR**—So ‘antenatal’, ‘perinatal’ and ‘prenatal’ mean postnatal?

**Dr Dean**—Yes. I think it is an editorial problem; it should be postnatal.

**CHAIR**—It is an extremely interesting one, making a huge difference to the sentence.

**Dr Dean**—It makes a great deal of difference to the meaning.

**CHAIR**—Yes, it does. In the last two lines of that paragraph there is a reference to Cochrane, who recently reviewed the provision of antenatal care managed by care providers other than obstetricians, compared with obstetricians, looking at the care of low risk pregnancies. I see that is a footnote. We will try to get hold of that document. Can you tell us what that found? Is it safer to have your care in the hands of a midwife than a doctor or vice versa?

**Dr Dean**—None of these studies are big enough to make very definitive statements about life and death, particularly in a country like Australia, where mortality, morbidity, rates are fairly low. The studies which were done in Australia showed no difference in that aspect. It was no safer to have a baby with specialist care throughout compared with shared care. If I recall, this was about comparing a form of shared care which consisted of the woman’s antenatal care being mainly done by a general practitioner, but with some visits to the public hospital and with a delivery taking place by a different group of people in the hospital, as opposed to women who are looked after by the obstetrician led team in the public maternity hospital. This is not like private care by an obstetrician.

Of the differences that stood out, it appeared that in these studies shared care has not worked as well perhaps as was predicted. There is a problem in that the people who follow

the woman antenatally do not necessarily follow the woman through childbirth. This seems to be a deficiency. Women were saying also that they were getting conflicting information and that they had perhaps equally long waiting times when they were being seen by general practitioners as when they waited in the clinics in the public hospital. That data and the references are all available. Another report is being done by La Trobe University, looking at a review of shared obstetric care in Victoria. I think this is now a public document. It is very interesting.

**CHAIR**—The committee would welcome that. If this is here and I have missed it please tell me, but if it is not could you provide for me the changing infant and maternal mortality rates running parallel year by year with the increasing interventions? For a long time Australia has been up there with the best in terms of infant mortality, neonatal mortality and maternal mortality despite our pretty dreadful Aboriginal figures, which are getting better. So we are looking at very fine adjustments and they may not show. If we do see any difference, has the infant mortality rate improved at all by this clear increase in intervention?

**Dr Dean**—Paul Lancaster would be much more able to talk about that relationship statistically. We need to look a lot further than intervention rates when we are looking at our improved mortality and morbidity. I think we would find that changes in living conditions, improved nutrition and the wider spacing of children—a whole number of factors—which are not necessarily related to interventions are more likely to be responsible for our improving mortality and morbidity rates. Having said that—

**CHAIR**—Please say the next sentence quickly, Dr Dean.

**Dr Dean**—At the very edges, where we are looking at a reduced birth rate, at increasing maternal age at first birth and at situations where very tiny prem babies are surviving, these are the areas where interventions have a relationship to improved mortality and morbidity. I think I should leave that to Paul to comment on.

**Prof. Lancaster**—I think it is dangerous to try to oversimplify it and draw conclusions that, because the perinatal death rate and the infant mortality rate have continued to decline over a period of decades and during that same period the caesarean rate has gone up, it is a matter of cause and effect. The causes of perinatal death are much more complex, as indeed are the factors contributing to caesarean section. As Dr Dean indicated, the regionalisation of perinatal care, whereby high risk mothers and babies are transferred from smaller units to tertiary care centres, has probably been the predominant factor in reducing perinatal death rates.

Having made that as an initial statement, apart from the higher perinatal death rates in the Northern Territory for obvious reasons, the states and the ACT have very similar perinatal death rates. But, as we have indicated, there are substantial differences in caesarean rates between those states, so I guess that supports the fact that there is not a direct cause and effect relationship.

**Senator GIBBS**—I have a few quick questions about women who choose to give birth at home. Do we have any data on this? Is this happening more in regional areas and in the outback where it is hard to get to hospitals? Or is this happening more in both country areas

and metropolitan areas? I notice that you do say that a small number of women choose home births. Further on you talk about midwives and private midwives who are not covered by Medicare. I was wondering whether we have figures on how many women do choose to have home births. Do we have a breakdown of regional and remote areas as opposed to metropolitan city areas?

**Dr Dean**—I think Paul may have some of that information for you.

**Prof. Lancaster**—We conducted a project funded by the NHMRC in the mid-1980s up to the 1990s on home births in Australia. First of all, there are relatively few home births in Australia—fewer than 1,000 a year—so they account for about one in 300 births these days. Women who sought to avoid what they would regard as unnecessary intervention and may have chosen home birth for that reason and for the type of care that they get are increasingly using birthing services linked to hospitals for their care. So we are not seeing an increase in home births in Australia. I think the majority of home births are not in remote living communities; they are in capital cities more often than not, and in regional centres as well. Home births are infrequent, I think.

**Senator GIBBS**—That is interesting. When you talk about the birthing services, is this the alternative birthing services program that the department has set up? I notice here we have ‘incentive funding is provided by the Commonwealth to the states and territories to trial models of birthing services’.

**Dr Dean**—The question was, Senator: is home birth related to alternative birthing services?

**Senator GIBBS**—Professor Lancaster said that a very low percentage of women do have home births, but other women who do not want unnecessary intervention are using birthing services which are attached to hospitals. Am I right?

**Dr Dean**—Yes, in the main.

**Senator GIBBS**—Is this the alternative birthing services program which is in the health department’s submission?

**Dr Dean**—Yes, Senator. ‘Alternative birthing services’ there refers to the Commonwealth funded alternative birthing services. That fits the description that Paul has given you. In the main, these are birthing centres which are situated within hospital grounds and with very ready access to the services of the maternity hospital.

**Senator GIBBS**—Who would staff these birthing services? Would it be the same as the hospital? Would you have doctors and nurses on call? Or is it basically staffed by midwives—midwives are nurses? How exactly is it staffed?

**Dr Dean**—These birthing centres are staffed by midwives, but they do have the services of general practitioners who may go to those birthing centres and may in fact deliver the babies as well, as an alternative to the midwife, or in combination with the midwife.

**Senator GIBBS**—Do we have any statistics about the home births? Basically, I want to find out if it is safe for women to have a home birth. What happens if—

**CHAIR**—You drop it in the lounge room?

**Senator GIBBS**—I would be terrified. I would want the doctor there just in case. I would want everything there, just in case. Is it safe for women to have home births? Do we have any statistics showing, for all of the women who have had a home birth, that everything has gone smoothly and is okay? I am not just talking about the accidental thing where suddenly it starts.

**Prof. Lancaster**—In general, women who have a home birth are low risk compared to women giving birth in hospitals. They have a lower perinatal death rate as one measure of their outcome, although in a paper published last year we showed that there were some particular risks associated with home birth for a small subset of women. In general, they do have a lower rate because of lower risk, but there are some identified problems in terms of babies dying from problems related to lack of oxygen in term or post-term where the pregnancy has gone beyond the normal expected period of pregnancy.

**Senator GIBBS**—I guess they would do this in consultation with a doctor—I do not know if many doctors agree with home births—and the doctor would say, ‘Okay, this is fine.’ Would the doctor be there, or do they make their own arrangements?

**Prof. Lancaster**—More often it is midwives, but certainly there are some doctors who practise home birth, and there are specialist obstetricians who work with teams of midwives in birthing centres in hospitals and care for women in that setting as well.

**Senator GIBBS**—Thank you.

**Senator TCHEN**—Dr Dean, are you a medical doctor?

**Dr Dean**—Yes.

**Senator TCHEN**—I understand there have been quite considerable improvements in surgical techniques over the last few decades so that surgical intervention is much less traumatic. Is that right? I have read reports that one of the reasons for shorter hospital stays is improvement in techniques.

**Dr Dean**—Certainly, techniques have been developed which are less invasive.

**Senator TCHEN**—‘Invasive’ is the word.

**Dr Dean**—Is laparoscopic surgery what you are referring to?

**Senator TCHEN**—Yes. I understand that people who go into hospital for surgery are now staying for much shorter periods, generally.

**Dr Dean**—This is also true.

**Senator TCHEN**—Is the same trend also true in caesarean deliveries?

**Dr Dean**—The trend for early discharge from hospital following childbirth has been across the board, whether there are interventions or not. In general, women with interventions and, in particular, caesarean section, stay in hospital, I believe, on average about two days or so longer than women who do not have a caesarean section. This would be a shorter period of time than, say, 15 years ago when a woman may have stayed in hospital for two weeks following a caesarean section. Professor Lancaster may have more accurate figures on that.

**Prof. Lancaster**—As Dr Dean indicated, the trend towards earlier discharge affects both those who have had intervention and those who have not. Certainly, caesarean section, like other surgical interventions, is a safer operation. And these days, for that particular operation, there is less requirement for general anaesthetic. Women are much more likely to have a spinal or an epidural. Of course, associated with that operation are increased risks of infections and not only longer hospital stays but increasing costs. There are, indeed, also problems for the babies. There are increased risks of breathing difficulties for babies born after elective caesarean compared to those born vaginally. It does not just affect the mother; it has implications for the baby as well.

**CHAIR**—On page 10 of the department's submission you say:

The cost of insurance and perceived threat of litigation also deters many GPs from continuing to practise in obstetrics and gynaecology. This issue of indemnity extends to obstetrics and gynaecology specialists in some capital cities, where in some instances, government has become involved in assuming responsibility for covering the cost of obstetrics and gynaecology indemnity.

Can you take us through that a little?

**Mr Maskell-Knight**—We might have to take that on notice, Senator, as none of us here are particularly well versed in this. At a very general level, I understand that several state governments have entered into arrangements with their visiting medical officers to pay some proportion of their indemnity insurance, but I believe there are people back in Woden who would know more about it.

**CHAIR**—The committee would appreciate that because one of the concerns we have had put to us is that there is a pressure on doctors. I am not sure whether it is more on GPs than specialists. If you had any information along those lines we would welcome it. We have been told there is a pressure because of the likelihood of parents to sue, or, let us say, the likelihood of litigation. Therefore, there is a pressure there for intervention. Could the department provide us with any data about that. I will certainly follow that up by talking to the medical defence people. I will ask why the rate is going through the roof.

**Mr Maskell-Knight**—Are you asking for data about greater intervention because of greater litigation?

**CHAIR**—I am talking about fear of litigation being a contributing factor towards more intervention.

**Mr Maskell-Knight**—I do not think we have any data that would allow us to form a view on that. It would be impossible to disentangle.

**Prof. Lancaster**—There have been surveys of obstetricians conducted here in Australia and in the United Kingdom and the United States. When you look at those surveys, the threat of litigation is the stated reason by the majority of obstetricians for the increasing caesarean rate. The additional information might help, but in a period of a decade or so, for obstetricians, at least in my home state of New South Wales, the premium has gone from less than \$2,000 to \$45,000 in the most recent year, and it is likely to double to \$90,000. We are following very closely what has happened in the US over a period of decades up to the 1980s in that case.

Undoubtedly, this encourages the practice of what many would term ‘Defensive medicine’. Undoubtedly, it is a factor, although, as was indicated earlier, it is a factor that we cannot readily measure in the increasing caesarean rate. In some states there is information recorded about the indications for caesarean section. People do not ever write down, ‘Fear of litigation’ or ‘Convenience’; they use other terms like, ‘Failure to progress’ and ‘Repeat caesarean section’. ‘Repeat caesarean section’ accounts for about a third of the increase. Sometimes those terms are loosely defined, if defined at all. They can be euphemisms for other occurrences in the care of the woman during a pregnancy and the birth.

**CHAIR**—Professor, you told us earlier that the caesarean rate in America has fallen over the last 10 years, which is curiously contrary to the increasing fear of litigation in the States. Do we know whether that has anything to do with pre-paid health plans?

**Prof. Lancaster**—I do not know that single factors can be regarded as the prime reason, but there have been studies done in the 1980s. First of all, a high caesarean section rate has to be recognised as a problem. Until people recognise a problem it is unlikely that anything will be done to reduce the rate.

In one particular study that has been widely quoted from, by getting better information recorded in the hospital record about the reasons for caesarean section, and by getting a second opinion about whether the caesarean section was necessary, in that particular hospital—I think it was in Chicago—the caesarean rate over a two-year period dropped from about 19 per cent to 11 per cent. Because of consumer concerns, and because of the concerns about litigation, there has been a groundswell to try to address the issues and to inform obstetricians of their own caesarean rate—if they were not already aware of it—and how it compares with their colleagues.

In our submission we mentioned that, back in the 1980s and into the early 1990s, Tasmania had a lower caesarean rate than all the other states. The perinatal collection in Tasmania was set up by a professor of obstetrics, with a view to obstetric audit of what was going on in the state. He regularly fed the information back for the whole state of Tasmania to individual practitioners. I would like to think that that was a factor in keeping the caesarean section rate down in that state—although I cannot prove it; it is my hypothesis. Since he retired, the caesarean rate—as we said in our presentation—has caught up with the national figure.

**CHAIR**—There are many questions. Mr Maskell-Knight, I think this is a question for the Commonwealth. I thought that before we heard from Professor Lancaster you were suggesting that maybe there would not be data about that, but the Commonwealth is now paying some of the insurance costs.

**Mr Maskell-Knight**—No, Senator. Wherever we have said ‘government’, we should have said ‘state government’.

**CHAIR**—So the Commonwealth negotiated with the states?

**Mr Maskell-Knight**—Certainly not. State governments employ doctors. With the honourable exception of people like Margaret Dean and Health Services Australia, we do not employ any doctors at the Commonwealth level.

**CHAIR**—We note this changing world, Mr Maskell-Knight.

**Prof. Lancaster**—We do pay Commonwealth medical benefits.

**CHAIR**—I am a bit concerned. I would like to ask you some questions about why caesarean section is not a separate item. The Commonwealth has recently increased the payment for obstetric care, has it not? I thought that part of the negotiations at that time were to deal with the concern that lots of obstetricians had about the increase in the cost of insurance. Does my memory fail me here or was it a package?

**Mr Maskell-Knight**—To take the first question first—I would have to check this—I believe the disappearance of the separate item for caesarean section was part of a move to lump together all the elements of an episode of antenatal and delivery care and to remove any differentiation between caesarean section and other modes of delivery. The view was that having a separate item might actually encourage it, so the item was removed and lumped in with a general item that covered antenatal attendances and the delivery process. That was in the late 1980s. In about 1996 or 1997 the schedule was changed to revert to separate items for antenatal attendances and then items for the delivery. There is a separate item for caesarean section where the delivery has been conducted by a practitioner who has not previously been involved in the care of the patient. That is used very little.

**CHAIR**—Would the department object to the proposal put forward by Professor Lancaster that we go back to making it a separate item?

**Mr Maskell-Knight**—I cannot speak for the department off-the-cuff, Senator. I would need to take advice.

**Senator GIBBS**—This is not a question; this is just a matter of interest. I was looking at Professor Lancaster’s submission about the caesarean rate. Although South Australia has a higher percentage of caesareans, if you look at the comparison of public patients versus private patients, private patients have more caesarean sections. It is very interesting. In South Australia there are only eight per cent more private patients than public patients. The national average is 8.9 per cent but Queensland has the highest—13.2 per cent of caesarean births are in private hospitals as opposed to public hospitals. South Australia and Western

Australia have a rate of eight per cent and 8.7 per cent respectively, and the national rate is 8.9 per cent, but it seems that we do it in a big way in Queensland. It is quite significant. It would be tremendous if the department could look into this and try to get us some statistics.

**Mr Maskell-Knight**—Can you refer me to the page in the submission, Senator?

**Senator GIBBS**—It is on page 6/10 of the institute's submission.

**Mr Maskell-Knight**—That is in our submission.

**Senator GIBBS**—Yes. I found it very interesting that there was such a large proportion in Queensland, as opposed to the national figures and the two other states.

**Prof. Lancaster**—I am sorry, Senator, where are you talking about eight per cent?

**Senator GIBBS**—It says:

In Queensland, the caesarean rate was 20.6% (16.2% for public patients, 29.4% for private patients)—

Are my figures correct? I am not very good with mathematics.

**Prof. Lancaster**—That is saying that, for each 100 women who are admitted as public patients in Queensland hospitals, 16.2 per cent of them will have a caesarean section, and for the private patients it is 29.4 per cent.

**Senator GIBBS**—So that means that in Queensland 13.2 per cent of caesarean sections are in private hospitals, as opposed to—

**Prof. Lancaster**—No. This is talking about the accommodation stages of the mother, not the type of hospital she is delivering in. It is whether or not she is admitted as a public patient or a private patient.

**Senator GIBBS**—So what you are saying is that this is a private patient in any hospital in Queensland.

**Prof. Lancaster**—In any hospital in Queensland.

**Senator GIBBS**—What is the difference? Maybe I have worded this wrongly. Maybe I should not have said, 'in private hospitals', but for a private patient who is covered by private health insurance, wherever she goes—a public hospital or a private hospital—there is still that difference of 13.2 per cent of private patients in Queensland having caesarean section, as opposed to women who have to use the public health system.

**Prof. Lancaster**—Women who are private patients are almost twice as likely to have a caesarean section as those who are admitted as public patients.

**Senator GIBBS**—Yes.

**Prof. Lancaster**—But again I caution against using those figures in the way we have there. Among the public patients, there are more older mothers, so if we took account of the differences in age groups the disparity would not be as great as it seems there, or as it is with the crude figures.

**Senator GIBBS**—So you are saying the older women go for the public hospital system?

**Prof. Lancaster**—No, the older women are more likely to have private health insurance. Because the caesarean rate goes up with the advancing age of the mother, any subgroup in the population that has more older mothers, other things being equal, will have a higher caesarean rate.

**CHAIR**—Senator Gibbs's point is interesting—that the difference between private and public in Queensland is significantly different from public and private in South Australia.

**Senator GIBBS**—Does that mean we have a higher percentage of older mothers in Queensland, as opposed to the other states?

**Prof. Lancaster**—No. In general, there are not big differences.

**Mr Maskell-Knight**—Just to muddy the waters further, it may well be that the proportion of the population with health insurance in Queensland has historically been lower than in other places. As Professor Lancaster has suggested, there is an age effect in that people with health insurance are more likely to be older mothers to start with. Because of the low proportion of the population as a whole that have health insurance in Queensland, that bias may be exacerbated.

**CHAIR**—It is interesting, is it not, that other parts of these two studies do suggest that the age of the mother is not really a significant factor to account for the difference between private and public patients? It may be a contributor—and we cannot say it isn't—but one would reasonably say, 'Well, yes.' Somewhere in these two reports I read that if you are aged between 35 and 39 and you have private health insurance in this country then your caesarean rate is 39.9 or 40 per cent, which is significant.

**Prof. Lancaster**—In general, if you compare women admitted as public patients with women admitted as private patients and take account of their age and how many children they have had, the caesarean rates for the private patients are about 20 or 30 per cent higher in most age and parity groups.

**CHAIR**—There are two lines I would like to read from this same page which I think deserve our serious reflection. If the department can add anything further, I would be really interested. The last paragraph on page 6 of 10 states:

While caesarean rates for hospitals grouped by size were generally similar, there were still marked variations for individual hospitals. For example, among hospitals with more than 2,000 births per year, one hospital had a caesarean rate of only 9.8% but others had rates in excess of 30%.

One just has to worry very much about that kind of percentage difference. The next page states that, for individual obstetricians:

. . . the caesarean rate ranged from 6.6% to 37.7%. Similar variations were evident in obstetric practices of all sizes.

You would have to say that that kind of percentage difference makes you think that it is far more the practice of the obstetrician than the age of the mother or the streaming in of people at risk. I think those two lines are of grave concern. The last line on page 6 of 10 states:

. . . policies within a particular hospital may also be a factor.

Can you comment on that, Professor Lancaster?

**Prof. Lancaster**—As your previous summation indicated, caesarean section is a significant operation. There are different attitudes among individual practitioners as to when a caesarean section ought to be performed for a particular mother, and this is one of the factors that have been effective in helping to reduce the caesarean rate in the United States—if indeed you believed it was too high. There are advocates for caesarean section for every pregnant woman around the world these days.

But if you have leaders within a hospital who are concerned about the caesarean rate and, hopefully, practise that way themselves, they can influence their colleagues by the sort of audit we talked about earlier—by reviewing the indications for caesarean sections and by looking at individual obstetrician's caesarean rates. In some hospital settings we know that that is a factor now. It is not always linked necessarily to outcomes of those pregnancies—it is usually much more difficult to make that particular link because of relatively small numbers, even in larger hospitals—but it has a lot to do with attitudes of individual obstetricians and therefore the policies within their hospital.

**CHAIR**—That certainly tends to be a factor of concern in some of the evidence produced in both these submissions. Can I ask the department: what about the whispers some people have been giving me that it is better for a hospital if women have a caesarean section because the hospital gets more money?

**Mr Maskell-Knight**—It depends on how the state casemix funding system works.

**CHAIR**—Please elaborate.

**Mr Maskell-Knight**—In some states—and I do not know the detail state by state—if you have a casemix funding system where the hospital is paid so much for a weighted episode, the weights for caesarean sections are greater than the weights for normal deliveries; therefore, the hospital gets more money.

I believe anecdotally that some states have taken action to reduce the objective difference in the cost weights in recognition of the fact that this may create incentives. They have introduced what they call normative weights in some areas. I am unaware whether or not they have done that for things like caesarean section.

**CHAIR**—Is that something you could find out for us?

**Mr Maskell-Knight**—I can try.

**CHAIR**—I would appreciate that.

**Mr Maskell-Knight**—Yes, the hospital gets more money, but it also costs them a lot more. There would be a benefit to the hospital in doing that only if they thought they could make a profit on the caesareans because the amount of money they received for a caesarean was greater than the amount of money it cost them as against the profit, if you like, they could make on a normal delivery.

**CHAIR**—I appreciate this. You have given me quite some comment by way of response to that question, but I would appreciate it if the department could provide anything further. It is quite a significant anecdote out there. Sure, if you have a caesarean section, you may need theatre or a possible blood transfusion or God knows what else so the cost may indeed make it a zero sum gain. But other people are suggesting the increased funding for caesareans may be one of those things pushing hospitals in that direction. I find that unlikely, but I would like to be assured that there was not a cost pressure to a different sort of practice.

Dr Dean, do you know whether people are still being told that there is a hazard to having a caesarean section or whether they are being told, ‘Oh well, you can have a baby. You can shove it into the world, or we can just pop it out for you through the belly. There is no difference between either of these processes?’ Do you have any idea what advice is being given to parents when it comes to interventions, particularly caesareans?

**Dr Dean**—I cannot comment on what individual practitioners tell their patients or what hospital practices are in place, but in general terms there are guidelines about the information that should be given to patients—or clients or whatever they should be called in these circumstances—before any intervention takes place. I have no reason to believe that the risks of caesarean section are not explained to women before they have a caesarean section.

**CHAIR**—You said that you have no reason to believe that the risks were not explained. If you did have a reason to believe that it was not being adequately explained, would you be concerned?

**Dr Dean**—Of course. I would be as concerned as I would be in any circumstance where a practitioner did not explain the risks and benefits of any procedure which was to take place which would allow—when it was possible—in this case, the woman to consider those factors and to consult with family members and other practitioners if that were desirable.

**CHAIR**—One of the things concerning me, Dr Dean, is that people are saying, ‘Of course, the reason lots of caesareans are being done is that women are demanding it.’ I find it quite extraordinary that women who have had an opinion for hundreds of years were not listened to at all but now, apparently, they might be contributing to the increased number of caesarean sections that are being done in this world. Where would we be without women to blame? Can you actually say whether you have any evidence in the department that the demands of women are contributing to increased caesareans?

**Dr Dean**—We only have evidence from the published literature, and I do not think the published literature is saying that women are demanding caesarean sections for reasons of convenience. I think the evidence we have is that when the risks and benefits of a caesarean section are explained to some women, as in the situation with public patients in one hospital in Western Australia where a very careful study was done and women were certainly taken into account in the decision to go for caesarean section, it does appear that women influenced the decision to proceed to caesarean section.

I should say that this is not a wanton decision and I think we need to know a lot more about how people make decisions and what influences them. For instance, it may be that if a woman is given extremely adequate information about the risks and benefits of a breech delivery, including the fact that there is no really strong evidence that routine caesarean section is indicative for a breech delivery, we do not know how a woman comes to a decision here. It may be the woman will say, ‘Well, yes, there is no real evidence that a routine caesarean section for a breech delivery is an advantage for the baby.’ There are other things that can occur—the position of the baby can be changed, and this may involve forceps, or there can be a trial of a breech delivery. We do not know how women actually process that information. It may be that a woman will decide that, okay, there is no evidence that routine caesarean section may be an advantage but there is no absolute evidence that it will not be; and, in considering the outcome of her pregnancy, she may decide, ‘I will go for a caesarean section.’ I do not know how people come to these decisions. It is extremely complex.

**CHAIR**—I had a phone call yesterday from a woman who said she had had a caesarean section for very agreed reasons for her first baby and wanted to have a trial of labour for her second one, and when she arrived there the doc was there, the anaesthetist was there and the theatre was practically ready, so she ran a long battle for a number of hours until she was safely delivered of her child in a normal delivery. She actually had to both shove the baby into the world and fight off the team that were there determined to do another caesar because she had had one before. I guess it is a question, as you say, of how this information is filtered. We know there are women who are very strong about minimal intervention and there are ones who are less able to decide. What you say is very interesting. Do you know if there is any research on how people decide under those situations?

**Dr Dean**—No, I do not believe so, though other people may know of this research. I think it is an area that we do need a lot more research on.

**CHAIR**—We have got to conclude now. Unfortunately, this session has provided me with about 5,000 more questions. We have given notice of some to the department. If we provide some more questions on notice, I am presuming but I would appreciate it if you could assist the committee further with information about the different sorts of data collections. For example, Professor Lancaster has written that health insurance data have been grossly underutilised for comparing the patterns for health services within Australia. He goes on to say that a specific item for caesarean section would be of assistance if it was reinstated. Would you care to comment on, for instance, the conversation we have had about that, and perhaps too—in the light of your information, Mr Maskell-Knight—on why one fee for the delivery that included caesarean section was introduced in the late eighties and whether it might not be time to reappraise that?

It is going to be a little difficult, I think, to stay focused in this inquiry. We have got five sections for the department of health—I did not mean to do that to the department—but it is a terribly important area in the general principles of where the Commonwealth's responsibility for the allocation of its dollars starts and finishes in terms of determining practice and good care, and where you butt up against the profession—and I guess that is called a lively tension. This is certainly a question that I believe this committee is going to have to pursue. If you have anything further to make that clear for us, I would appreciate that.

I am also particularly concerned about where the responsibility for the allocation of Commonwealth dollars stops when it comes to the borders with our states. I find it always a bit surprising when the federal department says to me, 'Oh, we do not know that, we would have to ring up the states and find out,' because I am very concerned about these precious taxpayers' dollars.

I am also concerned about the service of care that the Commonwealth funds. Health care across this country is not vastly different from one state to another. I have looked at the department's mission statement and it does not say any more equity across the nation. In fact, it actually says:

. a nationally coherent health system which provides both choice and universal access and allows regional and state variations;—

Under that vision statement for the department, does that mean that you are not troubled by South Australia having a much higher caesarean rate than the other states?

I would be interested if you would care to look at the Commonwealth's global vision statement and mission statement to see whether that variation between states is something that is new or is of no concern. Certainly to the citizens it is a concern that in some hospitals in some states and in some situations you are much more likely to have a caesarean or an intervention than in others. That variation is of major concern to this committee. I do think it goes very much to how the dollars are allocated and how the data is collected. I am still concerned, Mr Maskell-Knight, that you said that you get data from the states that does not really allow you to know necessarily which particular hospital. But if you looked at what Professor Lancaster provided you, you might. And are you actually inadvertently finding facts that are not strictly under the Medicare agreements?

I would like to thank you all very much for your contributions this morning. I am sure we will be talking to you some more.

**Proceedings suspended from 11.26 a.m. to 11.42 a.m.**

**LEONARD, Helen, National Executive Officer, Women's Electoral Lobby Australia**

**McKENZIE, Ms Ingrid Carolyn, Convenor, Childbirth and Breastfeeding Working Group, Women's Electoral Lobby Australia**

**VERNON, Dr Barbara, Member, Childbirth and Breastfeeding Working Group, Women's Electoral Lobby Australia**

**CHAIR**—I welcome representatives from the Women's Electoral Lobby. The committee prefers that all evidence be given in public, but should you at any stage wish to give your evidence, part of your evidence or answers to specific questions in camera, you can ask to do so and the committee will give consideration to your request. We have before us your submission, which is No. 164. Do you wish to make any alterations or additions to that submission?

**Ms McKenzie**—No.

**CHAIR**—I now invite you to make a short opening statement and then field some questions.

**Ms McKenzie**—In my opening statement I will cover something that we wanted to have as part of the evidence.

**CHAIR**—Feel free. This is not about trying to make you feel confused about the exact use of words. If you are adding things at any time, that is fine.

**Ms McKenzie**—First of all, I would like to apologise on behalf of Emma Baldock who was going to be here with us. She works as a casual on-call midwife at one of the hospitals here in Canberra. It would not release her for one hour to appear before the committee, and we thought that was rather telling in itself.

I would like to remind committee members about WEL's vision. WEL Australia is an independent organisation dedicated to creating a society where women's participation and potential are unrestricted, acknowledged and respected, and where women and men share equally in society's responsibilities and rewards.

Senators might wonder what interest WEL has in childbirth procedures. I think the key point is that the treatment of women in childbirth is an indicator of women's status in society. In Australia, women are not doing very well in childbirth, particularly if they are in a hospital.

I would just like to reiterate some of the things that we said in our introduction, because it is so important. Birth is a profound event in a woman's life, and women on the committee who have birthed will no doubt know this. It involves intense physical and emotional challenges and marks a key transition in a woman's life, one which changes her perceptions of the world forever in its emotional and physical process. Both aspects are intrinsic to it, and that is the key point in our submission.

Any development of a philosophical basis for provision of care and models of care have to recognise these points. Importantly, these services are for women, and this seems to have been forgotten in any number of reviews, any number of models of maternity care.

Women are the consumers, and surely these services should be provided with women in mind. Surely the models of care should be developed in consultation with women. I realise that this is only the first day of hearings, but I looked down the list and there are not many consumer groups listed there. There is the Women's Electoral Lobby, and I will be interested to see from which other consumer groups you will be provided with evidence.

On that point, I just want to note that there have been a number of other reviews. I think there are about four or five reviews that have happened in the last decade which have come up with recommendations, a lot of them along the same lines, about reform of maternity services. Sadly, these have all fallen by the wayside or been ignored. They have not resulted in the changes that they have recommended.

Something that I want to add that was not in our submission is about indemnity. Professional indemnity insurance is often used as a justification for the increase in intervention rates. Members of the committee might be aware of the Australian government report of 1996 entitled *Compensation and professional indemnity in health care: final report*. In that report is a chapter specifically on childbirth procedures, and the author looks at the evidence, something that is often lacking in the area of childbirth. She finds that one of the key points is that cerebral palsy—and this is the myth—is caused by foetal distress, and therefore a caesarean has to be done quickly to prevent that from happening. They are really scared of litigation, of being sued, because of damage to babies.

There have been a number of very well publicised cases on this, and they say that this is why we have to do caesareans. The report points out that evidence for intervention lowering the rates of cerebral palsy is non-existent. They have looked at the research on groups where the emphasis has been on caesarean births and on one where the emphasis has been on vaginal birth, and the rates of cerebral palsy have not altered. That is the first point.

She points out that rising premiums are not caused by rising litigation. There are a number of reasons for the rise in premiums. Another myth is that the rise in premiums is due to the rise in litigation around cerebral palsy and damage in birth. She again looks at all the evidence and finds that there is none.

The last point is that only 20 per cent of litigation against obstetricians and gynaecologists is for obstetrics, and the litigation for cerebral palsy is a very small percentage of that 20 per cent. There are very few cases about this, although the payouts in some of them have been very high. This is what happens: the media grabs hold of these high payouts, and there is an enormous amount of publicity about this and everybody gets really scared. When you look at the evidence, the rise in litigation has not caused the rise in premiums. Certainly the evidence for intervention, helping prevent cerebral palsy, is non-existent. In any case, an obstetrician who intervenes for reasons that are not backed by evidence is going to find himself or herself, very rarely, falling foul of the negligence duty of care. So that is the point I wanted to add about indemnity.

The last thing I wanted to talk about was cost. The current rates of intervention cost the federal government an enormous amount of money. One example of this is covered in our submission. I would like to tender this article on *Ultrasound: more harm than good* by Marsden Wagner, which points out that an enormous amount of money is spent on ultrasound and the evidence is that it has no benefit for low risk women. The federal government is funding baby photos. So there is enormous social cost involved, which is all covered in our submission.

I did want to point out that there is a lot of evidence that a rise in intervention causes a decrease in breastfeeding rates. There is an enormous amount of evidence that senators will be aware of that the health of a breastfed baby is far better than that of a formula fed baby. Formula fed babies have many more trips to the doctor and to the hospital than breastfed babies. The Commonwealth should not be having to fork out money for that kind of thing. Intervention should be lowered so that breastfeeding rates can be raised and there will be less call on the public purse.

**CHAIR**—Thank you. Does anybody else wish to speak at this time?

**Helen Leonard**—I am happy to take questions from you.

**Dr Vernon**—I just wanted to make a brief introductory comment. I am a recent member of the Women's Electoral Lobby and have come to have an interest in and be informed about birth issues only recently, having had a baby myself last year. It was very interesting, in that process and in coming to look at the Senate committee's terms of reference, to realise the extent to which a consumer voice really is not as present as it ought to be in discussion about childbirth procedures. So that was my main interest in being here today.

I think there is one quick point I would really like to underline. As Ingrid has already mentioned—and I think the submission makes this point very clearly effectively—childbirth has emotional dimensions as well as physical dimensions, and that seems to be one of the key areas that is not being adequately addressed in the current provision of services. The approach that is often taken—and I have done quite a lot of reading and had discussion with many women about this—is one that deals with the physiology of childbirth and does not recognise the emotional dimension to that experience. Consequently, even when women agree to many interventions they may not be aware of the emotional implications; that is, how they will feel about that birth, and the fact that they may feel they have failed at the birth, because that affects their relationship with their newborn baby, et cetera.

So I think it is a very important thing that you are meeting with groups of women around Australia who have experienced different kinds of childbirth services. Of course, their views on those services ought to be taken more into account in the development of policy, not just in this committee but also generally.

**CHAIR**—Thank you very much.

**Senator GIBBS**—I noticed that on page 6 of your submission you mentioned that it is well documented that privately insured patients receive higher intervention in birth than public patients. The witnesses we had before from the department of health said that, of

course, the whole caesarean section is complex, but they maintained that there is a higher percentage of women who have babies at a later age who take out private health insurance as to public health insurance. Therefore, that was the reason why this came about with a higher number of private patients receiving caesareans. Have you found that in your research?

**Ms McKenzie**—No, and I would question whether because the mother is older that means she has to have a caesarean. I do not know that there is any evidence connecting age and intervention.

**Senator GIBBS**—Have you found out anything in your research about this? Is it the woman's choice? Is it the doctor's choice? We can all understand having a caesarean if you go into hospital for a birth and things start to go wrong. But have you found any indication that people choose caesareans deliberately—that the woman makes her own choice, for whatever reasons, or that it is the doctor's practice? What exactly have you found out about this to make this sort of statement?

**Helen Leonard**—I will give you an idea of where my view on this comes from. Until two years ago, I was a nursing mother's breastfeeding counsellor for about 27 years. In that time I have spoken to many women in that early period, mostly after they have had their babies. For the vast majority of those women, the difficulties that they had in breastfeeding—for which they came to me—had their seeds in the birthing experience. There are many stories about that.

During that period with the nursing mothers, we did quite a bit of research into a question that you raised with the previous people sitting at this table: how do women make their decisions? Where do they get their information to make their decisions? With regard to breastfeeding, it was clear that they listened to their medical advisers. Around that time of life, there are lots of conflicting views about how a woman should be conducting the process of life. For breastfeeding, it made a huge difference if the doctor said something positive like, 'You look like you will have no trouble breastfeeding,' rather than, 'You are going to have to fix your nipples.' The inference and the words used at that crucial time of life made a big difference.

With the birthing area of life, the messages that the doctors bring are just as important—probably even more so because the woman is focused on the birth rather than on the breastfeeding. They will think about that after it has all happened.

**Senator GIBBS**—Initially.

**Helen Leonard**—Yes—until it happens. Until the moment after.

**Senator GIBBS**—That is right.

**Helen Leonard**—One of the reasons that our other witness was not here today—and I wrote this down as she was talking—is that it is Friday. Friday is induction day. She said things like '9 to 5 obstetrics': doctors try to keep it within hours so that they can have a rest of life. But she was also talking about the training system for obstetricians, which feeds very much into the attitudes that they bring to the women that they are assisting to birth. In order

to become an obstetrician, you have to go through a process and do procedures a number of times. The term used for the women in hospital is 'teaching material'. It is not unknown that women can have 10 vaginal examinations so that the young doctors can get their numbers up. They have to get their VEs.

**Senator GIBBS**—Excuse me for interrupting, but is this in the public hospital system?

**Helen Leonard**—Yes, in a public teaching hospital. Those practices fit with the question that you are asking in that the medical profession is taught not to see the women in their whole experience—in the emotional part of their experience and in the things that feed into this huge change in life—but simply to deal with the potentially worst outcome. That is the framework that all of the rest falls out of.

We talk about an environment of fear that has been created by the medicalisation of birth and I think it has very much come out of this: the training and the profits that can be made from it. If you look back, the whole male takeover of childbirth happened—or increased, at least—around the time that baby bonuses were introduced in Australia. Midwives did most of the birthing before that but, when there was some money available for this birthing thing and it was the fashionable thing with the elite in England, it was taken over by obstetricians. The experience for the woman herself and her expectations and knowledge about what it might be like are so confused and mythologised that it is really difficult to make those decisions.

**Dr Vernon**—Can I add one quick point to that, too? It is interesting to note that the World Health Organisation's recommendations on appropriate technology for birth found that the countries with the best clinical outcomes in terms of morbidity and mortality had the lowest intervention rates. They had around 10 to 15 per cent of intervention, all up—that is not just caesarean rates, that is obstetric interventions—and that was good practice. In order to get the best outcomes, you had reasonably low interventions. That assumes that around 80 per cent of women are capable of giving birth to their babies with midwifery support, with monitoring, et cetera, but without obstetric intervention. There is a whole list of the sorts of interventions we are talking about in the submission.

In Australia that picture is very different, even anecdotally; it is hard to get an indication from the statistics because the statistics are not clear on non-intervention births. Most hospitals will rank a vaginal delivery that has had any number of obstetric interventions as being normal. They do not have the separate category of non-intervention birth, and rank it as normal. So it is hard to get a picture in Australia but, anecdotally, it seems that the intervention rates are much higher—in some places as high as 60 to 70 per cent of women presenting to birth in hospitals.

**Senator GIBBS**—What countries are we talking about?

**Dr Vernon**—New Zealand is one of the prominent ones. Finland, I think, is another.

**Senator GIBBS**—This is for non-intervention?

**Dr Vernon**—Yes.

**Ms McKenzie**—Also the Netherlands.

**Dr Vernon**—They each have strong models of periphery care, where a midwifery model is supported in many practical ways by the national governments—through funding, through education and through options available to women. That has very different implications for the sorts of services women are choosing and their success in birthing without obstetric assistance.

**Senator GIBBS**—We heard from previous witnesses that there are now birthing programs attached to hospitals. Have you found from your research that more women are actually choosing to go to these places rather than to the larger hospitals?

**Ms McKenzie**—I know that in most birthing centres they have a limited number of rooms. Often women turn up and there is no room for them, so they have to go upstairs. They also have strict protocols—which, to our mind, would be too strict—as to who could access the birthing centres.

**CHAIR**—Like what, Ms McKenzie?

**Ms McKenzie**—You are not allowed to be overdue by more than a certain amount of time. I would have to take that on notice and get the protocols from the centres here. As soon as you are induced in certain hospitals, that is an intervention—you have to be upstairs in the delivery suite. You have to go upstairs for things like breech birth—which should be able to be handled perfectly adequately in a birthing centre—multiple births and high blood pressure. You have to go upstairs for a lot of things. There is a very narrow view about what is normal and what is a low risk pregnancy. Their definition of low risk is not the 90 per cent that is recommended by the World Health Organisation. It is certainly much lower than that.

**Senator GIBBS**—That is interesting. We were also informed before that there are very few women who have home births. Have you looked at home births at all? Of course they have to be low risk ones. I noticed in your submission and previous ones that private midwives are not covered by Medicare. I take it that midwives in hospitals are a different matter. Have your studies indicated that more women would actually choose their births to be delivered by midwives? Is there any indication that if the Medicare allowance was applied to midwifery, private midwives, that there would be a change in birth practices?

**Ms McKenzie**—On average, an independent midwife will be \$2,000 for the first birth. How many women can afford \$2,000 to be guaranteed an intervention-free birth? It is just not accessible to women. I know of a number of women who would choose a home birth if they could.

**Senator GIBBS**—But home births would be a lot more dangerous, though, wouldn't they?

**Helen Leonard**—That is the myth.

**Ms McKenzie**—That is certainly the myth.

**Helen Leonard**—Can I carry on with the Medicare thing? I think if independent midwives were accredited and covered by Medicare it would be a signal that this is an appropriate way to birth with the appropriate criteria and all the rest of it. One of the reasons why New Zealand have such low intervention rates is that their system of home birth and hospital transfer is seamless. In Australia, if a woman elects to have a home birth and there is a problem, there are even delays—the woman will decide to delay if she does not want to get to the hospital because she knows the hassles she is going to get. The midwife is going to be excluded; she is probably going to cop it from the doctor and nurses and all of that kind of stuff. In New Zealand it is completely different. The systems work together. It is assumed that most births can be dealt with by a midwife—and even there it is not about a patient being delivered, it is about a woman giving birth, which is a completely different philosophy about what is happening.

**CHAIR**—Would you allow, though, that in some parts of Australia there is a very different arrangement from what you have just described for home births?

**Helen Leonard**—In terms of transfer?

**CHAIR**—In terms of transfer, acceptability, doctors doing the delivery, brawls that were had 10 years ago with the obstetricians which are all sorted out now.

**Helen Leonard**—I think there are pockets, and I will only say that because that is changing around, and what has been happening in New South Wales over the last year is really affecting the whole of Australia. It is rolling back.

**CHAIR**—If there is anything you can provide for us on that, that would be very important to know.

**Senator GIBBS**—I was just interested where you say that relations between obstetricians and many independent midwives are so poor that most of these midwives do not have the support and back-up needed to provide the best service to women. Correct me if I am wrong here but, to be a midwife, do you not actually have to be a fully trained nurse and then do your midwifery after that?

**Ms McKenzie**—At the moment that is the case, but there are calls and moves towards having direct entry midwifery courses.

**Senator GIBBS**—But at the moment you do, so you are a trained nurse and then you do your midwifery as an extra.

**Helen Leonard**—This is fairly new, too, because there have been traditional midwives who have had an accreditation system through another process. I know the New South Wales situation where legislation was brought in to prevent midwives who were not trained as nurses first and then did their midwifery afterwards. The argument from the home birth movement is that that has changed the perspective, the philosophy of it, because again nurses are trained in medicalised birthing as opposed to the woman-centred way.

**Senator GIBBS**—When did this legislation come into being?

**Helen Leonard**—In New South Wales, two or three years ago.

**Ms McKenzie**—I would like to reiterate that what we say in our submission is that you should be able to have an intervention-free birth in a hospital. We are not particularly advocating home birth.

**Senator GIBBS**—I understand that.

**Ms McKenzie**—Although, at the moment, it is the best model of care for women. Women should be able to choose to birth where they wish and have the kind of birth that they want to have. You said, ‘Is it not safe to give birth at home?’ There is a lot of research to show that home is actually the safest place to give birth, and that is because of everything we go through. Intervention leads to the non-safety of birth. Ninety per cent of women are low risk women who find it safer to give birth away from the doctors who cannot keep away from them and cannot wait for a slow birth to unfold, to assist a woman to give her confidence that she can do this. She gets to the second stage when she says, ‘I can’t do this any more,’ realising that that is about second stage of birth—it is not about whether she can birth.

**Senator GIBBS**—That is called the pain threshold, isn’t it? Some of us have it a lot lower than others, I can assure you.

**Ms McKenzie**—It is not necessarily about pain because birth, as you know—I presume you have children and you have been through it—

**Senator GIBBS**—Yes, I have children.

**Ms McKenzie**—It is hard labour, and a lot of women do not experience it as pain, or have methods of dealing with the pain. How you are in birth determines the level of pain you experience.

**Dr Vernon**—Could I add a point here? I had a baby at home last year, and I found that one of the greatest gifts of the independent midwife I engaged was that she supported me. I trusted her judgment implicitly that if I required assistance we would transfer to hospital. She had an informal arrangement with the hospital that would allow her to continue to be with me, but she is not allowed formally to practise there. I knew that she would make an informed and extremely experienced judgment with over 300 births at home that she has attended and countless before that as a hospital midwife.

In the process actually leading up to the birth, she gave me support to come to terms with the emotional challenge of labour and of the pain that you are talking about. It is a physical process but it is also very much a mental and emotional challenge. How am I going to feel? Am I going to cope? What is it going to be like? It is very common for women to get very close to the end of first stage—which is where the cervix is being dilated—before second stage which is where the baby is then being pushed out and to find that it is overwhelming. That is a very common point in my discussions with very many women about this over the last two years. They say, ‘I really can’t cope with this,’ and the hospital system

says, 'Fine, we will help you.' They have epidurals, they end up with forceps deliveries, caesareans or whatever.

Women at home experience exactly the same point. They get to the same point where they think, 'I can't manage with this,' but it is quite a short lived point. It is a transition point to the next stage of labour which is a lot less painful for many women. They have the support of people around them and practical things like hot packs to deal with that transition point. If you are actually anticipating that you are going to get to the point of feeling that you cannot manage, and that it is a normal part of the experience, you do not panic because you see it as part of the process.

A continuity of care model that is provided in home birth midwifery at present really does provide women with the support prior to birth to have confidence in their ability to labour and to see that as a natural process rather than as a fraught process. Most of the antenatal training that is going on at the moment teaches the physiology, but it does not prepare women emotionally and mentally for the birth experience. They are often quite surprised with the first baby to find the intensity, that they feel a bit out of control, that it is very painful or whatever.

**CHAIR**—We are very strained for time. We started a bit late and I will certainly give you a few more minutes, with acknowledgment to our next witness that we will try not to run over. I wonder now if we can keep our answers more focused. I would particularly like to ask you what you are going to say about women who march into hospital and say, 'Right; I don't want any pain, I don't want any nonsense; I want to have a caesarean and get this out,' or 'I'm very thrilled to have my baby on Friday, induction day.'

**Helen Leonard**—It is all in our vision. It is about options. If a woman is at that point and wants to make that choice, fair enough. It would be nice to be able to share some information so that, if she had a second child, her options were wider.

**Ms McKenzie**—Would she make that decision if she had had the education that Barbara was talking about—if she knew that complications from caesareans are very much more serious than a lot of complications from vaginal birth, that caesareans are 10 times more dangerous than a vaginal birth? Women are not informed about that. I did hear the end of the evidence given by the previous witnesses, who talked about that. But women are not informed about that. Nobody knows that a caesarean birth is 10 times more dangerous than a vaginal birth. The women who march in there have been enculturated in this climate of fear. They have seen their doctors who pathologise birth. If there is the education which our first recommendation is outlining, evidence based education—and that is a major point, that most of the practices around birth are not evidenced based—then those women probably will not make that choice. I do not think doctors can say, 'Women are asking us to give them caesareans.' Have they educated those women? Have those women had the education that Barbara was talking about?

**CHAIR**—We have got on the record a comment, and I think that it is very important.

**Senator GIBBS**—You talk about psychology and all sorts of things in your submission. It is very good. You talk about both private patients and public patients being simply not

educated enough in the process of giving birth to their first child and that, if we educate women better, give them far more information when they are having their first child, we will alleviate a lot of these intervention processes, because women these days speak their minds, they are better educated and they will say, 'No, I will not have that.' Years ago, when I had mine, you just thought doctors were gods and they did whatever they liked. Is that basically what you are saying?

**Helen Leonard**—That is a lot of it. Life is busy these days. Women are likely to have only one child. At the most, they would have two. They tend not to think about this area of life until they are actually going to be doing it, until they are pregnant, and then there is a whole lot of other stuff which happens. Again, they are going to get conflicting information. It is more than simply the education. The information needs to be there, but it needs to be in such a context that there is trust about where that information is coming from and within an environment where there is support for it to happen. That is why I think organisations like the childbirth organisations, nursing mothers and others, where women are able to swap stories with others who have done the same sort of stuff, are so incredibly important, because male doctors, in particular, have not done this stuff. Their intention is to end up with healthy mothers and infants and to bring their skills, as they have learnt them, to that, but their experience about the process is very different from that of the women and it does not meet the needs of the women.

**CHAIR**—Can you discuss your recommendation 16, which reads:

That the medicare Schedule be amended so that it does not provide incentives for intervention in birth.

**Helen Leonard**—Maybe I could start with the sort of cascading effect of interventions and somebody else can talk about the Medicare part of it. I am going to say something that I hate saying: it is well documented. I usually like to have a footnote at the bottom and I have not got that. Once the first intervention starts, and if it is an induction with a drip, a whole series of other things are likely to happen, because the woman is going to be stuck in one place, usually lying on her back, which is not the easiest way to give birth.

**Senator GIBBS**—The worst. Sitting is better.

**Helen Leonard**—Exactly. You use gravity and you use the muscles the way that they were made. The birth slows down and some ideas about what are risks are brought into place by the medical establishment. Maybe membranes are ruptured, the labour is long so there is some pain intervention, and maybe it is an epidural—the whole sequence of events that are going to happen. Each of those things attracts a cost to Medicare which is greater than if the woman was at home with a midwife.

**Dr Vernon**—Or in hospital with a midwife.

**Helen Leonard**—Or even in hospital with a midwife, yes, but in a supportive environment where the process of labour was allowed to occur under good supervision, providing the things that assist the woman to actually use her body to make it happen as easily as it can, with good outcomes to both.

**CHAIR**—I am interested in this and maybe I will have to check for further information so I am absolutely clear. As I understand it, for the process of delivery anyhow there is now one Medicare fee that covers the delivery, unless the caesarean section is done by somebody who has not previously seen that person. I would need to check whether or not that fee covers the caesarean section but I understand it might. It is interesting that you have made your points. I actually have a large sympathy with them but I understand that in the late 1980s the medical benefits schedule was changed to have a one-up fee so that there was not the same kind of inducement for procedures to be done.

**Helen Leonard**—I will go and check that footnote.

**CHAIR**—I think we do need to get some facts on that. The interesting thing is that certainly our previous witness, Professor Lancaster, was saying that this means that we now no longer have access to data from the Medicare benefits schedule on the number of caesarean sections done. We might have to look at whether or not putting it together to prevent the incentives has actually confused the picture and duded us perhaps of some of the access to data.

**Ms McKenzie**—My understanding is that—not that I have a lot of evidence about it but from talking to health care professionals—there has been an amendment to the schedule recently and there has been a new item inserted for complex births.

**CHAIR**—And complex is anything from having an episiotomy to what?

**Ms McKenzie**—I do not know. I cannot give the information on that. We would have to do more research.

**CHAIR**—I would certainly appreciate your comments on that, Ms Leonard. I think what all of you have provided us with is very useful. As you say, once the intervention starts then it tends to lead to others. Maybe the financial arrangements are encouraging that. I certainly have to say I appreciate now that there is more for me to find out about that, too. We will look at it, but I note your points about that. Do you have any evidence that people would use the midwife more often if it was at no cost or lower cost?

**Ms McKenzie**—Anecdotal evidence only. I do not know how you would get that kind of research. But, presumably, a \$2,000 fee would be a pretty good discouragement for a lot of women.

**Dr Vernon**—I think it is possible to actually go one step further. Changing the Medicare rebate to include independent midwifery would be a positive step for consumers, in my view. I do not think you would get a rush on that rebate from people because there is quite a small number of women who are keen to birth at home. What we ought to be doing is looking at what are the key elements of a home birth midwifery model that should be transferred more into a hospital setting, so that women who choose a birth centre or a hospital can still receive all the kinds of positive things that women are getting in home births.

One of the things that would be good and I would really recommend to the committee to look at in a bit more detail is the New Zealand model. My understanding is that they have a

system where they identify someone called a lead maternity carer. From the moment a woman is pregnant until after her baby is born by several weeks—because there is postnatal care—the lead carer of the woman's choice is the person that gives her support, whether professional, medical et cetera. That system does not discriminate between obstetricians, GPs, midwives, and there is one other—

**CHAIR**—Can I say that that sounds like very useful information and the committee will certainly follow that up. Thank you very much.

**Dr Vernon**—There are some references in this paper, and I am aware of another submission that has references to further information on the New Zealand model.

**CHAIR**—Is the Women's Electoral Lobby aware—you have talked a bit about it and I think you are, but can I just get it on the record—of the idea of home birthing in hospitals with the midwives involved outreaching from the hospital to people in the community where you have midwives on salary to a public hospital, so it is at low cost to the parents out there who want to use them? Does this get a tick from the Women's Electoral Lobby?

**Ms McKenzie**—Yes. The team midwifery model also provides better outcomes in the research than the hospital based ones. It is the continuity of carer that provides the difference for women.

**Dr Vernon**—I do not know WEL's formal position on this but anecdotally there is a lot of indication that women find it very beneficial to have follow-up care from a person that they know, the person who was present at the hospital when they went and who then attends them in their own home to look after their baby and do early postnatal checks.

**CHAIR**—We are running out of time. If there is anything further that strikes you, please feel free to let us know. I also appreciate very much the way your submission is written, giving us some very bold recommendations. We could go home now; the recommendations are written. We are going to have to weigh them up, including the evidence that might support or allow the committee to concur with your recommendations, but it is a very useful way of putting it.

I also think that, while it is not the intention of the committee to suggest that birth is that thing that happens once you get into hospital and get out again, I think it is well for the committee to be chided to remember that birthing is a process that starts before you go to hospital and continues after you leave. I think those points about the wellness of the woman particularly, but also of the family, are very interesting. I particularly like your comments about that leading to a higher likelihood of breastfeeding and the consequent good health outcomes down the line because of that.

If you had any data that could confirm that, I think we would be very pleased to receive it. I thank you very much for your attendance this morning.

**Dr Vernon**—Thank you very much.

[12.28 p.m.]

**SULLIVAN, Mr Francis, Executive Director, Catholic Health Australia**

**CHAIR**—I welcome Mr Francis Sullivan from Catholic Health Australia. The committee prefers all evidence to be given in public, but should you at any stage wish to give your evidence, part of your evidence or answers to specific questions in camera, you may ask to do so and the committee will give consideration to your request. We have before us your submission. Do you wish to make any alterations or additions?

**Mr Sullivan**—No, Senator.

**CHAIR**—Would you like to make a short statement and then field questions?

**Mr Sullivan**—I would like to make a couple of qualifying statements. Firstly, our submission is the result of three major members of Catholic Health Australia—St John of God Health Care, the Mater groups in Brisbane, the Mercy for Women in Melbourne and Mater North Sydney. Generally speaking, the Catholic hospital sector, 26 Catholic hospitals in particular, conduct obstetrics and gynaecology in the non-government sector at a greater proportion than anybody else. For example, the Mater in Brisbane does 7,500 deliveries a year, the Mercy for Women in Melbourne approximately 4,000 and the St John of God, Subiaco and Murdoch, approximately 3,200. So in the area of women's health, the Catholic sector has a significant contribution to make.

**CHAIR**—The Mercy figures of 4,000—that is both private and public?

**Mr Sullivan**—The Mercy for Women in Melbourne is a public hospital.

**CHAIR**—So that is all public?

**Mr Sullivan**—Yes.

**CHAIR**—Are these figures all public hospital figures?

**Mr Sullivan**—In the case of the Mater in Brisbane, no. That 7,500—I am just not sure if we have the breakdown. We can give the public and private figures to you on notice if you like, which would be easier for you.

**CHAIR**—That would be great. But St John of God—

**Mr Sullivan**—Is all private.

**CHAIR**—All private?

**Mr Sullivan**—Yes.

**CHAIR**—So we have 3,200 all private from St John of God, WA?

**Mr Sullivan**—Yes.

**CHAIR**—And we have 4,000 all public from the Mercy in Melbourne?

**Mr Sullivan**—Yes, under that title.

**CHAIR**—And 7,500 who are probably a mixture?

**Mr Sullivan**—A mixture. In Brisbane, as you know, there is Mercy, there is the adult, there is the Mercy Mothers, Mater Mothers and so on, and there is a private.

**CHAIR**—If you could provide us with any further breakdown, that would be really useful. Thank you.

**Mr Sullivan**—Yes, I will. Firstly, the technical information here is best addressed to Professor Con Michael. I understand the committee may go to Perth. It would be in your interest to call him because he is the professor of obstetrics and gynaecology who, for most of his time, has worked in the public sector and now, of course, is the chief medical adviser for the St John of God Health Care system. He has been a professor that has taught in the area for many years. He informed us on a lot of the research that comes with this submission. He would be the person that would give the best accurate detail about trends and the like.

I also qualify some of our comments by saying that the Mater, which put in its own submission out of Brisbane, is also part of a delegation here this afternoon. I am not going to waste your time in going over things that they may say.

We particularly wanted to put in a submission that went straight to your terms of reference and what you are looking for. The general impression that we have received is that—it is a point that you made earlier, Senator, and I think it is a very important point for the inquiry—you are looking for empirical evidence rather than anecdotal. We have basically been advised that in some areas the data is not very good. Therefore, as far as general trends go, is it the case that interventions, for example, are more the case in the private setting than in the public setting? If there is any data to demonstrate one or the other, what are the real reasons getting underneath that? It is obviously more than insurance status, whereas there could be that common view. It has a lot to do, I understand, with the age of women, with the circumstances they are in and so on. This is obviously a view coming from hospital based providers.

The other important point here that I noted in the previous session was about Medicare rebates. The most recent Medicare rebate in this area was to do with complicated deliveries. It appeared to deal with the issue of gaps. It had little to do with the issue of quality, access and the like. One could argue access is related if there is a gap component. It appears from earlier evidence, again, that it has addressed gaps to some degree, but certainly you could not argue anything about it improving quality or standards of care and the like—as we know the medical profession has an issue with this—unless we attach payment to those outcomes, which is a much more direct arrangement. It will be interesting to see how that unfolds. They are the general comments.

**CHAIR**—Thank you.

**Senator GIBBS**—I have only a few quick questions because your submission is very detailed. With the case of the private patients as opposed to public patients, we heard from the previous witnesses that the increase in caesareans over the years is a result of older women giving birth. Have you found this to be factual with the research that you have done? A lot of older women can actually have normal births, so I do not know about that higher proportion of older women. In Queensland there seems to be a high discrepancy because we seem to have a huge rate of teenage births in Queensland, and we have had in the last couple of years. Do you have any evidence?

**Mr Sullivan**—The information that we have got in our submission and the general commentary that we are supplied with indicates that that is a moot point. Obviously, we are told that the over-35 age group of women are likely to have more intervention, but that could be because of complicating factors. As we say in our submission, it is important for more research to be done on tailor making birthing procedures for specific groups in the community. They may be ethnic specific or they may be to do with the health status that has come from being low socioeconomic, as we know the factors there. As far as our submission goes, there is not a definite position on that. Clearly issues of age come into it, but not necessarily as the determinant.

**Senator GIBBS**—We should look into this specific data for different areas before we can have an answer to this question. It is quite disturbing. I am sure a lot of people are quite disturbed about it, including the medical profession.

**Mr Sullivan**—Yes. I would simply qualify everything I say by saying that the people at the coalface in our hospital system and others, whom you will speak to today and in Perth, will be able to qualify what is the experience. We have been heavily pressed to make the point about proper data and how it can be obtained. Frankly, I do think it is incumbent upon the Commonwealth to look into this, particularly when we want to talk about best practice benchmarks and the like. I think you will obviously get the cooperation of the colleges with that regard, but there needs to be a leadership role here by the Commonwealth.

**CHAIR**—I am interested in page 12—I cannot miss the opportunity, Mr Sullivan—which states:

Patient care has not been influenced by the increasing funding, nor would you expect it to be as the standard and quality of care should always be related to patient needs rather than a Medicare number.

I am glad you smile. For the *Hansard* record, Mr Sullivan smiled.

Partly I know what you are saying—that is, what you hope is that the funding is sufficient to cover a reasonable cost so that a person is not prevented from getting service because they cannot afford it. At the same time, the hospital, the provider, the general practitioner or the midwife also needs to be reasonably remunerated. If I were being picky, I might also say that funding does make a huge difference in terms of, for example, access to adequate antenatal screening to the point where that whole thing is up for grabs. Have we had too much intervention and so on? Would you like to now put a rider on that statement?

**Mr Sullivan**—Probably a qualifier in the sense of saying that what we were trying to express there was what I probably led off with—that is, the notion of the rebate was all to do with getting the gap addressed. I think I was trying to say that we would not expect that gap mechanism to automatically improve standards of care and the like. I take your point. When we are talking about funding in the broad, then obviously proper funding means that we are going to be able to put in place proper clinical protocols. We are not trying to imply the broader issue.

**CHAIR**—What data do you have of what services you provide for people of Aboriginal background?

**Mr Sullivan**—Mainly in Queensland there would be some. It is not a significant amount. It is somewhat of an embarrassing commentary for us at the present time, the degree to which we are significantly involved in Aboriginal health in general.

**CHAIR**—It is actually interesting to think about it, seeing the Catholic church has been so involved in Aboriginal care, that it is not in terms of health care.

**Mr Sullivan**—Further to that, you may have noticed recently that when the Northern Territory was looking at the administration of its public hospitals, one of the first groups that put its hand up was ourselves to be in that discussion. We were very interested in the areas where many of the for-profits would not want to go, the Alice Springs areas and the like. It was the Mercy Hospitals of Brisbane and up in Rockhampton along with the St Vincent's system which put together a joint expression to the government to say that we would be very interested because we want to move. Equally, at Balgo in Western Australia, the only Aboriginal health service in that area for years has been conducted by the Sisters of Mercy. But my comment was qualified: a significant contribution is not there at the moment as we are adjusting, like everybody else, to survival in the hospital sector.

**CHAIR**—Do you know the outcome of that Northern Territory decision yet?

**Mr Sullivan**—I understood a decision was made in cabinet to take it off the boil.

**CHAIR**—So all your submission work is back on the shelf again.

**Mr Sullivan**—One can only assume that it is all good intellectual property.

**CHAIR**—I have had the pleasure of launching a book at the Mercy Hospital in Melbourne acknowledging the extremely comprehensive program that the Mercy has introduced for people having babies taking regard of their multicultural background. I am not sure whether it was 26 or 40 different languages. The Women's Electoral Lobby has just told us of the importance of birthing for women. The Mercy Hospital also pointed out the importance of it for a culture—that whole ongoing aspect of the race, of family, et cetera. The Mercy have put a huge effort into having interpreters, trying to be culturally sensitive, having all sorts of different things taken into account. Do you have any data about the outcome of that and, in particular, the cost of it? I understand that this was done in the public sector area and done with a huge amount of consultation. I would just like to know whether you were given a grant. As I was representing the minister for multicultural affairs

and not the minister for obstetrics, it may well be that the Mercy Hospital were getting funding but from a different ministry. Could you provide us with any data about any funding they got and the range of their consultations, because I do not recollect it, and I suppose data on the outcome. Presumably one would have to say this is a good thing, but has it made a difference?

**Mr Sullivan**—I will certainly do that. My understanding at around the time of that launch was that the whole purpose of it—as you know, around the Mercy for Women there is quite a significant Vietnamese community in Richmond, that area of Melbourne and the like—was certainly a part of the Sisters of Mercy's idea of serving local communities. It would not have been done in a half-baked way. I will certainly get some background for you, and any outcomes they have got we will supply to the committee secretary.

**CHAIR**—If you can do that, that would be very useful. I am terribly interested in it because, in my own state of South Australia, one of the hospitals, the Queen Elizabeth Hospital, is under enormous pressure to close—if not the whole hospital, at least its maternity area. The community group associated with that has highlighted that the maternity section is particularly owned by the local community, and that it is also very culturally sensitive, particularly for the Vietnamese community, but to others as well. So your data might be useful for us when we look at other states, too.

**Mr Sullivan**—It is important that people understand that communities view hospitals and hospital services as very much part of their local fabric. I think we have lost a bit of that in the debate of late.

**CHAIR**—It is quite interesting because some of your hospitals probably actually own a sense of community. You might tell us how they do that. Even though they do not necessarily do that per the actual local community, they have a kind of loyalty attached to them from people who have been there. There may be others who would write and say, 'Never again,' so we will not say it is all heroic, but that notion of community around your hospital is a bit interesting. That is a distraction from what I was just going to ask you; I am sorry.

**Senator GIBBS**—While you think about it, I want to ask about Aboriginal women. I am particularly interested in Queensland. I know in previous submissions—we are talking about caesareans here—it was shown that teenage Aboriginal women had such a high percentage of caesarean sections. I take it the hospital in Rockhampton looks after people in Woorabinda and the Rockhampton area stretching out to that area.

**Mr Sullivan**—I can take it on notice and get specifics for you.

**Senator GIBBS**—I was just wondering if you had any statistics on the number of caesareans on teenage Aboriginal women—and why. I know the excuses are here that say poor health, alcoholism and all the rest of it, but, as we both know, a lot of the communities are dry and a lot of Aboriginal women are teetotalers because they have seen the destruction that happens. I think every church is out there in Woorabinda. The nuns who have been working out there for years are my friends. Sister Mary has gone back to Ireland now, but

she tells me that every church is out there, even though there are a lot of problems. I would really like to know why, if you could.

**Mr Sullivan**—I will certainly ask for whatever information we can give you on that. As to the why, we can give our ideas about that.

**CHAIR**—Can tell us today but provide evidence later about the difference between your public and private patient deliveries that is matched across the broader statistics? Also, are your hospitals prepared to provide us with data on a hospital-by-hospital basis?

**Mr Sullivan**—On the specific issue of?

**CHAIR**—Whether your caesarean sections are higher in your public patients or your private patients. And, if they are higher in your private patients, as I suspect will be the case, would you be able to give us this on a hospital-by-hospital basis? Also, can you tell us if you have any reasons that might justify any differences that are there. I note that on page 4 you say:

There is an implication that differences which exist between public and private patients exist because of their public/private status. Studies of this area repeatedly indicate confounding factors. Unpublished data (personal communication) postulated a higher rate of Caesarean section in insured patients but found this association disappeared when this was controlled for the age of the patients.

I think some of the evidence earlier today suggested that age might contribute to some explanation of some of the difference but it is not sufficient for all of it. Is personal communication, by the way, a new way of saying ‘anecdotal evidence’?

**Mr Sullivan**—No. That would be a great question to give to Professor Con Michael because I am assuming it is his.

**CHAIR**—Thank you for that. That would be really interesting. The other question I wanted to ask you about was this: given that you have created a sense of community around some of your hospitals, do you have a program of midwives around the Catholic hospitals, and are any of them able to do outreach from the hospital and, in particular, would you encourage home birthing?

**Mr Sullivan**—I cannot answer the last one by way of policy because I am not aware of the general policy. But we are also being pressed by many of our members to put on the public table the idea of midwives having admitting rights and the like with hospitals, so by implication they are also talking about the whole continuum of care. I pick up the comments in the previous submission. We are keen on the continuum of care, integrated care, connecting up with community nursing groups and the like, so it is not outside the realm of our thinking or philosophy to go down that path. But we have no specific policy, as you have couched the question.

**CHAIR**—Do you have home birthing, alternative birthing, home-birthing centres in any or all of your hospitals?

**Mr Sullivan**—I could not be specific but I can give you details.

**CHAIR**—Could you? That would be great. And if you could give us any data on how many people are choosing the birthing centres and whether that indeed is increasing, that would be really helpful.

**Mr Sullivan**—Okay.

**CHAIR**—Any further questions?

**Senator TCHEN**—Mr Sullivan, in your comments referring to term of reference (j) on page 12, earlier you answered a question to Senator Crowley. To qualify some of this statement, in here you say that certainly gap payments have been reduced by the new funding and that this has been a positive initiative. Are you able to say whether the introduction of the new complex birth rebate has been of benefit to patients?

**Mr Sullivan**—The comment we are making here is that the rebate has reduced gap payments, and it is quite obvious that people with insurance find that a nuisance, so to reduce the gap is a benefit.

**Senator TCHEN**—Thank you.

**CHAIR**—A nuisance, Mr Sullivan?

**Mr Sullivan**—I would find it a nuisance, Senator.

**CHAIR**—I do not think that is quite the word that most people use, is it? Another sort of pain, I suspect. As there are no further questions, I thank you very much indeed, Mr Sullivan. Thank you for your submission and for your offer to find some more data for us.

**Mr Sullivan**—Thanks for a week's work!

**CHAIR**—The committee stands adjourned for lunch.

**Proceedings suspended from 12.53 p.m. to 1.37 p.m.**

**CAHILL, Ms Anne, National Director, Women's Hospitals Australia**

**GOLDSTEIN, Dr Stan, President, Women's Hospitals Australia**

**JARVIS, Ms Jennifer Beverley, Member, Women's Hospitals Australia**

**OATS, Professor Jeremy J. Nicolls, Executive Member, Women's Hospitals Australia**

**SWEET, Dr Ross, Member, Women's Hospitals Australia**

**CHAIR**—Welcome. The committee prefers all evidence to be given in public, but should you wish to give your evidence, part of your evidence or answers to specific questions in camera you may ask to do so and the committee will give consideration to your request. We have before us your submission, No. 69. Is there anything you would like to add or any alterations you would like to make?

**Ms Cahill**—I have a page of alterations that are mostly statistical, as more data has come in.

**CHAIR**—Much appreciated, Ms Cahill. That is fantastic.

**Ms Cahill**—Rather than read it out, would you like me to hand it over?

**CHAIR**—Yes, thank you very much. Is it the wish of the committee that that be incorporated in the submission? There being no objection, it is so ordered. Would you like to speak to your submission? Then we will field questions.

**Dr Goldstein**—Women's Hospitals Australia and the Australian Health Care Association congratulate the Senate on this important public health initiative and emphasise the following issues arising from their submission. Firstly, childbirth is the single largest reason for hospital admissions in this country. It impacts significantly on the population's mortality and morbidity in later years and hence influences future health budgets. It should thus be recognised as a key priority area in the health portfolio in the same way as are cardiovascular disease, cancer, accidents, diabetes, mental health and asthma.

There are enormous social and economic costs involved in adverse outcomes of childbirth, not only when direct health outcomes are less than perfect but also when childbirth consequences impact on the family, the development of the child and the capacities of the individual or family to optimally function into the future. As our data that we wish to table shows, there is great variation in practise across the country. One of our strong recommendations is that support be provided as a matter of priority to gather, analyse and then interpret the evidence so that guidelines and best practice can be developed to meet the conditions, expectations and requirements of the Australian community.

Women's Hospitals Australia is concerned that little recognition is given to the antenatal care of women. In particular, there are no Australian based data which have evaluated the wide range of antenatal screening tests which are currently used. A number of these

investigations are expensive and can cause discomfort to women. A detailed study is essential to evaluate and develop evidence based guidelines for appropriate standards for antenatal screening tests and the use of health resources. A review of the NHMRC report *Options for effective care in childbirth* is required to examine the validity of the recommendations in the context of 1999 and into the next millennium. Following that review, we anticipate that some funding would be required to enable implementation.

Finally, identifying and implementing best practice is a cornerstone of any program to enhance childbirth procedures in this country. Women's Hospitals Australia and the Australian Health Care Association propose 12 key areas be targeted. These are listed on page 34 of the submission. Thank you.

**CHAIR**—Does anybody else wish to make a comment at this time?

**Dr Sweet**—Senator Crowley, I am not sure if it is an appropriate time, but I have brought with me an example of one health care institution's attempts to write best practice protocols for 41 of the conditions associated with pregnancy, labour and childbirth. I wonder if the members of the committee might be interested in it as an example. I must say that these guidelines have been developed on clinical practice views and not on evidence based medicine. It is our hope that evidence can be found and brought to bear on the subsequent publication of guidelines, hopefully on a national basis.

**CHAIR**—Thank you, Dr Sweet. On behalf of the committee we would be avid to receive such information. Are you prepared to tell us which hospital?

**Dr Sweet**—It is the hospital in which I am employed—the Women's and Children's Hospital in Adelaide, South Australia.

**CHAIR**—Oh, well, lots of things recommend this inquiry, Dr Sweet. South Australia has the highest caesarean rate, and the best clinical guidelines, and a few other things, so that is particularly interesting. When was that concluded?

**Dr Sweet**—This is the third edition, which was completed in 1996.

**CHAIR**—What work are you doing to develop evidence based back-up for those clinical claims?

**Dr Sweet**—At the moment we are trying to utilise as much clinical evidence as is available through such organisations as the Cochrane Collaboration and to publish subsequently the level of evidence available. But I have to say that, at this time, the evidence available for many of these protocols does not exist. We need to find that evidence.

**CHAIR**—Who contributed to this? Was it only the doctors and the midwives, or also concerned mothers to be?

**Dr Sweet**—No, this document has been entirely developed by health care professionals, at that time without consumer input, which is something which will be looked at seriously for the future publications.

**CHAIR**—Just wait until the Women’s Electoral Lobby read that line. They have already given us evidence this morning and I am sure they would be particularly interested, as I understand all of you would be too. That is particularly interesting. I think Westmead is establishing an evidence based centre, at least for nursing, with Professor Nagy. I am referring to the paediatric centre at Westmead.

**Dr Goldstein**—The Children’s Hospital at Westmead is separate to Westmead Hospital, which is a general hospital, including women’s health services. I am not aware of the goings-on there.

**CHAIR**—I appreciate that. I understand they are trying to establish an evidence based centre particularly for nursing, I think, at the Children’s Hospital at Westmead. That might be an addition at some stage, or a place to go. It is still a struggle, is it not, to get evidence based information to practitioners in a timely way? What is your average lead time between what you know is a good practice and when it actually becomes practice?

**Prof. Oats**—It is very hard to give an informed answer to that. There are a number of projects going on. For example, in Queensland, through NHMRC funding, Professor James King at the Mater Perinatal Epidemiology Unit in collaboration with Queensland Health have a project looking at the introduction of evidence based guidelines for the management of premature rupture of membranes at term and also the management of group B strep infections. Part of their examination is the adoption by all the units of the evidence. I do not believe there is very good evidence, certainly in obstetrics and neonatal paediatrics, to answer your question.

**CHAIR**—That is very useful.

**Dr Goldstein**—As Dr Sweet put forward, I think that one of the problems is that the evidence is, in large part, lacking. The other is that there is little national coordination of how that might be incorporated into a guideline protocol or otherwise influence the practice, and therefore there would be a large range of time between when one hospital might adopt something that might look like an evidence based practice and when the rest of the nation might catch up.

**CHAIR**—Do you think it is necessary to go to a national perspective on this, or would state-wide do? If your answer to the question is, ‘We think national,’ what role do you think the Commonwealth department would have in that?

**Dr Goldstein**—We think national. I think that to do other than national would be a duplication of effort and no doubt a duplication of resources to go with that effort. The department, I would think, would have a role in providing some financial resource to allow it to happen, because it would take people hours to make it happen, and perhaps some oversight or input into the process so that it met their needs as well.

**CHAIR**—That certainly is the evidence from the previous witness from Catholic Health Australia.

**Dr Goldstein**—I do think, however, that the department could not be the prime mover of that process.

**CHAIR**—Because?

**Dr Goldstein**—Because I think that it has to be a clinically driven process. It has to be a process in which the stakeholders feel as though they have not only input but some degree of ownership of whatever is the final output. I do not think that there is any structure within the department to maintain it as a clinical structure.

**CHAIR**—I am very interested in those comments. It certainly goes to one of our terms of reference, which is best practice for safe and effective birth being demonstrated and so on. This is not about a bureaucratic takeover of standards of professional care at all. But I can also see that, if the department were sufficiently concerned about variations in standards of best practice, it might be appropriate for them—and I would be interested in your comments on this—to say that something must be done, and therefore charge the NHMRC, the college or whoever to do something about it. So they could be an initiator in that they can look at the data and say, ‘Whoops!’ but then ask the professional players to set the standards. Would you have any trouble with that?

**Dr Goldstein**—We would agree in principle but hope that they would charge Women’s Hospitals Australia with that role in that. I can explain that: we have a multidisciplinary approach. We have a mixture of management and all the various clinical professions, as well as some degree of empathy for allowing consumer input into the sorts of things that we do, as you might read in the policy documents that I think have been made available. That is not always available to NHMRC or the colleges, other than through an indirect means.

**CHAIR**—Could I say ‘sought by them’?

**Dr Goldstein**—I am sure it would not be my place to say.

**CHAIR**—You are smiling, Ms Cahill. Is that in recognition that that might be an affirmative reply?

**Ms Cahill**—I have been to many meetings where the Australian Council on Health Care Standards might be running all sorts of developments and where consumers and we as hospitals have stood up and asked for consumer representation. But different people have said to us, ‘No, that will make the committee too big.’ Likewise, I have raised the issue about hospitals. One hundred per cent of people who give birth are women, consumers, and 99.9 per cent of births happen in hospitals.

**CHAIR**—This is a breakthrough statistic, this one. Ninety nine per cent happen in hospital, and 100 per cent of people having them are women, despite recent movies which suggest to the contrary.

**Senator GIBBS**—Previous witnesses had data—or a lack of it—about caesarean section and a comparison of the amount of caesarean section operations undertaken in public hospitals as opposed to private hospitals—or should I rephrase that: public patients as

opposed to private patients. It seems that one of the reasons—not the only reason—is that women these days are older when they give birth for the first time. Have you found in any of your research or data in your hospitals that this is the case—that there is a bigger percentage of caesarean section in this country because women are now older when they give birth, and of course older women take out private health insurance?

**Dr Sweet**—There is some evidence that the age of the woman having a first baby and caesarean section are related, but the difficulty we have with raw caesarean section data, be it comparing hospital to hospital or private to public sector, is the vast number of at least anecdotal reasons given why the rates vary. We would wish to be enabled to undertake a study that allows us to look seriously at the reasons which are discussed on a clinical basis but not on an evidential basis as to whether these are genuine or not and which may then allow us to look seriously at the reasons why the differences appear.

**Senator GIBBS**—You do not keep any records. I know there are various reasons but I just cannot believe that suddenly the high rate of caesarean section in this country is because some women are leaving it later in life to have children. It just seems preposterous. Would you agree that possibly hospitals should keep records not only of caesarean section but also of intervention? Previous witnesses have said that there is no distinction between whatever the intervention is and caesarean section as far as data goes. Do you think we should have some sort of legislation or recommendation that hospitals actually do this so we can find out why we have one of the highest rates in the world?

**Dr Goldstein**—I feel very sure that all hospitals keep that data. All states legislate that that data is kept, so hospitals keep that data in various forms. What there may not be is a way of reflecting causality in the way that data is collected. It is definitely the case that older women giving birth for the first time have a higher caesarean section rate and that that is unrelated to private or public insurance one way or the other. But there are multiple reasons why caesarean sections are advised or undertaken.

**Dr Sweet**—One of the reasons that is believed to have influenced the caesarean section rate over the last decade or so is the belief that it was appropriate to deliver extremely low birth weight babies as a means of ensuring their delivery, as British Airways undertakes, ‘with a minimum of fuss’. That evidence is in fact now not believed. The introduction of reproductive technology has certainly influenced caesarean section rates. There is a risk of a caesarean in twin pregnancies of some 35 per cent; in triplet pregnancies, some 75 per cent; and in quadruplet pregnancies, 100 per cent. There has been a belief—rightly or wrongly—that the only way to deliver a baby presenting by the breech is by elective caesarean section, and in some places that occurs almost without exception.

**CHAIR**—Since when, Dr Sweet?

**Dr Sweet**—I haven’t the evidence for that, but I do know breeches equal caesarean section in some health care institutions.

**CHAIR**—Those are the sorts of questions that need to be chased down. It was not the case in the 1960s, in the textbooks of that time.

**Dr Sweet**—Indeed, it was not.

**CHAIR**—So what you are telling us is that low birth weight, for some extraordinary reason, suddenly became a cause for caesarean section. The data now says no.

**Dr Sweet**—I am saying that there was a time in the middle 1980s where, once the technology was available to ensure the survival of very low birth weight infants, it was believed for a time that it was appropriate to undertake a caesarean section as the safest means of delivery, that is, without trauma. What evidence there is now suggests that that is inappropriate and there has been a slight move away from that.

The point I am trying to make is that the reasons given by clinicians for caesarean sections are multifactoral. We have the evidence that they are occurring but we desperately need the tools to find out whether the clinical justification for these caesareans is based on some evidence.

**Senator GIBBS**—In medical terms, what is regarded as a low birth weight?

**Dr Sweet**—It is 2,500 grams or less.

**Senator GIBBS**—What is that in pounds?

**Prof. Oats**—About 5½ pounds.

**Senator GIBBS**—Five and a half pounds?

**Prof. Oats**—Yes. One also has to further break that down because we now talk about low birth weight and very low birth weight. Very low birth weight is between 500 grams and 1,000 grams, which is 2.2 pounds. We are now talking about gestations where babies are delivered for foetal reasons at 24-weeks gestation. That has also influenced, only in a small number, the performance of a caesarean section. Of course, the influence of that is that next time around, if the person is being delivered very prematurely, it may well determine that the person must have another caesarean section because they have had to have a classical caesarean section.

That is one of the other problems with our data. If we are just looking at raw caesarean section rates, we need to break between elective, particularly repeat caesarean sections, and those done for emergencies. There are obviously two parts to that. One part is getting good data—that is the evidence based guidelines—to help people make the decision about the right time or not to do the first caesarean section. The Women's Hospitals Australia, with support from the NHMRC, has just finished a project on so-called VBAC, vaginal birth after caesarean section, where we have got together agreed guidelines through all the member hospitals in Australia to help clinicians manage a person who has had a previous caesarean section.

One of the other important points—and coming back to a point raised by the chair—about the expectation that all babies presenting by the breech are delivered by a caesarean section, is very much now a community perception. This was highlighted for us. We tried to

participate, at the Mater Hospital for Women in Brisbane where I am the Director of Obstetrics and Gynaecology, in an international multicentre trial on trying to allocate, for a breech presentation, either to elect a caesarean section or a trial of labour.

We found we could not recruit into that. We recruited two patients over a period of about 12 months. Each time we thought we had presented our lack of convincing knowledge on this and why we thought it was important to be a part of the trial, the women—or her family, often—either had expected a caesarean section, or they wanted a vaginal delivery. There was no equipoise between the two. I think there are a lot of reasons driving caesarean sections of which community perception is an important one. Obviously, we need the evidence to then get the education programs to convince people that a vaginal delivery, under circumstances that the community expects, is reasonable.

**CHAIR**—Just before you go any further, Professor, can I suggest that expressions like ‘a trial of labour’ are not conducive to enlisting folk. ‘Would you care to assist us with our research project?’ might be much sexier.

**Prof. Oats**—I certainly reassure you that we do not use that terminology directly to the couple involved.

**CHAIR**—I am glad I asked the question, although ‘a trial of labour’ does have its term. You are saying, ‘We are running a trial.’ It is interesting that if I had not asked I would not have known that that is not what you tell the potential members of it. I am sorry to chide you, but I think words like ‘trial’ do not actually have the sense of comfort, sweetness and light.

**Prof. Oats**—I was using it in a medical, epidemiological sense.

**CHAIR**—I do appreciate that.

**Prof. Oats**—But your point is well taken, Madam Chair.

**CHAIR**—Yes, it is the language.

**Senator GIBBS**—In previous submissions, particularly from the department, we saw there was a high percentage of teenage Aboriginal women who were having caesarean section. I find that extremely disturbing. The reasons, of course, were varied. There was poor nutrition, poor health, and alcoholism. Do you have any data from your hospitals—obviously, you would if you represent all the hospitals—of the percentage of teenage Aboriginal women and why they are having the caesarean sections?

**Prof. Oats**—Within my own institution in Brisbane, yes, we can get that information. The largest number, of course, are delivered probably in Cairns and Townsville in Queensland. They would certainly have that data because they do keep very meticulous data. I could not answer your question directly at this stage, but we could get that.

**Senator GIBBS**—I would be very appreciative if you did because I just find it very disturbing that teenage women are actually having caesarean sections.

**CHAIR**—All your hospitals are elegantly listed here on pages 1 and 2. Are you talking about public patients or public and private?

**Dr Goldstein**—It is mixed.

**Dr Sweet**—It is a mixture of both.

**Dr Goldstein**—It is a mixture of both in each hospital.

**CHAIR**—Of your own hospitals and your own data, can you confirm that private patients are more likely to have a caesarean section?

**Prof. Oats**—Yes, that is certainly the case at the Mater. At the Mater Mothers Private Hospital, which is attached to the Mater Mothers Public Hospital, the caesarean section rate in private patients is higher than in public patients.

**Dr Sweet**—In fairness to the 12 or so hospitals listed, it varies from institution to institution. But, if we are fessing up, as it were, my hospital has a higher private caesarean section rate than the rate for public patients. They are treated in the one building, so they are side by side.

**Dr Goldstein**—In general, while it would not be uniform, your statement would be correct for the majority.

**Ms Cahill**—We did not pull that data specifically for this hearing but we can do that. When I spoke with each member hospital there were a couple that said that older women are more likely to have a vaginal birth than a caesar, just a couple, but—

**CHAIR**—Older women are more likely to have—

**Ms Cahill**—They are more likely to have a vaginal birth rather than a caesar.

**CHAIR**—Which is contrary to the usual—

**Ms Cahill**—That's right. But there are only one or two—

**Senator GIBBS**—That's interesting.

**CHAIR**—Ms Jarvis, did you wish to say something at this point?

**Ms Jarvis**—I was going to say exactly what Dr Sweet has said, that the caesarean section rate in private patients in the women's and children's hospital was higher.

**CHAIR**—Would you be able to, let alone willing to, provide to the committee from your member hospitals the obstetric data from your public and private patients?

**Dr Goldstein**—We would be in a position to provide the committee with the individual numbers of caesarean sections and the rates of caesarean sections for hospitals, identified by

hospital, and we could differentiate between public and private patients, if that was your wish.

**CHAIR**—I am getting conflicting evidence from the department. We are told that under the Medicare agreements the states collect data on, in this case, obstetric practices, the number of births delivered and so on, and they provide that to the Commonwealth. As I understand it, the public hospitals provide the data. Some private hospitals might be in there but sometimes the private hospitals are not providing the data and/or it is amalgamated. If I got the department to provide me with data, they keep saying, ‘We could not tell you which hospital that was,’ or, ‘We might be able to provide it but we would have to look it up.’

**Ms Jarvis**—Do you want the hospitals identified?

**CHAIR**—Yes.

**Ms Cahill**—By name or by number?

**CHAIR**—I would prefer by name. I am actually getting data from people who are ringing up because of this inquiry and saying, ‘We want this information to be confidential. Here is hospital X,’ and it is named. ‘Here are the number of people who came in for delivery, the number of patients born, the number of deaths, the number of caesarean sections and the number of interventions.’ I find it a bit disturbing that people feel they have to provide that information to this inquiry under the counter.

**Ms Jarvis**—Personally, I would not see a problem with that because, in reality, the state governments all have that data. They all have the hospitals identified. It is readily available anyway.

**Dr Goldstein**—I also do not have a problem, but I think we would have to ask each member hospital whether or not they would be prepared—

**CHAIR**—I appreciate that. I also appreciate that we certainly will not want to cause a major uproar in this country—little ones I am perhaps not troubled by. We were told that the privacy laws in certain states maybe mean that that qualifies the data that is provided to the Commonwealth government. I note that you frown, Dr Goldstein. I was very interested to discover this, and I have already asked the secretariat to seek out the privacy legislation in each state and territory so that we can see how that might impact on data provided to the Commonwealth under the Medicare agreements. As is usual between the Commonwealth and the states, it is a bit of a search and destroy mission. But we would like data. What the community is screaming for is data.

We now know that, if you are a private patient in Australia, you are more likely to have a caesarean section than if you are a public patient. People in the community want to know why. It is also interesting that, if you have your baby in South Australia, you are more likely to have a caesarean section than anywhere else. But, if you should go to one unnamed public hospital in South Australia that is under threat of closure, you would be very much less likely to have a caesarean section. Would this influence the community of South Australia in

telling the health minister of South Australia which hospital to keep open? This is fair information for the community to have access to.

**Dr Sweet**—Part of the difficulty of raw rates is that to which you have just referred. With the greatest respect, the obstetric risk factors at that hospital which is threatened with closure are significantly different from risk factors in my hospital and in some other institutions where the rate is higher.

**CHAIR**—Most of the people in the community understand that very well. They particularly understand it if they are told that. Why have a women's and children's hospital? Because it is state of the art and, if things go wrong in other places—by helicopter, by bus, by train, by transport, by foot—we will get you there. That is what most people in the community know. They also appreciate that sometimes, even in another hospital or in private hospitals or with home births or something else, things can go wrong. Most people do have a sense that there is going to be a difference. What they would like is some explanation of the differences.

**Dr Goldstein**—Could I draw your attention to a series of annual publications from the New South Wales Midwives Data Collection. I have a feeling that much of the data that you are talking about is already published in that, at least for that state.

**CHAIR**—Thank you very much.

**Dr Goldstein**—It is readily available as a public document.

**Prof. Oats**—I was also going to add that most hospitals do publish annual or up to triennial clinical reports, which are in the public domain. All the information that you are seeking has been published for most of these hospitals, and it is a matter of bringing that together.

**Ms Cahill**—We brought a data set with us today, which we will leave with you if you would like us to. It is a chart that shows caesareans, induction rates and those sorts of things for the 17 out of 20 member hospitals that we have collected data for. We have not done it on a public and private basis just because there was not the time to do it. We have not done it on an indigenous health basis either. This is the sort of data that we are collecting, which probably asks more questions than it answers. We have started the ball rolling.

**CHAIR**—That is fantastic.

**Senator GIBBS**—That is what we want.

**CHAIR**—Again, I am not asking you to do hours of statistical work, but if, in the next little while, you were able to further subset that into public and private without too much major trouble, the committee would welcome it. I also think your comments are very useful for the committee. If this data is on the public record, then it does seem to me curious that it is not being readily assembled in proper epidemiological ways for the nation. We will certainly have a look at it but, if it is available, it seems to me that there should be somebody who is actually comparing all this or putting it in the one place.

**Ms Cahill**—It is because it is not easily linked at the moment. That is why there does need to be a national approach, as Dr Goldstein said.

**CHAIR**—What do you mean when you say that it is not easily linked?

**Ms Cahill**—That the Cairns Base Hospital, for example, might put out a clinical report which might sit on someone's bookshelf and I may not even see it and therefore may not be able to link it to the data set that I have. Professor Lancaster may or may not see it to link it to his data set, and so forth. It is very difficult to link all these different data sets that are around and ensure that they are valid, reliable and useful.

**CHAIR**—That is a very interesting point. So most hospitals are collecting the data but there is no guarantee that it is all finishing up in the one place.

**Ms Cahill**—That is right.

**Prof. Oats**—There is an initiative in Queensland now with a state database called OBICARE. It is a common database which will be introduced into all Queensland obstetric hospitals. It has been developed by Queensland Health in conjunction with the King Edward Memorial Hospital in Perth. It is on trial now in two of the main hospitals. Once it has been through the trial period it is anticipated that by the end of the year it will be used state-wide. That will link with Professor Lancaster's database as well, so the statutory reporting requirements will come from that. There is certainly the hope that that will be spread Australia-wide, and then the data that you are after will be readily accessible.

**CHAIR**—What is the name of it?

**Prof. Oats**—It is called OBICARE.

**CHAIR**—Has that got a sense that I can understand?

**Prof. Oats**—Obstetric information care—OBICARE.

**Senator GIBBS**—Professor Lancaster was here before as a witness and we were looking at the caesarean rates with private patients and public patients. Even though South Australia has the highest rate of caesarean section, in Queensland the difference between the public patient and private patient having a caesarean section was 13.2 per cent, as opposed to the national average of 8.9 per cent difference, and in South Australia, even though it was a lot higher overall, the difference was only eight per cent. It seems very extraordinary to me that in Queensland there is this difference in caesarean sections between the public patient and the private patient. One has to wonder why.

**Prof. Oats**—I can in part answer that. In our own hospital we have the data on the indication for caesarean section and whether it is a repeat caesarean section. In the emergency caesarean section rate there is not a great deal of difference between the private and the public patient—

**Senator GIBBS**—That is understandable.

**Prof. Oats**—but the difference is in the repeat caesarean section rate. With the data we were talking about getting with OBICARE and with the data we have access to through WHA, we are able to look at and start drilling down onto the indications, the reasons, for interventions like caesarean sections or induction of labour—things like that.

**Senator GIBBS**—It has been suggested to us that a lot of people opt for caesarean, whether it is the doctor's choice or the woman's choice, to fit in with their lives. The doctor wants to play golf at the weekend or maybe to see his family—he probably has not seen them for six months. She wants to organise something and will say, 'I will have my baby between 2 and 4 on that particular day,' and will pop in and have it done. I have no doubt this happens. Let us face it, we live in a society and we are all human. Would the hospitals frown on this sort of practice if it was known? Or is this the priority of the doctor-patient relationship and the hospital does not interfere?

**Prof. Oats**—Answering from a public hospital perspective first of all, it is certainly becoming quite commonplace. We are now honing in on a person who is not, for argument's sake, having a repeat caesarean section. This is a primary caesarean section for reasons that are not related to obstetric complications. My estimate is that, once every two to three weeks, a patient at their first antenatal visit makes a declaration that they wish to have an elective caesarean section.

**Senator GIBBS**—On a certain day at a certain time?

**Prof. Oats**—Basically, they are saying that they do not want to go through labour; they just want it to be delivered. The timing becomes an issue later on.

**CHAIR**—What do you say to them, Professor?

**Prof. Oats**—What we do is go through and discuss it with them. First of all we ask why they want one. Is it a fear of the childbirth process itself? Is it a fear about inadequate pain relief or one that comes from stories told by relatives or friends? What is their perception of the difference between vaginal delivery and caesarean section? One has to be very sympathetic to this. I do not believe that we have the right to make autocratic decisions on it. It has got to be a partnership decision. What I normally do is say, 'We will talk about it again. We will discuss this when you come back at around 36 weeks and explore the issues again.' Frequently, by the end, because of the childbirth education that has gone on, the issue does not arise again. In the end, it is extremely difficult to force a person either way, for obvious reasons. We stress that it is a partnership decision. In the end, the number of women who are delivered that way electively, without a good obstetric indication, is very small.

**CHAIR**—If a patient arrived in hospital and said, 'I want to have an appendicectomy,' no professional doctor would say, 'Your opinion is important. We understand.' There is something very curious going on here, is there not? Women who—bless their hearts—have been denied having an opinion for some centuries have now gone all the way to being responsible for some elective surgery. Is there any further wisdom you can offer?

**Senator GIBBS**—It is particularly curious in such a natural process as childbirth. One can understand that, if there are complications, you have to have the caesarean. Let us face

it: women have been having babies for centuries, otherwise none of us would be here. Women do keep the world going. Years ago, you became pregnant and you had the child. It is a natural process. This is extraordinary.

**Dr Sweet**—While Professor Oats is collecting his thoughts, I will give my summation of this situation, and that is that the patient's input to any clinical management decision cannot and must not be overlooked. It must be as well informed as possible, but in the end it becomes a clinical decision. There are a number of reasons—and Professor Oats may be about to enumerate them—why denying a patient a caesarean section may in fact be causing her, then and subsequently, an enormous amount of grief in various ways. But we would not simply give a blanket yes to a caesarean section request.

**Senator GIBBS**—We are all frightened of pain, Dr Sweet, I can assure you.

**Dr Sweet**—As am I.

**Senator GIBBS**—Having children is not much fun, but nature has ways of making one forget about it. It is like getting drunk: nature does that to you so you do it again, not that many women do.

**CHAIR**—That is the line of the day, I think, Senator Gibbs.

**Senator GIBBS**—I just find it absolutely extraordinary that, for such a normal everyday occurrence and natural process as childbirth, unless there are complications, women could actually say, 'I don't want to go through the pain. Just cut it out, doc.' It is dreadful. I find it extraordinary.

**Dr Sweet**—It does happen. I must say the numbers are minimal, but I believe that the patient has a right to express that decision and we, without a medical indication, have an obligation to go through the implications of that decision carefully and honestly but, in the end, it comes to a decision which has to be made.

**Dr Goldstein**—We have come here in actual fact to put forward the case for having a degree of data, indicators, outcomes and evidence that could be used throughout this country in order to establish practice that makes sense on the basis of evidence. While there may be ad hoc practice—in fact, while there is ad hoc practice through the lack of evidence—what we are trying to make a case for is to establish the sort of evidence, the sort of data collection and the sort of database that will provide for clinical indicators and clinical outcomes that can be used by all in order to be able to make good clinical decisions.

That includes the provision of good health information for the consumers, customers, clients, patients—whoever they may be on a particular day—in order that they too can participate in decision making, but not on an ad hoc basis. There are other ways of avoiding pain than through caesarean section. What we are trying to do, through our organisation, and the reason why we came together, being all from different states and not necessarily having a lot to do with one another on a day-to-day basis, because we felt the need is to put together our data, our experiences and our expertise—not to duplicate it—and to come up with as sensible an approach to women's health care as is possible in this country.

We put up a number of submissions to the Commonwealth in order to be able to review what we do with antenatal care, to make sure that the sorts of tests that people are being offered, or even subjected to, are useful, are cost effective and are made with information for the patient that will help her or her family to make a sensible decision given that evidence. Your point is well taken; there should be the sort of evidence that will assist that, but at the moment it does not exist.

**Senator GIBBS**—Obviously we thank you for your submission and what you are trying to do is extremely commendable, but can you see it from my point of view, Dr Goldstein? This practice can be abused. I am sure most doctors would not and I am sure there is a whole ethical thing, but let us face it, it can be, can't it? We are all human.

**Dr Goldstein**—We could accept that point of view.

**Ms Jarvis**—I would draw the committee's attention to the fact that there is much more to look at in the way of data than just a caesarean section rate. Before conclusions are drawn about the caesarean section rate, there needs to be consideration of other intervention rates—for example, forceps delivery rates. Is there any relationship between the caesarean section rates escalating and forceps deliveries reducing? There needs to be consideration of induction of labour rates, et cetera. It is important to consider all those interventions against the caesarean section rate. I think there is a direct relationship.

You have raised the subject of the age of women for first delivery. What we are doing through the Women's Hospitals Association, because of the issue of caesarean section rates, is undertaking a benchmarking exercise of caesarean section rates. What we have done is really draw criteria from our databases so that we can in fact get, for want of a better description, a standardised woman—I know it is a terrible phrase—where we can do reasonable comparisons across hospitals and states. I think it is really important that we have got a level playing field upon which to draw conclusions from the data.

**Ms Cahill**—And if we 20 hospitals cannot do that, I do not think anyone can.

**CHAIR**—I think we are going to be enormously assisted by what you are doing. It is really excellent and I would have thought most people who look for good answers in terms of hard data will find your combined contribution, particularly if you ever get the funding, as recommended, to be of great assistance. Professor, had you finished your three comments about the woman who comes and says, 'I want a caesar'?

**Prof. Oats**—I had finished with that. I did want to make a comment in clarification on antenatal screening that I heard raised this morning if I may. Is it an appropriate time to make a comment?

**CHAIR**—Yes.

**Prof. Oats**—This morning the question about what was antenatal screening was raised. Antenatal screening, certainly from our submission, is the full gamut of tests that are routinely performed during pregnancy.

**CHAIR**—Right. So you do include care of the mother?

**Prof. Oats**—That is correct. It includes the blood tests, particularly blood tests on a mother for things like blood group, screening for infectious diseases and tests done to assess foetal wellbeing, but what we are talking about in the screening implies routine testing not testing for perceived implications.

**CHAIR**—I am interested in that because I guess what we will have to do is make clear what is meant by antenatal screening. It has in the past had that broader meaning and so I was a bit surprised to discover it might have meant only the high-tech interventions. I can understand why the department is interested in high-tech interventions because they come with big dollars but thank you for that point of clarification.

**Prof. Oats**—I was going to add that there are other screenings that are being done for things like domestic violence and sexual abuse. There are some pilot projects going on, particularly in Queensland, at the moment.

**Senator GIBBS**—Yes, I noticed that.

**Prof. Oats**—I would enlarge the antenatal screening to pathology type investigations and these other risk factor assessments, so it is a tool that is being applied to all women, not because of perceived indications.

**Dr Goldstein**—It should be applied to all women.

**Prof. Oats**—Yes.

**Senator GIBBS**—Is that what you call the psychosocial condition?

**Prof. Oats**—Yes.

**Ms Cahill**—The federal health department told you this morning that there was a proposal to look at antenatal screening from the Australia Association of Paediatric Teaching Centres. In fact that proposal is from us. We have lodged that three or four times with federal Health and have been unsuccessful in moving that further.

**CHAIR**—That antenatal screening is, I think, terribly interesting. I have been appalled to read that it is coming into Australia too that women are now being held liable for any potential damage to a child if they should do drugs, alcohol, smoke or whatever during pregnancy. Do you test for these things in your antenatal screening?

**Prof. Oats**—We do not routinely. We only test with consent—informed consent.

**CHAIR**—So you would ask people whether they smoke, for example?

**Prof. Oats**—We certainly ask that. We do not routinely test for hepatitis C or HIV in Queensland—I can speak only from my own institution—although again I believe this is one of the tests that does need proper evaluation within Australia. On the other side, all

institutions routinely test for syphilis. There is some degree of double standard going on, but we just do not have a good evidence base for a recommendation in Australia.

**Dr Goldstein**—I just add that given the broad definition of antenatal screening I would think that most hospitals actually do screen by inquiry as to whether or not women have used or might use cigarettes, alcohol or drugs or have had sexual contact with people with HIV, so in that way there is some screening. I think most of our member hospitals have some sort of programs for women who are taking drugs and offer programs to quit smoking and whatever.

**CHAIR**—Does the HIV protocol for childbirth, as you have outlined it, conflict with the HIV protocol for surgical procedures in a hospital?

**Dr Goldstein**—In what way conflict?

**CHAIR**—I am not sure what the state of play is for HIV but I thought there was some considerable concern amongst surgeons that there be established a proper operating theatre protocol so as to make sure that nobody who did not have HIV got it, and that the proper protocol would protect everybody, both the people who might be HIV positive and those who were not. I would presume the same thing would apply to any surgical procedure in childbirth, but I am just wondering about anything short of surgical procedures.

**Dr Goldstein**—There is a secondary issue in childbirth in that the HIV can be transferred to the infant.

**CHAIR**—Exactly so.

**Dr Goldstein**—The possibility of that happening can be markedly reduced through appropriate treatment. So it is not only an issue of danger to the health professionals; there is also an issue of danger to the child.

**CHAIR**—But it is not routinely tested for?

**Prof. Oats**—I think it varies from institution to institution. I am not aware of any. Certainly, there are no national guidelines. There has been a recommendation from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists that all should be offered screening. My understanding is that it is not routine practice.

**Dr Sweet**—I think the practice varies not only from hospital to hospital but also from practitioner to practitioner. So, again, it is an area where it would be very useful to be able to establish the appropriateness.

**Senator GIBBS**—That is true. I would imagine there are a lot of illicit drug users in this country, as you would know, and a lot are mothers. What sort of testing or screening is done for women who take drugs if they have not admitted to you that they take drugs? There is no national program or whatever.

**Prof. Oats**—It is estimated that we only probably identify about 50 per cent of those. They can be picked up by screening questionnaires, but there is not routine testing, say, from urine metabolites of the various drugs without consent. The other major time it is picked up is if the child shows withdrawal symptoms after delivery. Part of the problem now with the early discharge program, with a lot of people going home within a few hours of delivery, is that, if it is not identified before delivery, these babies are going home and then exhibiting their withdrawal symptoms out in the community where people are not trained either to realise that is what is happening or how to manage them. That is another concern that we have with the early discharge program.

**Senator GIBBS**—I would suggest that this is one of the screening imperatives, surely, with the wide use of illicit drugs in the community. I have an interest in this area, and I have been reading lately about the number of babies that have been born who are addicted. It is becoming quite a concern and a nightmare for doctors. But it is interesting you talk about this early release because, way back when Senator Crowley and I became mothers, we stayed in hospital for, what, seven days?

**CHAIR**—No, 10.

**Senator GIBBS**—I knew it was somewhere about there. Ten days. Now they are out within hours or a couple of days.

**Prof. Oats**—There is a significant group that go home within 12 hours of delivery.

**Senator GIBBS**—Twelve hours! Good God.

**Prof. Oats**—I should add to that, of course, that they go home with a program which the hospital runs where midwives go and visit them at least once a day.

**Senator GIBBS**—Okay. That is different.

**Prof. Oats**—In our own program, up to four days.

**Ms Cahill**—And by choice.

**Prof. Oats**—Yes, this is a choice, this one, yes.

**CHAIR**—We have got to the end of time. I have any number of questions, and so have you, and I am terribly pleased you have asked them. I am just reminded that a while ago herpes was actually regarded as a reason for caesarean. Is that still the case?

**Prof. Oats**—Only if it is a primary infection at the time of labour.

**Dr Sweet**—Or within two weeks.

**Prof. Oats**—Yes, of the primary infection—having just read the protocol on the way down from the Women's and Children's Hospital. The other part is that, if somebody has got a recurrent infection, even though the data is fairly strong that does not lead to neonatal

encephalitis, if there are active lesions I think most people would deliver by caesarean section at that point. But, having said that, that is actually a very uncommon reason to do a caesarean section.

**CHAIR**—If we cannot get these questions answered now, perhaps you can take them on notice. You actually say there is increasing evidence that adult diseases begin in utero.

**Prof. Oats**—Yes.

**CHAIR**—I am not quite sure what we mean by ‘adult diseases’. Also, do you believe there is a case for increasing antenatal screening?

**Prof. Oats**—If I could answer that very briefly, this is the so-called Barker hypothesis, the data from Southampton which showed that a low birth weight was associated with a much higher incidence of diabetes and hypertension later in life. So it is one of the arguments about obviously screening for interuterine growth restriction, also for diabetes during pregnancy, and for hypertension. So it is for disorders that can have a long-term effect.

**CHAIR**—Is it persuasive or just interesting at this stage?

**Prof. Oats**—There is certainly very strong acceptance of it. In fact, Professor David Barker is coming out to the Perinatal Society of Australia and New Zealand next year—in Brisbane, in March—to address that. But there is a lot of accumulating literature. There are some dissenting voices to it, of course, but it does have strong support.

**CHAIR**—If you have a good memory, Professor Oats, can you make sure that we three senators get to know about that?

**Prof. Oats**—The data?

**CHAIR**—The visit—when the professor gets here.

**Prof. Oats**—I will arrange to send a synopsis of his conclusions if you wish.

**CHAIR**—That would be great, thank you. Antenatal screening—presumably that is going to be a case for increasing screening. To your mind, does increased antenatal screening lead to increased intervention?

**Prof. Oats**—I think that there are two issues. One is making sure that the tests that are done are useful—making sure that we are using the appropriate tests. The classic one is the screening for gestation diabetes. That is the subject now of a National Institute of Health—NIH America—big international study to try and sort that out. So that is why I deliberately did not mention it in this. I did not think there was any point because that study is costing \$US9 million to look at. There is certainly no doubt that the diagnosis or the label ‘gestation diabetes’ does increase intervention. So, yes, there is evidence that some of the tests do themselves lead to an increased intervention. What we need to make sure is that those interventions are justified and that the outcomes reflect it.

**Dr Goldstein**—However, it is not our position that we are actually looking at increased antenatal screening tests being done.

**Prof. Oats**—There may well be a reduction.

**CHAIR**—You, I note, do not support the establishment of a target for interventions. Can you say why not?

**Prof. Oats**—I believe we do not have the evidence of what an ideal number is, and that is the problem. Once we do have a good evidence base, then I think the guidelines can address that.

**CHAIR**—Can you also provide from your hospitals how many of your hospitals have an alternative birthing centre—if that is easy, and that one presumably is. How many deliveries are done there? I note that you talk about the need for almost the seamless delivery, but people may go home earlier—they may have a midwife or a mothers' and babies' nurse or somebody of that sort coming to see people so that they can cope differently. Are there places still with pockets of total resistance to alternative birthing or to the midwife? Does Queensland have the elegant brawl that Western Australia has had about obstetricians fighting alternative birthing?

**Prof. Oats**—I do not believe, certainly within the main public hospitals, it is. I do not see that as an issue.

**CHAIR**—So it has fairly much now moved on?

**Prof. Oats**—I think it has moved on considerably over the last five years, yes.

**CHAIR**—The Women's Electoral Lobby gave evidence earlier that they felt there was a change of climate, particularly in New South Wales, and that this was actually turning back a lot of that cultural shift towards alternatives to just obstetricians doing delivery. You know nothing of that in Queensland—or in any of the other hospitals?

**Prof. Oats**—I am not aware of it, no.

**Dr Sweet**—Certainly not in South Australia.

**CHAIR**—We can certainly tick off on South Australia.

**Dr Goldstein**—Are you referring to more women now being seen by midwives in New South Wales?

**CHAIR**—No, they are talking about a move away from people feeling comfortable with midwives, and I think probably a change—perhaps I should have asked for more detail—but I sensed that there was a move away from encouraging women to think of alternative birthing.

**Ms Jarvis**—Certainly in South Australia there is a very strong movement being led, in fact, by the chair of obstetrics and gynaecology at the Northwest Health Service for midwives to take a much higher role and play a much greater role in low risk births, and that has been very well accepted by the community that they service. Certainly I can only speak for our hospital in the state. That is certainly not the case with our organisation. We are moving more and more towards models of midwifery care which see the midwives really taking the whole course of the pregnancy right through.

**Dr Goldstein**—My experience in several of the large hospitals in New South Wales is that that would not be the case. There might be a movement towards greater coordination so that there is a safety net for alternative birthing, but I do not think that there has been any major change away from a portion of the clientele going that way.

**CHAIR**—We have to finish. Can I give you two questions on notice, if you would not mind. I do not mean a PhD—some dot points on a page would be more than sufficient. It seems to me particularly curious that South Australia, which I know probably a little better than other places, is the state that now has the crown for the highest number of caesarean sections. It has certainly been a state that has been very eager in parts to try and sort out alternative birthing, and it has been very encouraging of it. So we do have contradictory themes running. I think that is another area of concern.

Can your hospitals give us any clues in terms of data about how it is that you can have increasing numbers of caesarean sections and increasing alternative antenatal care for birth and post-birth? I was saying earlier, not on the record, that I suspect one of the problems is that we are now dealing with that percentage. We are in a country that has very low infant mortality, maternal mortality, so we are dealing with the statistics about the tough end of the game. Maybe that is a skewing factor, but it would be good to have any evidence of that. The other question, you will be pleased to know, I have forgotten.

**Prof. Oats**—We would be very happy to answer it, Senator Crowley, if it occurs to you later.

**CHAIR**—I might have to call you on it. I must say that your submission is really a breath of fresh air and a real encouragement to those of us who are concerned at the variation between hospitals, patient status—public-private—and between states. My understanding is that if we are looking at the equity of delivery of care across this country then it should be a concern when there is a big difference.

The last question I wanted to ask you was if you can give us any particular information from your hospitals about Aboriginal health. My colleague Senator Gibbs was mentioning earlier on her concern about some of the differences there. Although they have improved since 1984-85, we still have a long way to go, in Queensland in particular, but if your other hospitals can provide us with some further data on that I would be very pleased to look at it. I would be interested in things like whether the Aboriginal obstetric care is different in Redfern than it is in Darwin, for example. That would also be of importance.

**Dr Goldstein**—Would you allow us to make one final comment?

**CHAIR**—Please.

**Dr Goldstein**—On the issue of postnatal care, one of the issues that we wish to draw to your attention is the lack of facilities, support, recognition and understanding of long-term consequences of postnatal care. It arises when we talk about early discharge. In actual fact all our member hospitals are concerned that the social consequences of women being isolated or families being isolated or children being isolated by incapacitated mothers in the early period after birth are enormous and have long-term impacts on the community in terms of social welfare, crime and various other things. That particular area of obstetric or maternal care, however you want to phrase it, has not received adequate attention in any of the enhancements thus far to maternal and child welfare.

**CHAIR**—That is terribly useful, and it does remind me of yet another question for you. I did not stop and interrupt you at the time, but you made an interesting comment that, ‘Sometimes women will say to me at the first antenatal visit, “I want to have this baby by caesarean section”, and you say, ‘We will talk about it at the six-week visit.’ When they come back, quite often, the antenatal care or antenatal information that they have had means that this is never raised again.

I would like you to say, in just one or two dot points, what goes into antenatal education. Do you contribute to it, or is it something they get apart from you so that when they come back they are all wise? Interestingly, antenatal care has made a massive difference to infant mortality over the years. How does that fit together, the coming into the hospital part of the system and the going out, the postnatal care as well? Thank you very much.

**Senator TCHEN**—What has happened to the infant welfare services which used to be provided? Has it gone?

**Senator GIBBS**—Which infant welfare services?

**Senator TCHEN**—The local council used to coordinate it.

**Dr Goldstein**—You mean baby health centres or early childhood centres, or whatever the terminology is in the various states. It differs in each state.

**Senator TCHEN**—Are they still operating?

**Dr Goldstein**—Yes.

**CHAIR**—I am going to be very mean and say, ‘The Senator comes from Victoria.’ I will take him aside and explain what has happened to infant welfare in Victoria, and it goes directly to tendering.

**Senator TCHEN**—It comes back to Dr Goldstein’s comment about postnatal care because that is the—

**Ms Cahill**—The number of visits to infant welfare centres in Victoria is rationed. New mothers do not have free and ready access to those services whereas, in the past, if they felt

bad one week or the next, they could roll in each week, each day, or whenever they felt like it. But now they are only allowed to have a certain number of visits, postnatally.

**CHAIR**—It is a terribly important question and we may need to follow it up. We are way over time and I beg your pardon for keeping you. Thank you all very much. I suspect we might try to catch up with you. We will be visiting other states and hopefully in some places we will try to make hospital visits. But anything you feel we should know, we would be pleased to receive it later on.

**Ms Jarvis**—And please, when you come to South Australia, come to the Women's and Children's.

**CHAIR**—I will certainly do that when we go to South Australia. I am trying to see if we can have our hearings at the Women's and Children's.

[2.47 p.m.]

**SCHNEIDER, Mr Russell John, Chief Executive Officer, Australian Health Insurance Association Ltd**

**CHAIR**—I welcome Mr Schneider from the Australian Health Insurance Association. I must tell you that we prefer all evidence be given on the public record, but should you at any stage wish to give your evidence, part of your evidence, or answers to specific questions in camera, you may ask to do so and the committee will give consideration to your request.

We have before us your submission, No. 146. Do you wish to make any alterations?

**Mr Schneider**—No.

**CHAIR**—Would you like to make a brief opening statement and then field questions?

**Mr Schneider**—In the interests of time I will keep my statement very brief. As our submission has indicated, the statistics—which are not only our own, they are pretty common statistics—do indicate that there is variation. We are not equipped to make any value judgment as to whether those variations are appropriate or not, but we do say that when you have that level of variation, you must question whether all procedures are appropriate. We are not in a position to be definitive about that, or to make a judgment. Other than saying that, it is probably more convenient for you if I answer your questions, and if there is anything that I cannot specifically answer I would be very happy to provide written answers.

The other thing that I would draw your attention to is that at the time we prepared the submission we had no details of some fund activities in the birthing area, in the benefit area. I do now have some and if you wish I would be happy to table those, or otherwise make them available to you.

**CHAIR**—That is much appreciated, Mr Schneider.

**Senator GIBBS**—I was interested in the gap payments. You suggest that the introduction of the new Medicare rebate for complex births has not reduced the gap payments and, in fact, some doctors have actually put up their fees.

**Mr Schneider**—Yes, this is one of the difficulties of uncapped gaps. Let me hasten to assure you, our preference would be to have a system in which gaps were capped because that would make it possible to insure for them and satisfy the consumer. Unfortunately, we do not have the power to cap gaps, nor do you. The state governments do, but they are reluctant to do it.

So, we are in a situation where the best we can do currently is hope to apply market forces by encouraging people to shop around. We need to go further down the path of seriously encouraging, at the very least, informed financial consent so that the consumer or the patient can at least find out the level of gap before they commit themselves to a

particular practitioner. I do not think that is an ideal situation but, given the constitutional limitations, we do not have much choice.

**Senator GIBBS**—How do you feel about Medicare payments for home births? As we have heard from previous witnesses, not a lot of women have home births, but it seems to be a trend where women with low-risk births are encouraged, and midwives are used. How do you respond to that?

**Mr Schneider**—We provide benefits for home births. In some cases we do not actually call them midwife benefits or home birth benefits, they are at times called nursing benefits. As you would be aware, there has been a lot of controversy about home births. There are disagreements as to the relative skills of midwives and obstetricians. Traditionally, the industry has preferred to avoid getting itself involved in that dispute and prefers to be in a position where, if there is a bona fide nursing visit, which may be a midwife's visit, we will pay a benefit for it.

**CHAIR**—The story of health insurance is nothing if not repetitive. Is that right, Mr Schneider?

**Mr Schneider**—If you mean we have seen it all before, yes.

**CHAIR**—I am beginning to think that doctors are creatures of extraordinary habit. The submission says:

Hence, an Ezyclaim benefit of \$950 was put in place to help cover the gap. The practitioners retained the flexibility to charge a co-payment to the patient of up to \$800 if they so desired . . .

Does that mean that the government's Ezyclaim was going to cover them for \$950, but the doctors were going to charge \$1,750?

**Mr Schneider**—That is probably it, yes. The charge could be \$1,750.

**CHAIR**—The submission goes on to say:

. . . but in practice the South Australian obstetricians using the Ezyclaim have rarely charged a co-payment. In Victoria there is more often a reduced gap.

A reduced gap means what?

**Mr Schneider**—It means less than the \$800 allowed, less than the copayment which the fund allows.

**CHAIR**—In other words, what you are saying is in South Australia, by and large, obstetricians did not charge more, but in Victoria they did. Is that correct?

**Mr Schneider**—Yes.

**CHAIR**—I like the language, thank you.

**Mr Schneider**—I do not have the numbers. One assumes that there are more obstetricians in South Australia per head of insured population than there are in Victoria.

**CHAIR**—Why do you assume that?

**Mr Schneider**—That would explain the different market situation.

**CHAIR**—If you go back and look at it you will find that under Medicare, doctors in South Australia have been less inclined to charge above the Medicare rebate than their colleagues on the eastern seaboard. But, I have discovered that, unfortunately, South Australian doctors are beginning now to catch eastern seaboard diseases. So, we could take some money on how long it will be before they introduce a gap on Ezyclaim. One thing that is interesting, as you go on to say in the submission, is:

South Australian data ahead of the introduction of the 30% Government Rebate shows clearly that those members—  
presumably of the insurance association—

who utilised the Ezyclaim with no gap for obstetrics have a 50% greater retention rate six months out than those who have not used this process.

In other words, with the old hit-and-run members, as you call them, who get insured to cover themselves for the pregnancy and then drop out again, if there is an Ezyclaim program there is an increased likelihood that 50 per cent, which is not anything like your 100 per cent, will not drop out.

**Mr Schneider**—Yes. I think that the hit-and-runs, as they are called, fall into two areas.

**CHAIR**—It is not my term, I have to say.

**Mr Schneider**—There are some people who do exploit the system and it needs to be protected from them. There are others who act very rationally. If people have paid \$1,000 or \$2,000 in premiums, and it may be in some cases that is their first experience of the health insurance system, they then use it for child birth. If they find that there is a very large co-payment, which may be equal to or exceed the premium, they act very rationally and they drop their insurance. It is a logical thing to do.

It was a theory which we held in the industry in many areas prior to Ezyclaim's introduction, that if we could solve the gap problem we would significantly improve retention rates. Mutual proved that, and I think the 50 per cent retention rate is quite significant. I understand, anecdotally, that that does not only apply to childbirth, it applies to virtually all of its experience—that people who do not have gaps stay insured.

**CHAIR**—We have been told, and all the data says, that if you have got private insurance you are much more likely to have a caesarean section. I am interested to know if private health funds who are finding it extremely difficult to get people to join them or even to stay with them—and I will resist all the other things I could say at this point, Mr Schneider—

**Mr Schneider**—Thank you.

**CHAIR**—I would have thought that insurance companies would have to be extremely interested in data that says that if you are privately insured you are far more likely to be having a caesarean section.

**Mr Schneider**—Yes, we are. One of the problems for the health insurance system has been that data collection has traditionally been aimed at paying claims as distinct from providing analytical information. Over the last few years, since about 1995, our capacity to gather information has been enhanced via the hospital casemix protocol—that was a requirement that was imposed in the 1995 election. It has one defect in that the data is not required to be supplied with the claim, so there can be a lag between the payment of the claim and the collection of the data. That data has provided us with a much greater capacity for statistical analysis. Unfortunately, it will still show us that there was variation; it will not show us the causes of the variation—and, other than insured status, that is difficult for us to pursue.

To the best of my knowledge, there are no actual financial incentives for one procedure as against the other. It is not a case of differential benefits being paid by the health fund for a caesarean or for natural childbirth, although if it is an episodic payment there may be a higher payment for a caesarean because of the longer expected length of stay.

**CHAIR**—Do you think we should go back, as has been recommended earlier today, to listing caesarean section as a separate number?

**Mr Schneider**—I think it would be useful. It would certainly make it possible to get a much greater information base. Just talking about financial incentives again, I can volunteer an anecdote. From a visit to the United States several years ago, I understand that in one state there was great concern about the variation between natural and caesarean procedures. All sorts of efforts were done to try to bring the variation back to the norm, including a lot of education, a lot of peer group pressure and so on, and nothing happened until, finally, the benefit for a caesarean was made less than the benefit for a natural birth. Almost instantly, the two things returned to the national norm. One can only assume from that that financial incentives can play a part in determining outcomes, but that is an American experience.

**CHAIR**—How elegantly you understate it, Mr Schneider. Financial incentives can be a determinant of medical practice!

**Mr Schneider**—I was reluctant to throw that in.

**CHAIR**—Really, indeed, Mr Schneider. What was that you said about constitutional requirements and gaps earlier on?

**Mr Schneider**—I was trying to be very mild.

**CHAIR**—I would have thought that private health would have been concerned about it in terms of an increasing number of claims for privately insured people, the higher likelihood of increasing gaps and, if nothing else, at least a higher likelihood that the minute the baby is born they are going to leave private health insurance because it is not delivering Ezyclaim.

**Mr Schneider**—Yes. Our concern is there; it is a very great concern. Our problem, though, is that there is not a lot we can do. In the legislation itself there is a sanction against a fund doing anything at all in the contracting environment, with either doctors or hospitals, that would affect clinical decisions. So, to a certain extent, we are the captives of the clinicians—and I am not saying that in a derogatory or critical way. We have to rely, however, on establishment of proper clinical practice and the adherence to clinical practice, rather than on any action that we, as insurers, can take to influence behaviour.

**CHAIR**—Do you have any evidence that the obstetricians in Australia, if they were funded less for a caesarean section than for a normal birth, might behave like the American doctors?

**Mr Schneider**—I have no evidence.

**CHAIR**—For it or against it?

**Mr Schneider**—For it or against it. One can make one's own assumptions.

**CHAIR**—I am glad that you feel that you are a captive to good clinical practice in this country, Mr Schneider. There is some evidence that that may not be the only determinant. On another matter, the problem we are dealing with is the lack of comprehensive nationwide data. As I understand it, the Health Insurance Commission was a single source of all the claim data. Is that still the case or have the changes to private health insurance meant that private funds now have to provide that data from a number of different sources?

**Mr Schneider**—No, we provide our claims data via the hospital casemix protocol to the department of health, which collects it and does whatever it may wish to do with it. It is going to provide aggregate reports back to the industry. Unfortunately, that is not all the data. We can collect private health care data and the HIC will collect Medicare benefit payments but, of course, we lack public hospital data. So, theoretically, a patient can present in a public hospital for part of the nine-month period for treatment as a Medicare patient and there are only the hospital records of that which are not instantly provided to any central repository. The patient may then have the birth as a private patient, a benefit is paid for that, and that is recorded both by the HIC and by the fund. So we can capture the actual private episode, but if there is any public component of that episode it disappears into the state reporting systems.

We have found it very difficult—not impossible, but difficult—to get exact matches of utilisation, public/private, from the state record system. I suspect that would be compounded when we get into the area of people who are not even insured. So it makes it very hard to drill down and get very detailed data.

**CHAIR**—I am very interested in those comments and we might have a look at them. If, in looking through what you have said, we have further questions, would you mind if we put them to you?

**Mr Schneider**—I would be very pleased to respond.

**CHAIR**—I would like to read to you very briefly from the Australian Institute of Health and Welfare's National Perinatal Statistics Unit submission. On page 8 of 10 it says:

Health insurance data have been grossly underutilised for comparing the patterns of health services within Australia. Analysis of national data from this source in conjunction with data from the perinatal collections would give a much clearer picture of factors influencing prenatal and postnatal clinical services. A specific item for caesarean section should be reinstated in the Medical Benefits Schedule.

Are you nodding in agreement or is it something you would like to look at and perhaps make a comment on?

**Mr Schneider**—I would like to look at it and make a comment. It seems a logical comment, but I would like to actually look at it and analyse it, if I may, and then provide you with a definitive—

**CHAIR**—Before we even get to the last item in that extract, there was the comment:

Health insurance data has been grossly underutilised for comparing the patterns of health services—

I would like to know whether you agree with that.

**Mr Schneider**—I think that was true within the industry up until recent years. The move towards hospital contracting has concentrated the minds of health fund executives on data use. In fact, the use of data is now seen as a competitive advantage between organisations.

**CHAIR**—We have also been told that the data provided from hospitals to the states may be comprehensive about head counts and procedures and so on for the public sector, but sometimes it does not include anything like the same kind of breakdown of data or provision of data from private hospitals.

**Mr Schneider**—I think that is true. I should not speak for them but the private hospitals claim a number of difficulties with the provision of data. Our experience has been that data quality improves enormously if there is a financial relationship to it. Any data supplied which results in a payment higher or lower, depending on its accuracy, can be much more reliable than that which is supplied for statistical or research purposes. We have in fact been discussing with the hospitals ways in which we can improve the delivery of data. From our perspective what we would like to see is the extended HCP data provided with every claim at the time the claim is lodged. We have some more data sets of our own. That would put a very real stimulus on the hospital to ensure that the data it provides is accurate and it would allow us to do much more speedy analysis than we can today.

**CHAIR**—They may indeed find that the benefit of being accurate with your data is financial reward in itself when it provides ways in which further better practice could help.

**Mr Schneider**—Indeed.

**CHAIR**—Data collection depends on a financial benefit being attached to it. I am tempted to think that it is a bit like good clinical practice, is it not, Mr Schneider? On that

wicked note, we have to finish today. I thank the witnesses, yourself, Mr Schneider, and all others, for appearing. Thank you. The committee stands adjourned until next time.

**Committee adjourned at 3.06 p.m.**