COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Childbirth procedures

TUESDAY, 7 SEPTEMBER 1999

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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Tuesday, 7 September 1999

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

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 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 9.07 a.m.

KEIRSE, Professor Marc Jozef Nikolaas Cornelius, Head of Department, Flinders Medical Centre

MARSHALL, Associate Professor, Peter Blake, Director of Women's and Children's Division, Flinders Medical Centre

CHAIR—Good morning, I declare open this public hearing. The Senate Community Affairs References Committee is continuing its inquiry into childbirth. I welcome Professor Peter Marshall of the Flinders Medical Centre. 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. 108. Before we proceed, I notice that your submission talks about childbirth procedures. We will have to leave that word out in the future, because one of the submissions suggests that childbirth procedures is not a holistic approach. Do you wish to make any alterations or additions to your submission?

Prof. Marshall—No. I may wish to make some additional comments that relate to questions you may wish to put to me. The other point is that Professor Marc Keirse, professor of obstetrics and gynaecology, was aiming to join me this morning. He may yet appear but he has not arrived yet.

CHAIR—If you would like to make an opening statement and then field some questions.

Prof. Marshall—The first thing I should say is that at Flinders we have been focusing on our maternity services for some time and looking at different ways of delivering services. We have been quite innovative over the last few years in that we have moved to providing off-site antenatal and postnatal clinics at Noarlunga. We provide evening antenatal clinics at Flinders and we provide probably the most broad based set of choices that any woman could wish to have in the delivery of obstetrics services, ranging from midwifery care, shared care, off-site antenatal and postnatal support, and delivery within either a birthing centre environment or a conventional labour ward.

But we have become increasingly aware that the services that we are providing are constrained by the existing funding structures within which we operate as well as, in many cases, existing mind-sets as to how the operations should operate. We have been trying to look outside the box a bit and think of different ways of doing things. It has become very clear to us, as we have done that, that the way in which the health system is operating is extremely fragmented. That fragmentation is very substantially contributing to limiting the options available for doing things differently.

Perhaps one example of that is the fact we have two systems of health care in this country both publicly funded: a federal system which is uncapped and a state system which is heavily capped. Within that fragmented delivery of services, there is a very strong emphasis on endeavouring to cost shift to the next agency, and preferably a cost shift of the uncapped federal system.

The other compounding variables within that are such things as Casemix. I might just give you a couple of examples of how the sorts of funding pressures produce perverse outcomes. Funding pressure under Casemix rewards those who admit everybody they possibly can, so there has been a strong pressure to convert outpatient attendances into in-patient attendances which get a Casemix income. In the postnatal ward environment, this means that admission for postnatal support, which is breastfeeding support after discharge—often only for four or five hours—results in a DRG payment but it also results in the progressive diminution of the payment for real admissions within that DRG.

CHAIR—Are you saying that you have a limited amount of money so that if you admit people for management of breast feeding this restricts the number of people you could admit for some other reason?

Prof. Marshall—It is a much broader issue than that. The way in which hospitals in most states, and certainly in South Australia, are funded is on Casemix, and casemix is a very broad based lumping of patients. If you are in a postnatal ward being admitted for breastfeeding, you are linked with other patients who are conventional patients having had a baby. It is the same case payment for being readmitted for four hours of breastfeeding versus five days of postnatal care, which means that the Casemix income for those real patients is then diluted. The people who are admitting these patients are blissfully unaware of what they are doing. I should introduce you to Professor Keirse who has now arrived.

CHAIR—Welcome, Professor Keirse. Can you just explain how this dilutes it? If you have a person who under Casemix comes in for four hours of breastfeeding adjustment and you get the same money as if she is in for five days of postnatal care, doesn't that mean you have just made a killing?

Prof. Marshall—In the short term it does. But in a year's time when the Casemix payment gets adjusted, that Casemix payment allows for the cost of the patient who was only in there for four hours. In two or three years time when you change practice, you then have to face up to the fact that the state government has now said, 'We are going to put a cap on the number of admissions and we won't pay for maybe five or six per cent of them,' then the pressure is no longer to do that. The result is that you have then got patients who are in beds for the real reasons getting a case payment which has been reduced by that previous practice.

CHAIR—Because in 12 months time when they review it they will say that this postnatal bed was occupied for four hours and not five days?

Prof. Marshall—No, they will take a mean.

CHAIR—So it is called the one factor called 'post a baby'. If you are post a baby—that will have the mail system on its ear, won't it? But after a baby is born and you are in hospital for four hours or five days—

Prof. Marshall—It is more likely three days today or even less.

CHAIR—That means that at the end of the year you will say the average time for all the patients who came in or stayed in post a baby was—

Prof. Marshall—Two days.

CHAIR—So therefore you will get funding in the next year for only two days?

Prof. Marshall—That is right.

CHAIR—It does take a little time to tease this out. What is clear to you, Professor, is not necessarily clear to us, so I am assisted in that.

Prof. Marshall—I am going to give you some more examples of the same thing.

CHAIR—It is really useful, thank you very much. These are state funding restrictions that we are talking about?

Prof. Marshall—Absolutely. I will give you some other examples of the same sorts of practices which impact on duration of stay. One is the practice in some hospitals of admitting patients for a cardiotocograph—and not all hospitals do this but some do. A tocograph is the measurement of the foetal heart rate. It is done frequently with a semi high risk case so he can see whether the foetus is okay. That may take half an hour or it may take 45 minutes, but it certainly is not a long time. However, there is a common practice to admit those patients in order to get the DRG payment for a full admission to hospital. The same phenomenon takes place.

We wonder why states like South Australia and Victoria had a relatively high admission rate to hospitals—it is about 10 per cent higher than the national mean—yet if you look at their funding it looks very much as though they are underfunded for public hospital health. A very large part of that is the overcounting that is driven by Casemix. I have given you two examples and I am going to give you some more.

Another good example is the admission of the newborn. I am a paediatrician so I know this very well. The admission rate for neonates in hospitals varies from about 18 per cent to 75 per cent. The criteria for admission vary enormously across the country, and the variation is largely Casemix driven. The real need for newborns to be admitted to a special care or intensive care nursery is probably somewhere between 15 and 20 per cent.

However, there are other babies who require transitional newborn care for perhaps four hours or six hours because of some transient problems with transition from foetal to neonatal state. Commonly, they might some temperature control problems; they might have some mild short-term breathing problems; and they may even require oxygen for half an hour to an hour. Those sorts of babies in the past have not been admitted. They have been cared for in a transitional care nursery for an hour or two or three or four and then moved on with their mother.

Once again, in order to get the Casemix payment—because the non-admitted or unqualified babies are not counted in the hospital statistics and do not get a funding payment

at all—many hospitals have admitted everybody. I happen to know the Royal Women's Hospital in Melbourne was admitting over 70 per cent of its newborn babies a couple of years ago, and that drove Victorians to a point where they had to change the system. I happen to know that in this state the range varies from 18 per cent at Flinders to about 60 per cent at the Lyell McEwin and Queen Elizabeth hospitals, and women and children's is around 55 per cent to 60 per cent. Those sorts of variations have driven the mean duration of stay for the low risk DRG for the newborn which is 727 in the version 3.1—it has just changed to a new version which I am not sure of—the lowest DRG from about three days to 2.1 days, reducing the costs. The same phenomenon is taking place.

CHAIR—Could you for the record help us understand the relationship between DRGs and Casemix?

Prof. Marshall—Sure. DRGs are diagnostic related groups of patients. The expectation was that these would be a homogeneous group of patients which had a homogeneous expectation for consumption of health-care resources. The reality is that the groups are not very homogeneous at all and that Casemix probably only operates on very large populations where the swings and roundabouts can actually be taken account of.

CHAIR—You have just stepped from DRG to casemix.

Prof. Marshall—Casemix is a concept of describing the mixture of patients in groups and the groups are called diagnostic related groups.

CHAIR—I know enough to be dangerous. I thought any assistance you could give us would be good.

Prof. Keirse—May I give some help on this. What Peter meant is that DRGs are identify groups of diagnostic cases.

CHAIR—Would you have one as big as child birth?

Prof. Keirse—No, it would be a bit smaller than that. It would be complicated or non-complicated.

CHAIR—So a DRG could be vaginal deliveries?

Prof. Keirse—Yes.

CHAIR—And then a casemix could be vaginal plus caesarean?

Prof. Keirse—No, the casemix is the general umbrella which stands over the DRGs.

CHAIR—It is interesting because sometimes people talk to us about the funding in terms of DRGs and sometimes they talk to us about the funding in terms of casemix. Now you have introduced another interesting layer which is the federal initiatives for DRGs and casemix in the first place.

Prof. Marshall—Yes, casemix was a federal initiative which the states have taken up as a means to reallocate and limit the resource allocation.

CHAIR—I would ask you if you could wind up the funding side of your submission. You have given us a very interesting and very constructive submission. I think it would be very useful for the committee if we could perhaps move on and then we can put some questions to you. What you are saying to us is that the funding arrangements have a very significant effect in determining the outcome and that, for instance, you might want to admit someone to assist with breastfeeding establishment but you know that this is going to disadvantage you in terms of funding for further birthing care in the 12 months later.

Prof. Marshall—There is no doubt that there are funding pressures which have perverse outcomes.

CHAIR—Can you tell us your caesarean rate?

Prof. Keirse—We have an elective caesarean rate of 5.5 per cent and an emergency caesarean rate of 16.4 per cent. They are the figures for the first half of this year. We have 21 to 22 in total, which is too high, if you ask me.

CHAIR—Tell us more.

Prof. Keirse—It is probably four to five per cent too high.

CHAIR—Is that from the elective or the emergency end?

Prof. Keirse—Both ends, but, obviously, in the emergency one there is more scope for decreasing the rate than in the elective one.

CHAIR—If I am a mother 8½ months pregnant with a baby in the breech position and it looks as though this kid is determined to come that way, am I an elective caesar or an emergency caesar?

Prof. Keirse—No, you would be advised that you have three options. One is that you can have the baby turned. The second is that you can choose to have it vaginally. The third is that you can choose to have a caesarean.

CHAIR—If I choose to have a caesarean then I would then become an elective.

Prof. Keirse—Yes.

CHAIR—If I go into a trial of labour and it all does not seem to be going well then I am an emergency, am I?

Prof. Keirse—Yes. I agree they are awkward terms. Emergency really means that you do not in advance determine the moment when you are going to do it whereas with elective you do.

CHAIR—Do I have to be a certain distance into labour before I become an emergency caesar?

Prof. Keirse—Not really, no.

CHAIR—Just as long as the show has started—pardon the pun?

Prof. Keirse—As soon as the moment cannot be determined any more or that an event has determined the moment it is called an emergency. The terms are a bit loosely applied. We really should talk about caesarean section before the onset of labour or during labour. That would be the better term.

CHAIR—How would you, do you, will you propose to reduce the number of caesareans?

Prof. Keirse—We have been thinking very carefully about that one for some time now. The big problem is that various attempts have been made internationally to address this. Canada had a trial in which they sent small teams to audit all the caesarean sections. What actually happens is that none of the interventions that have been applied to it really have been very effective. If they did anything, they just lowered the rate slightly and then it went up again. We lowered our rate to 18 per cent a couple of years ago and imperceptibly it has crept up again.

CHAIR—How did you lower it to 18 per cent?

Prof. Marshall—With some pretty aggressive monitoring, inquisitional surveillance with a very strong emphasis on supervision of registrars and audit.

CHAIR—So it was really like the peer group watching and supporting each other and saying, 'Think again before you necessarily do that?'

Prof. Keirse—We were pushing very hard for that.

CHAIR—How interesting. Have you finished your opening comments?

Prof. Marshall—I wanted to make a couple more comments and then I will stop. It has become very clear to us that with the various funding epochs for delivery of maternity services that it is virtually impossible to structure a system of health care delivery such that one could introduce key performance indicators as a driver for improving health care services. For example, if one wished to focus on the delivery of services in the first few days after birth and breastfeeding, a measurement of that in our climate is impossible because by the time they have moved on to the next service provider, which is out of hospital, we do not know whether they have even seen a general practitioner, let alone whether they are breastfeeding. We do not have the option to feed that back to drive the breastfeeding process. The funding mechanisms in place provide no funding incentive for achievement of successful breastfeeding. In fact they provide perversely the reverse—short duration of stay and no resources.

Senator GIBBS—You said at the beginning that you had a wide range of options for women to give birth. Do you have a birthing centre here run by midwives?

Prof. Keirse—Yes.

Senator GIBBS—We have heard a lot from midwives in our travels. Apparently, a lot of them have to work independently and there is no Medicare rebate. Would you support and do you think there is a need to have a Medicare rebate so that women can have this choice of birthing?

Prof. Keirse—That is a difficult question. I would say yes, but I would like to see a few things furthered first. I would like to see the quality of midwifery care increased considerably. Perhaps I should give a bit of background. I have worked in the Netherlands for 15 years where one-third of women have their babies at home.

Senator GIBBS—We have been told this. I am very impressed.

CHAIR—I thought it was possibly higher. That is interesting.

Prof. Keirse—It used to be higher, but it has been decreasing slowly over the last couple of years predominantly because women at low risk are allowed to choose whether they want to have their baby at home or whether they want to go into hospital with their own midwife and then return immediately home. Quite a lot of them are actually taking up that option rather than having the mess at home.

Senator GIBBS—With their own midwife?

Prof. Keirse—Yes.

Senator GIBBS—So far we have heard that that is not allowed anywhere. Do you support that method?

Prof. Keirse—Yes, I do. I would like to see the quality of midwifery care improved first. One of the problems is that midwives in this country are nurses who have done one year of midwifery. Whereas if we look at the Netherlands, there are people who have done four years of midwifery. The quality of that knowledge and experience—that kind of thing—is totally non-comparable. Here the midwives start learning midwifery once they are qualified, not before that. I think that is a big problem. You need to do something about that first.

Senator GIBBS—Yes. If the standard were raised then obviously it would benefit the mother and the child.

Prof. Keirse—Yes.

Senator GIBBS—We spoke to other witnesses about best practice guidelines. Yesterday I had it in my mind that if we were to have best practice guidelines they would be national.

Yesterday it was pointed out to me that, no, that could not happen; it would have to be hospital by hospital. Do you agree with that?

Prof. Keirse—No, of course not.

Senator GIBBS—I felt a bit foolish yesterday. I thought I must have been a bit silly or something. The witness was quite strong on that point.

CHAIR—It is a very important point that you make; I think we might just spell it out. We were told that you would need best practice for a country hospital that had no access to certain anaesthetics, for example. We should have perhaps pushed harder because I think our response was like yours. We would then need a subdescription that said 'depending on what is available'.

Prof. Keirse—Probably not necessarily. You have best practice guidelines, but it is like everything: you cannot expect a doctor who is called alongside the road for a car accident to apply the same kinds of things that he would do in a tertiary care hospital. That does not necessarily mean that the guidelines for practice need to be changed. What it means is that one has to take into account local circumstances. That is not a reason for saying that gross negligence or something like that would be acceptable in either one of those situations.

Senator GIBBS—So you agree with me that if we had best practice guidelines they should be national, Australia-wide?

Prof. Keirse—I would go further. I would say that they should be international.

Senator GIBBS—Maybe if we can start with Australia first, we can conquer the world afterwards.

Prof. Keirse—You may have heard of 'Effective Care in Pregnancy and Childbirth', which was published 10 years ago now, and which actually mapped out all the evidence throughout obstetrics and maternity care. I happen to be one of the authors of that, so I am bound to have a biased view, but it tends to go along with yours as well.

Senator GIBBS—Good.

CHAIR—Lots of good things come out of South Australia, don't they, Professor?

Prof. Keirse—They do.

CHAIR—It is a pity South Australia does not know about them.

Senator GIBBS—Just another quick question: you were saying before that you deliberately tried to lower your rate of caesarean births. This has been quite contentious as the committee has been moving around; obstetricians seem to think that this is the way to go. They say that women actually demand caesareans, and they comply. Is that happening here?

Prof. Keirse—It is, to some extent. But that is obviously not the only reason. I think it is more often used as an excuse than anything else. But, yes, there are women who ask. There is actually some evidence in the literature and that as well. Professor Fisk in London conducted a survey of female gynaecologists, presenting them with the example: suppose you have a normal pregnancy, nothing wrong, what would you choose? A lot of them would choose a caesarean section, predominantly to protect their perineum. That was published in the literature and is widely quoted and so on.

CHAIR—I cannot imagine why, Professor.

Prof. Keirse—Neither can I, but I am not a woman.

CHAIR—Does *Hansard* pick up heavy irony?

Senator GIBBS—Also we have heard on our travels that, because of the amount of caesareans, obstetricians are being deskilled. As one obstetrician, an older gentleman, said to me, 'It is the deskilling of obstetricians. In this particular hospital there are two of us who are actually expert at breech birth—natural birth. Three others would be comfortable doing it. But when I and this other doctor retire, there will be three out of 25 obstetricians who would be comfortable with a breech birth.' Everybody else says, 'Let's just flash out the knife.' Have you got evidence of the deskilling of obstetricians?

Prof. Keirse—Yes, and again that has been published. There has been a survey conducted by people in training in Australia. It was published earlier this year, late last year, on the number of breech delivers each of them did. There were really very few. So the young generation really does not get trained properly any more in conducting vaginal breech deliveries. Yes, I think that is a valid point.

Senator GIBBS—When I brought this up with a particular obstetrician yesterday, he said that with breech birth there was the danger that the child would be damaged in some way and the excuse was, 'If it is breech and we go for the caesarean, at least the child will be intact.'

Prof. Keirse—That is not necessarily so, because a breech presentation carries an added risk for the baby, irrespective of the mechanism of birth. So it is not necessarily because of doing a caesarean that you are going to solve all the problems. It sometimes can be very difficult to deliver the head of a baby through a uterine segment that is fairly thick. So sometimes it is actually more difficult than doing it vaginally. But there is no doubt whatsoever that doing vaginal deliveries in breeches will add a certain risk to it. How much, we do not know. There is currently a large international trial going on, sponsored by the Medical Research Council of Canada, to compare vaginal birth with caesarean birth. But irrespective of the results of the trial, it may not necessarily teach us that much if people really do not get the skill any more from doing breech deliveries. I think that is really a crucial point.

Senator GIBBS—Thank you very much.

CHAIR—Earlier you gave us some figures on elective caesareans and emergency caesareans. Can you break those figures down as to the number of each done in the public and private systems?

Prof. Keirse—Yes. We have very few private deliveries. Only four per cent of all our births are private, but the caesarean section rate among them is consistently higher. If I am talking the first half of the year, we had 13 caesareans out of 40 women giving birth privately and 271 out of 1,158 women giving birth publicly.

CHAIR—That is in the first six months of this year?

Prof. Keirse—Yes, the first six months of this year. In all hospitals, caesarean section rates are consistently higher for private patients than they are for public patients, and I have an opinion on that as well.

CHAIR—Let us have it, if you are prepared to give it?

Prof. Keirse—I think part of the problem is that private practitioners have their rooms and deliver women at various hospitals. If they were made to stay in one and the same spot they would be able to look after them more properly and they would not have to just end it quickly so that they could rush back to their rooms. If I had anything to say I would make it illegal to practice in two positions, but I must say I am not too popular when I say that to my colleagues.

CHAIR—Professor, you just said that you think sometimes this claim that 'women are demanding caesareans' is used as an excuse or a justification for why figures are high. I am very concerned about this line that says women who, in childbirth, have been completely powerless for 2000 years are now suddenly the cause of a considerable increase in intervention. It is an astounding turnaround in women's power.

Prof. Keirse—I know. Let me give an example. Because we have been talking about breech, let's take breech as an example. When I counsel women with breech presentation, I really a bit forcefully recommend external cephalic version, for two reasons. One is that, if they would wish to have a caesarean section, it can be avoided that way if the turning is successful, which it is two out of three times. Secondly, even if they go for a vaginal birth, the chances of caesarean section are still substantially higher, because it has to be smooth and all going very well, otherwise people are not going to accept continuing vaginally.

Whichever way you look at it, it is a mechanism by which you can avoid unnecessary caesarean sections. There is good evidence from controlled trials in the literature that that is fact. There are still some women who would say that they would not have an external cephalic version because they want a caesarean. You can be easy and let them go that way, or you can try to argue, and I am afraid some obstetricians probably do not argue enough.

CHAIR—I am interested in the way this expression is coming up: 'Women are demanding caesareans.' We are being told that the doctors are saying that, if women ask for them, the doctors will provide them, which seems to me, on the face of it, an extraordinary almost abdication of professional competence. If people walk in and demand an

appendicectomy, surgeons do not say, 'Well, yes, in the end, we'll give it to you.' I know it is not an exactly comparable situation, but we need to get our lines correct here. The committee needs to be assisted. How many women are demanding caesareans, and how many women are saying, out of a choice including a trial of labour at the baby after a previous caesar, that they prefer on balance to have another caesarean section rather than go through a trial of labour, which is maybe choosing a caesarean section on the evidence and not the same as demanding a caesarean section? Can you understand what I am saying here? The committee would be assisted if you could make some clarification for us here.

Prof. Keirse—I understand what you are saying. The only thing is I do not have any figures on that, and I do not think anyone has any figures on it—I do not know of any published figures, anyhow. But I would say a minority would request a caesarean. It is going to be very much dependent on how traumatic they felt their previous birth was. If they were in labour for a very long time, say, and were pushing for two or three hours, they are going to ask, 'Well, what's the likelihood of that happening again?' It is usually not big, but it is very real. Some of them will choose a caesarean for that reason. I must say, when they do, I would go along with that. In a particular situation like that, I would not be too insistent on trying to change their minds. In other situations, I would.

CHAIR—Can move away from just the caesarean statistics to the tenor of your article, which is that we need a much more holistic approach. We need a go to whoa approach, and whoa would be at least six weeks post the birth of the baby, when breastfeeding is established, the uterus is back to normal size, there is no leaking, discharge or whatever, everything is fine and the baby is growing beautifully. The whole emphasis of your article says that the funding militates against this and so does the design of services. Your article suggests that the antenatal care may be a visit to a GP, a referral to a specialist or some childbirth education from a third person or a different source. I would like you to briefly comment about that emphasis. Is Flinders like other hospitals, or are you singular? As I recollect the brawl that went on in this state about home births—and tell me if I am wrong about this—Flinders was early on into backing up home births.

Prof. Marshall—That is true. I do not know that the institution can take credit for that. There were some individuals who thought home birth midwives needed support. Andrew Ramsey particularly was heavily involved in that. We have had a track record of being innovative and looking at things from a broad perspective, so I think your comments are valid. We have a view that we need to look outside the box more. We have been increasingly trying to focus on how we can do that. We are interested to seek to be a model hospital and to look at innovative ways of delivering different forms of paternity services. That is ultimately what we would like to be looking at doing.

CHAIR—Have you done this in consultation with midwives or is it entirely with the medical profession?

Prof. Keirse—No, on the country. We have midwifery clinics and all of that. We are the only hospital in the state that runs morning, afternoon and evening clinics, as well. We do two evening clinics a week. We are also the only one that delivers antenatal care for public patients off-location, 20 kilometres to the south, where there is an area of greater need. We

also have clinics for young pregnant women, with peer support workers and other teenage mothers to help them. We do not think of obstetric teams, we think of paternity care.

CHAIR—I think we are assisted by this. We are learning that the pattern of care from one hospital to another is extremely different. We are also aware that, although there is a push for a holistic approach, childbirth is not an illness—this is a normal, happy bit of hard work; a marvellous process is happening here—but it is focused around hospitals. That is where care tends to finish for most people—at the time of birth. There is a sense in which people are fighting against that kind of hospitalisation, medicalisation and the 'sick' system. Women and their families are still struggling a bit. The women are saying, 'We're not sick, but we're in hospital, we've got shimmy shirts on and we're being told what to do.'

Prof. Marshall—Medicalisation is the normal process most of the time.

CHAIR—Are you content with that?

Prof. Marshall—We are not content with it, but we are struggling with the systems that are in place at the moment that make it very difficult to provide the sorts of incentives to achieve the sorts of changes that are required. One of the side issues here—whatever your specific questions—which you have not asked us about yet is the impact of the complex delivery funding on obstetrics. I cannot give you data on that but, essentially, a couple of years ago we moved away from a funding model for private obstetrics in which whether you did a caesarean section or not did not matter. You got the same amount of money. Now, caesarean section is a complex delivery, and you get paid more for it. That is a funding incentive to do caesarean sections. I cannot tell you that that is having an impact; I do not know. But I cannot see it having the right impact.

Senator GIBBS—Haven't we been told that there is no extra for caesareans?

CHAIR—There was not until very recently.

Prof. Marshall—It becomes a complex delivery.

CHAIR—It was changed in about 1987-88 to a package amount of money, and it has been changed again recently.

Senator GIBBS—How much more?

Prof. Marshall—I cannot tell you. I do not know. But there is a funding incentive associated with a complex delivery. We have that already defined in a different way as including caesarean sections. In my view, a complex delivery is something that needs to be defined perhaps as, say, the management of pre-term birth, which might well be more complex than a straightforward caesarean section. So it has been simplified too much, and the funding incentive there is potentially perverse.

Senator GIBBS—When women go to their GP, go to an obstetrician, want to go private and, at some stage, decide to have a caesarean, do you believe women are being given all

the facts of what can go wrong, what it can do to your body and all the sorts of complications you can have afterwards?

Prof. Marshall—No, I do not believe that happens. The reality is that it is very rare for a doctor to explain all of the things that can go wrong, because that is often a very counterproductive thing to do. Most obstetricians endeavour to provide their patients with the best possible care and endeavour to provide them with the information that is required. Your expectation that they would provide them with a full list of everything that can go wrong would not be appropriate.

Senator GIBBS—I am not talking about when it is a necessary thing—when the whole event is going and things are starting to go wrong and while she is lying there in agony. It is pretty obvious from our investigation so far that an enormous amount of women elect to have a caesarean. They are quite healthy, and there is nothing wrong with them, but that is the way they want it. They have a private doctor, so they do it. I am wondering whether those women are told what can go wrong. It seems to me that, if you are quite healthy and there is nothing wrong with the baby—the baby is quite healthy—and you have a natural birth, it is painful, but there are things to help. You forget it afterwards, and your body pops back into shape.

Prof. Keirse—I think there is probably one basic thing wrong in the minds of women, obstetricians and everyone else and that is that we see a caesarean as a caesarean birth. That is not what it is. It is a birth, plus a major operation.

Senator GIBBS—Yes, exactly.

Prof. Keirse—I do not think that that point is emphasised enough. If your question asked whether most obstetricians emphasise that very strongly to women, I am not entirely sure that they do.

Senator GIBBS—No. Because it seems to me from talking to different people and just over the years that there is a culture out there where people have this idea that, if you have a caesarean, they cut open your belly, pull the baby out and stitch you back up again—it is as simple as that.

Prof. Keirse—Yes, it is as simple as that.

Senator GIBBS—And that is actually what people think happens with a caesarean.

Prof. Keirse—Yes, and they forget that for six months afterwards you have the consequences of a major operation. I agree.

Senator GIBBS—That is right.

CHAIR—We do have to call other people, but this is a terribly important point. We have been told that people are saying, ‘I do not want to go through the pain of childbirth, so I will have a caesarean section.’ One wonders what kind of information they are actually getting.

Senator TCHEN—Can I reflect the comments of the chair and Senator Gibbs earlier and say that your submission has been very impressive and interesting. In fact, one is almost tempted to sample your service. Professor Marshall, you were talking about Casemix and the effect of funding on services. Casemix is really an accounting procedure because the funding had to be capped, otherwise you would have unlimited costs.

Prof. Marshall—It would be nice if they were.

Senator TCHEN—You referred to two hospitals which are trying to 'work the system'. One of these hospitals is in Victoria. Which one?

Prof. Marshall—There is no doubt that the Royal Women's Hospital led the charge in Victoria, but they all ultimately had to follow.

Senator TCHEN—What was the other one?

Prof. Marshall—In Victoria?

Senator TCHEN—No, you referred to one in Victoria and another one.

Prof. Marshall—Did I? Certainly, the Royal Women's Hospital in Victoria was a major contributor to the problem in Victoria. Here, I think probably the Queen Elizabeth and the Lyell McEwin hospitals were the major culprits. But there have been many others across the country that have done the same thing.

Senator TCHEN—You are a paediatrician and yesterday we heard from another paediatrician. We have been told by quite a lot of people that doctors are saying that caesarean delivery is marginal in terms of risk for the baby—it has a better record. As a paediatrician, do you have evidence, anecdotal or otherwise, for this?

Prof. Marshall—This is a caesarean for breech delivery?

Senator TCHEN—For breech delivery—for a difficult birth.

Prof. Marshall—I think most paediatricians sitting waiting while they see a breech delivery have a few shudders because it always looks to be difficult. They wait and wait and can sense the foetal heart getting slower and slower. So they have a natural inclination to be very concerned. Professor Keirse's comment earlier, that caesarean section does not always make it that much easier, is also true. I have seen many babies who have been very difficult breech deliveries by caesarean section as well. I think the area that paediatricians are most concerned about, however, is where babies are less than 32-weeks gestation. They are probably best not delivered as a breech. The evidence is all retrospective. The randomised controlled trials that have attempted to answer this question have failed because of lack of compliance, but I think most paediatricians would be inclined to prefer breeches prior to 32 weeks being born by caesarean section.

Senator TCHEN—In reference to another point raised in the evidence that we took yesterday in Victoria, can you tell me whether independently practising midwives are admitted to your delivery rooms in Flinders Medical Centre as practitioners and participants?

Prof. Marshall—Yes.

Prof. Keirse—Yes. They need to be accredited though, and we have an accreditation process for them.

Senator TCHEN—So it is accreditation that is important?

Prof. Keirse—Yes.

Senator TCHEN—The same applies to GPs?

Prof. Keirse—Yes, except for some procedures. Midwives are not necessarily going to be allowed to do all the procedures that they would do in a country hospital—but for normal births, yes.

Senator TCHEN—Does the same sort of restriction apply to midwives who are admitted?

Prof. Keirse—Yes, definitely. If midwives were thinking of starting to induce labour or of starting to do a caesarean section, they would have a difficult time.

Senator TCHEN—Yes, of course. You mentioned that, in the case of a foreseeable breech delivery, you would—I think the phrase was—'persuade forcefully' so as to avoid doing a caesarean section. At what point would you stop trying to impose your will on the patient?

Prof. Keirse—I did not mean to say that I imposed my will. I would make the argument pretty strong by pointing out that there are at least seven randomised trials in the literature which have clearly shown that by external cephalic version you will reduce the percentage of breech, and that will reduce caesarean section rates. I would clearly point out to them that, while a caesarean section may look fairly easy, you have to take into account that it is a major operation and that you are likely to suffer for six months afterwards—if not longer—like after any major operation. Therefore, there is an excellent argument for at least trying to avoid a breech in the first place, and then to argue further after that.

Senator TCHEN—But at what point would you say to your patient, 'Okay, it is your body. I will do what you say'?

Prof. Keirse—If she says, 'No, I am not having it,' that is it—if she does not want it, that is the end of the story. Mostly they do, but there are a few who do not want it.

Senator TCHEN—So most women can be persuaded?

Prof. Keirse—Yes, most women can be persuaded when you present them with the options: it does not hurt, it is not painful and it is a very simple procedure—either it works or it does not. I would choose a same thing myself, but I have never been pregnant though.

Senator TCHEN—Would you be able to put a figure on what proportion of women would actually insist on a caesarean section delivery, regardless of your persuasion?

Prof. Keirse—About five per cent.

Senator TCHEN—Only five per cent?

Prof. Keirse—Probably about five per cent.

Senator TCHEN—Thank you.

CHAIR—We were told yesterday that one of the reasons the caesarean section rate in Holland is so low is that the midwives in Holland are working with a homogeneous population, whereas in Australia we have a multiracial population. And large Australian men having babies with a small Vietnamese women lead to head sizes too big for Vietnamese women's pelvises. Would you care to comment?

Prof. Keirse—I do not know, but I have not seen so many small Vietnamese women with large Australian men to explain the huge discrepancy in the caesarean section rate. I worked in Holland and it is just as multiracial as Australia. It has an influx of people from Surinam, Morocco and Turkey. The whole of Europe is multiracial now. I would not care too much for a comment like that.

CHAIR—I thought it would be better for you to put those comments on the record rather than me. I was a bit astounded, but never mind. For example, two surveys were drawn to our attention—one in Dublin and the other in the UK—and again the caesarean section rate was very low. It was 2 per cent to 3 per cent, I think, in the Dublin study and about 19 per cent in the UK study. Again, we were told that Ireland had a much more homogeneous population.

Prof. Marshall—Be careful of the Dublin work: the published data from Dublin with a low caesarean section rate is also associated with a higher incidence of asphyxiated babies, so that level of reductions in caesarean section may be very counterproductive.

CHAIR—I think that we are in a very difficult situation here because it is not for this committee to be describing best practice or taking over from obstetricians, midwives or whomever. We have been asked to look at significant discrepancies in the practice of procedures across Australia. I do not believe the women of South Australia are so different that we should have such a high caesarean rate. The factor, I am told, is that we do have the highest number of obstetrician specialists. Is this true? Yes, it is, as our witnesses are nodding.

Prof. Keirse—I agree and I think that is probably a factor as well because there have been other studies done indicating that rates of hysterectomies, for instance, are closely

related to the number of specialist gynaecologists you have in countries, so that would not be inconsistent.

CHAIR—So you are telling us that South Australia has a very high rate of hysterectomy?

Prof. Keirse—No. I do not know, honestly.

Prof. Marshall—I think there is some data to suggest it is high. But that may also be a question of access to services too. I am a little bit careful about necessarily implying that the high rate is necessarily wrong; if the facility or the services are available and women are availing themselves of them, it may in fact be a good thing that they do.

CHAIR—We are also told that South Australia has a very low perinatal mortality rate.

Prof. Marshall—It does, and has had so for at least 15 years; it has led the nation. There are very good neonatal intensive care services as well.

CHAIR—We have to reflect on this. We have to finish now as we have run over time. There are still a couple of questions that I would love to ask you. Maybe I will ask you them, if you would not mind making a dot point or two in response on a bit of paper, not a thesis; I know how busy you are.

We have not talked about screening and I would particularly like to do so now. Firstly, what do you mean by it? Do you include the care of the mother—blood pressure, blood tests, haemoglobin diabetes tests, weight et cetera—or are you just talking about the high-tech things that we can do to check on the foetus?

Prof. Marshall—We are concerned about both.

CHAIR—When you call it antenatal screening does that cover both: mother and foetus?

Prof. Marshall—Yes, it does.

CHAIR—It certainly seems to be that you have some concern that some of the antenatal screening procedures are, one, being done too often and, two, are perhaps encouraging further intervention.

Prof. Marshall—That is probably fair comment. There is a strong view around the country that there is a diversity in the antenatal screening procedures which are performed. I think the women's hospitals of Australia are looking carefully at trying to standardise those, which is a good thing, or to put up a database to look more carefully at that.

There is no doubt too that when one does a screening test it is inevitable that it leads to intervention. I am reminded that some of the screening tests, like screening for Down's syndrome and other abnormalities of that nature, seem so benign until one sees a mother who is desperately worried about the outcome of that test, even though it may be negative.

We generate an enormous amount of anxiety by some of these screening tests and I am not sure that all of them are actually worth while.

CHAIR—Do you have discussions or fights with your hospital and professional colleagues in this state about the way you are proposing maternal care at Flinders? Are you so different that others worry about you?

Prof. Marshall—No, I do not think so. I think that probably this hospital and we are both quite innovative and I suspect the same can be said for Lyell McEwin—they are increasingly innovative. I suspect the women of this state are actually well served, apart from their caesarean section rate.

CHAIR—You both seem to be saying to us that you do think the caesarean section rate is too high in South Australia and you would both be encouraged if we could lower it.

Prof. Marshall—It is more appropriate that Marc comment on that as I am a paediatrician.

Prof. Keirse—Yes, Chair, I definitely agree.

CHAIR—You say that Flinders, by being very rigorous a few years ago, did lower it to 18 per cent and then it crept up. Do you have from that some suggestions, which you could put on a bit of paper as dot points to the committee, about ways you could recommend—a pattern or a program—that might indeed assist in lowering the caesarean rate in all institutions?

Prof. Keirse—I do not know whether it could work but I would be quite happy to try that; yes.

CHAIR—The proposals you put on page 5 are really quite an interesting spell-out of ways in which the whole process could be significantly changed, in that you would get best practice if we had a significant change in the funding for maternity care, if I can call it that.

Prof. Marshall—Absolutely. At the end of the day there is no better incentive than money; money drives the way in which we do things.

CHAIR—That is very depressing. Are you saying that financial incentives from governments outweigh professional practice?

Prof. Marshall—I am saying they have a very significant impact on the way in which everybody functions. Just as an aside, I think of chocolate frogs as a way of providing incentives in our hospital but I have no way of dispensing them in a way that actually works. We work on a combination of incentives and disincentives, and financial incentives are an important part of the landscape.

CHAIR—Can I thank you both very much for a very useful submission and for your contribution today. If you could give us any dot points about screening or a particular program, that would be very helpful.

Prof. Marshall—When would you like those?

CHAIR—In the next couple of weeks; this is called ‘please don’t break your arm trying to do it today’. Let us say dot points if you can; we do not want to put you to a thesis.

Prof. Marshall—Thank you very much for hearing our submission and we will go on to prepare the dot points.

Prof. Keirse—Thank you.

[10.08 a.m.]

ROBINSON, Professor Jeffrey Samuel, Member, Perinatal Society of Australia and New Zealand

CHAIR—Welcome, Professor Robinson. In what capacity do you appear today?

Prof. Robinson—I am here as a member of the Perinatal Society of Australia and New Zealand. I am here on behalf of my colleagues David Henderson-Smart, James King and Sue McDonald, who are interstate.

CHAIR—The committee prefers all evidence to be heard 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 we would give consideration to your request. We have your submission, which is No. 28. Do you wish to add to that or alter it in any way?

Prof. Robinson—No, I do not wish to alter the submission in any way.

CHAIR—I will ask you to make a brief opening statement and then to field some questions. I apologise for the lateness of the start.

Prof. Robinson—First of all, I would like to thank the committee for allowing the Perinatal Society of Australia and New Zealand to present its submission and for allowing me to act on its behalf. I should acknowledge Marc Keirse, who has just left the room. I have known Marc for many years and the Cochrane collaboration arose out of work that he, Iain Chalmers in Oxford and Murray Enkin, who is at McMaster University in Hamilton, did in the late 1980s. The three of them produced the Oxford database of perinatal trials, which was a landmark change in the way that evidence in pregnancy was viewed.

That is why we have emphasised in our submission to you that care in pregnancy should as far as possible be evidence based and that the systematic reviews from the Cochrane Library are one very good way to do this. I have actually brought along four reviews from the Cochrane Collaboration, or the Cochrane Library, which arrived in my current CD-ROM issue which may be of interest to you. I am willing to submit them to you, if I am allowed to do that.

CHAIR—We would be very appreciative of that, if that is alright with you. Thank you very much.

Prof. Robinson—If you think it would be worth while for me to try and obtain copies of the disk for the inquiry, I will certainly do that as well.

CHAIR—Do we wish to have it on disk or on paper? I think hard copies will be fine at the moment.

Prof. Robinson—These are simply examples.

CHAIR—If we need to, we will contact you for a disk.

Prof. Robinson—In doing this, I really wish to also highlight that at least two of the reviews that I have brought along have two Australian midwives asked co-authors of these reviews. One is from Adelaide, Georgina Stamp, and the other one is one of my co-submitters, Sue McDonald. The importance of this I do not think can be emphasised enough. For example, in his submission Marc Keirse emphasised the strength of offering evidence of external cephalic version for breech presentation. That has arisen out of the series of randomised trials that are summarised in the Cochrane Library. We would like to encourage everyone to use systematic evidence as much as possible. In relation to other things, I strongly support—and so does my society—a range of safe options for care in pregnancy. This should be encouraged. I think I would leave my opening comments at that, if I may.

Senator GIBBS—You say that care in pregnancy, childbirth and after birth should as far as possible be based on the principles of evidence based practice. Could you elaborate on that for me?

Prof. Robinson—In our submission on page 4 we have indicated how that evidence could be assessed. This comes from the recent NHMRC guide to the development, implementation and evaluation of clinical practice guidelines. In other words, we should use the best available evidence in assessing care in any form of medicine or other health care, and certainly it relates to pregnancy and all its aspects.

So, the best evidence we have is a systematic review of a number of randomised trials on a particular topic, and that evidence is categorised as level I evidence. Evidence obtained from just a single trial is level II evidence. Then there are less secure forms of evidence under levels III-1, III-2 and III-3. Under level IV there is evidence obtained from case series which do not have a direct comparison group. Level I evidence should be taken as the gold standard for effectiveness of health care interventions. However, there are many topics in all forms of health care that have not been subjected to a sufficient number of randomised trials so that level I evidence is available across the board. That is why in our first recommendation we have said that care in pregnancy, childbirth and after birth should as far as possible be based on the principles of evidence based practice.

Senator GIBBS—What is your opinion of the early release of women from hospitals? We have heard that women are out two or three days later.

Prof. Robinson—Yes. There has been a very rapid change in practice in Australia. When I arrived in Australia in the Hunter Valley, the average length of stay for a normal birth was 13 days. It has declined very rapidly and, indeed, when I was involved in the hospital planning for the John Hunter Hospital the health care group of administrators plotted a regression line and said that we would not need maternity beds by 1990. I said, ‘That’s not correct. People will have to stay in hospital for a period of time.’

There has been a very rapid shortening of the length of stay in all parts of Australia without evaluation of how this is affecting health care or the care of women and their babies. There is an evaluation of the short length of stay. It was in the Cochrane Library. For some women this may be beneficial but for others it may not be beneficial. The people for whom it may be beneficial are those who have family support, are breastfeeding and have had

babies before. Their early discharge may in fact maintain breastfeeding practices longer than those who are kept in hospital longer.

Senator GIBBS—We have heard quite a lot of evidence from midwives and women are choosing alternative birthing methods. They are going into a hospital but into the birth centre attached to the hospital. Are you in favour of this practice? I will put a couple of questions in one. All of the midwives work as independent midwives and they are not allowed to accompany their mother to hospital or be in the ward when she is giving birth if she chooses to have her baby in hospital.

Prof. Robinson—There are several issues covered by those two questions. Firstly, I am in favour of independent midwifery practice. I wrote the first document in relation to independent midwifery practice in the Newcastle Mater Hospital many years ago and persuaded the Sisters of Mercy there that we should have independently practising the midwives. Marilyn Rowley was the first independently practising midwife who started to work there, and subsequently has completed a randomised trial of team midwifery in Newcastle and you may have received that evidence already.

In relation to birthing centres, I have been a supporter of birthing centres. I currently am a supporter of the birthing centre in this hospital. I wrote the document, together with a group in South Australia, on birthing centre care for South Australia. We have produced guidelines for South Australia of the people who should be in a birthing centre, or should be informed about birthing centres, and who could go to a birthing centre. Individual hospitals interpret those guidelines differently. For example, the Queen Elizabeth Hospital allows women who have had a previous caesarean section to go to their birthing centre, whereas this hospital does not; although I pressurise this hospital from time to time to allow women who have had a previous caesarean section to use the birthing centre.

I believe there is a very strong place for birthing centres, but the randomised trials of midwifery led care show that it is one of the few things that does not change when you allow for comparability between different groups. Caesarean section does not seem to be reduced by midwifery led care when you look at the people who enter care and compare that with a similar group who have traditional care in Australia.

Senator GIBBS—Do you agree with the previous professor that midwives need more training and that they need to have a higher standard?

Prof. Robinson—The midwives here who work in the birthing centre are usually experienced midwives. They have usually done postgraduate training, or time within our delivery suite, before they work in our birthing centre. I think a midwife who has just completed her training will require help and supervision for a number of problems during labour. That can be done by a senior midwife, or it could be in conjunction with medical practitioners.

Senator GIBBS—Do you believe that if there was a Medicare rebate for independent midwives more women would actually choose to go that way?

Prof. Robinson—I think that more women would use birthing centres if given that option. I do not believe there is a great drive within South Australia for homebirths with independently practising midwives. Part of the inhibition of this may be the number of independently practising midwives, but I do not have evidence for that. A fee for it would make it easier for women to choose that option. It is a comparatively expensive option currently, because there is no rebate for it.

In relation to independently practising midwives within a hospital setting there is a difficulty of getting indemnity. There is a concern that the Health Commission, as it was in this state, asked midwives to carry indemnity which they could not readily achieve from insurers. So that is another issue that will affect how many independently practising midwives can practise through hospitals.

Senator GIBBS—It seems to me that there needs to be a change in culture, a change in practices, so that this can actually happen. It also seems to me that the women who do choose to have an independent midwife are not necessarily women on average incomes but those who are more privileged and actually have the money to pay, so the midwives are only really catering to a certain group of women and the rest of the female population is disadvantaged.

Prof. Robinson—Yes, that would have to be true, but the patients of independently practising midwives whom I have helped do not necessarily come from the higher echelons of the income group; they come from very much a broad spectrum of income categories, perhaps excluding the higher income groups. We have had independently practising midwives attached to this hospital and I have provided cover where they need obstetrician care over the years. Currently, Marc Keirse has pinched the one who was doing most of the independently practising midwifery through this hospital, so the number of people assisting has fallen as a result of that. But it would assist some women in making that choice.

Senator GIBBS—Thank you very much.

CHAIR—I am just interested in a couple of comments that I think would be useful on the record and I would like your comment about them. There is a wealth of epidemiological evidence that only a small proportion of the cases of cerebral palsy can be attributed to the events that occur around the time of the birth.

Prof. Robinson—Yes.

CHAIR—Before you comment, can I add that we have been concerned that one of the reasons driving an increase in the number of caesarean sections has been the fear of litigation and a fear that if something has gone wrong with the baby, particularly brain damage of some sort, this can be attributed to the process of delivery or the time of birth.

Prof. Robinson—It goes back as far as Little in the 1860s, who was convinced that cerebral palsy was due to events occurring during birth, and indeed this was supported by Osler in his book on cerebral palsy in the 1890s, who clearly argued that all cerebral palsy that was present soon after birth was due to the birth process itself. Sigmund Freud was

much more thoughtful in a way. He argued strongly that cerebral palsy and the birth process may arise from events that begin before labour.

The major paper that changed current thinking about that was from Nelson and Ellenburg in the United States, which is referenced in that confidential attachment that we submitted to you. They showed very clearly that about eight per cent of all cerebral palsy might be attributable to events during labour. The problem with cerebral palsy is that it often does not appear or is obvious until some years after birth and trying to relate the cerebral palsy to events during labour or to adverse antenatal events is not an easy task.

Fiona Stanley and her colleagues in Western Australia have to be congratulated for the work that they have done for cerebral palsy within a region. They have shown that cerebral palsy is associated with a number of adverse antenatal factors. When these adverse antenatal factors are present, they may not indeed appear as an event until labour starts. So it is a complicated issue. And by no means is it a resolved issue as to how clearly we could detect the antenatal antecedents of cerebral palsy, nor can we show in the majority of cases of cerebral palsy that there has been an adverse intrapartum event.

CHAIR—If I were to argue this in court, do you think I could be persuasive? I would send you actually, Professor. Could you? Or is it, for example, that that information is made available to courts?

Prof. Robinson—That information is made available to courts, but the way that evidence is weighted in courts is different from the way that medical scientists would weigh evidence in the sense that, in law, the definition of contributing factors is different from the evidence required for medical science.

CHAIR—So even if that is provided to the courts, it is not necessarily persuasive?

Prof. Robinson—That is correct.

CHAIR—Thank you. You say here that:

Continuity of midwifery care is associated with lower rates of intervention (induction, augmentation, episiotomy and vaginal operative delivery), but not in the rates of Caesarean sections (Waldenstrom and Turnbull 1998).

Can you tell us about that?

Prof. Robinson—Yes, that is a systematic review of randomised trials. It was published in the *British Journal of Obstetrics and Gynaecology*. You are in fact going to meet Deborah Turnbull this afternoon, who wrote that review. Indeed, I think it may even be in her submission that you have before you later today. It is based on a number of randomised trials where biases are excluded and comparative groups are truly compared, and that is the outcome of those trials.

CHAIR—I must say, I have tried to keep an eye on things to do with health—I know Australia has one of the highest caesarean rates in the world—but I missed the fact that it

has a national policy calling for a reduction of that, which you say is from the Commonwealth department of health 1993. Please put that on the record for us.

Prof. Robinson—The aim of Australia was to try to ensure that its caesarean section rate should not be beyond that which is reasonable. Defining what is a reasonable rate of caesarean sections is much more difficult. The reasonable rate of caesarean sections has been defined by the World Health Organisation as about 15 per cent. For example, here in South Australia, the hospital that has been most successful in reducing its caesarean section rate and is now trying to maintain that reduction is the Queen Elizabeth Hospital, through Brian Pridmore, whom you are also seeing later today.

CHAIR—Do you have a view about whether the medical indemnity or the threat of suing is actually contributing to the way medical practice is happening at the time of childbirth?

Prof. Robinson—The problem of medical indemnity is one that will continue to plague us. If you read the recent publication of the major insurer in Australia, obstetricians are currently having their medical indemnity subsidised by the rest of the medical profession. It was calculated by the chief executive officer of United that an obstetrician's true costs for medical indemnity would be somewhere above $90,000 per year. For people who earn an academic salary like me, paying $90,000 a year would be extremely difficult to sustain. For private practice, that would have a significant effect, I think, on the way people would choose to practice. It would lead to defensive obstetrics. In the Republic of Ireland—the southern part of Ireland, which is the other part of Ireland from my birthplace—the current rate of indemnity is 69,000 Irish pounds, which would equate to about $200,000 per year. If that were to come here, that would significantly adversely affect the provision of medical care. I have already addressed the question that independent midwifery practice cannot get unlimited indemnity, as indeed the medical profession have.

CHAIR—We were given evidence last Friday by Francis Sullivan from the Catholic Health Care Association that, if there were nationally established and clearly agreed best practice guidelines, conforming to those best practice guidelines could be used as a reasonable defence against medical claim.

Prof. Robinson—I keep hoping that, since I spend a significant part of my time writing guidelines for this hospital. Indeed, I strongly commend to you the guidelines on *Care around preterm birth: A guide for parents* that the NHMRC produced. Hilda Bastian chaired the group that wrote this document. It is a very good document because it addresses the levels of evidence, and it addresses what reasonable practice is and what the evidence is for that. I believe that there should be national guidelines prepared for a range of topics around childbirth. These will have to be interpreted locally in relation to practices that exist and what agreements can be reached between staff of all types, but it is likely in time that if there are guidelines these will be used by lawyers, either for offensive or defensive purposes.

CHAIR—We heard yesterday about someone who is really like a health ombudsperson. She is called the Health Commissioner in Victoria. Do we have a comparable arrangement in South Australia?

Prof. Robinson—No, we do not have a health ombudsperson, but there are strong links with the community by various hospitals in South Australia. In New South Wales, there is a patients' complaints unit, which is an alternative way of doing it. Often, people have tried using health advocates within the individual hospitals with mixed success.

CHAIR—The commissioner giving evidence to the committee yesterday suggested that the majority of patients—if we can use that shorthand word—who are complainants—mothers at the time of birth or families—very often do not want to go to court to sue. What they are looking for is some satisfaction in terms of practice that is unfeeling, unkind or even unprofessional. Quite often, the 'sitting down and talking it through' process that the commissioner has and sometimes payment of some kind of compensation have been very satisfactory. It has taken a lot of the pressure off the practitioners, and it has a lot of satisfaction for the families or women involved. Do you have any understanding of this?

Prof. Robinson—Yes, in the sense that I was head of medical service in the Queen Victoria Hospital and, when adverse events occurred, it was one of my tasks to meet with families. It was not a task, because I believed it was very important that it should happen and that the hospital should give people who have felt that things have not gone optimally for them ready access to talk through issues such as that. That continued when we moved over here, although it devolves through our medical chief, Dr Ross Sweet. Dr David Morris certainly undertakes a significant amount of that in helping the families. I am currently seeing one family who had an event that they thought was suboptimal, and I will continue to offer them support as and when it is necessary.

CHAIR—Do you feel that that opportunity for people to talk through their grievances does reduce the rush to sue?

Prof. Robinson—I have no objective evidence that it changes the rate of suits, but I have a view that it certainly should help to resolve problems and keep our professions providing the best care that we can.

CHAIR—Time being what it is, we have to say thank you very much, Professor. It is extremely useful, particularly the references to so much very useful research on which some of the decisions need to be made. We thank you very much for your submission. If things strike us that we would like to contact you about, is that okay?

Prof. Robinson—Yes, of course.

CHAIR—Thank you very much indeed.

[10.35 a.m.]

ABDULLAH, Mrs Ethel Rose, Health Worker, Adelaide Central Community Health Service

ANDERSEN, Ms Lynette, Aboriginal Health Worker, Karpa Ngarattendi, Flinders Medical Centre

BHATNAGAR, Ms Felicity Ann, Community Health Nurse, Adelaide Central Community Health Service

CAMERON, Ms Susan, Team Leader, Nunkuwarrin Yunti of South Australia Inc

MORGAN, Ms Catherine Mae Ann, Manager, Karpa Ngarrattendi Aboriginal Health Unit, Flinders Medical Centre

CHAIR—I welcome representatives from the Nunkuwarrin Yunti. The committee prefers all evidence to be heard in public but, should you 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, No. 77. Is there anything you would like to add or change in that submission?

Ms Cameron—We do not have any additions, but we have a short sentence we would like to give to you, please.

CHAIR—That is fine. If you would now like to make an opening statement and then field some questions. Thank you.

Ms Morgan—Within the Aboriginal culture, antenatal and postnatal care is women's business. Pregnancy is not viewed as an illness but as a normal life stage. We therefore need to take antenatal care and postnatal care out of hospitals and back into the communities. Antenatal and postnatal care needs to be a partnership between senior Aboriginal women, the midwife and female Aboriginal health workers. The program needs to be developed, delivered and owned by the Aboriginal women in the communities.

CHAIR—Your submission and those comments are nicely confounding to some of the other evidence we have had, so we are delighted to have you come along.

Senator GIBBS—You will have to excuse me. I am from Queensland, so I do not know where your health services are. Are they here in Adelaide or elsewhere? They are both here in Adelaide?

Ms Morgan—Yes.

Senator GIBBS—You obviously look after Aboriginal women.

Ms Cameron—Within the Adelaide metropolitan area.

Senator GIBBS—Right.

Ms Bhatnagar—There are two services: Nunkuwarrin Yunti is an Aboriginal health service, and Adelaide Central Community Health Service is a general service. We have an Aboriginal team and we are targeting our services to meet the needs of Aboriginal people as well.

Senator GIBBS—I was basically trying to establish if you have communities like we do in Queensland.

Ms Bhatnagar—We have community health services.

Senator GIBBS—No, I mean Aboriginal communities.

Ms Morgan—Yes, we have the rural communities which also feed into our hospitals and services in Adelaide. We have Port McLeay, which is Raukkin (Ngarrindgeri people) and Point Pearce (Narungga people). Within that, within Adelaide itself, we have Aboriginal communities scattered through the whole urban population.

Senator GIBBS—But you do not look after the women in the communities?

Ms Morgan—No.

Senator GIBBS—You are basically metropolitan?

Mrs Abdullah—Only if they are transferred into Adelaide and then the health workers within the metropolitan organisations give the service to the people.

Senator GIBBS—Do they have a service out in the communities at all?

Mrs Abdullah—In some of the communities they do not, but they do have a service in the larger communities. For example, in Whyalla they have Pika Wiya health service—I mean Port Augusta Pika Wiya Health Service. They have a health service in Whyalla, Port Lincoln, but on some of the reserves they do not have health services, so that is when they are transferred from the communities into the cities.

Senator GIBBS—We have heard in our travels quite a bit about the health care of Aboriginal women. I was quite distressed to hear that in Queensland there was a very high proportion of caesarean section for teenage mothers. Then I was told, 'They are ATSIC figures, so they are probably distorted because it is not a large group percentage wise.' Do you have a lot of teenage mothers here in Adelaide, or South Australia? Is that the norm?

Ms Morgan—Yes, it is. I have not got the statistics here, but for Aboriginal women under 20 years of age there is a very high pregnancy rate, more so than the non-Aboriginal women in that age group.

Senator GIBBS—Do you have any evidence that a lot of those women are having caesarean section?

Ms Morgan—I am not aware of that at all.

Ms Bhatnagar—We have not really got the stats related to age.

Ms Cameron—We could certainly get that for you, though. We do have a lot of statistics and we were not sure which ones you would ask from us. If it is all right with you, we can certainly get back to you with those sorts of figures if you would like them.

Senator GIBBS—Yes, that would be terrific.

CHAIR—Can I just ask what figures you do have. Do you have figures on caesarean rates for Aboriginal people?

Ms Bhatnagar—I will look through them.

Ms Cameron—One of the concerns we have is the attendance at antenatal classes that are based in the hospitals. Our figures show that in fact the young Aboriginal women are very reluctant to attend, and we feel this leads to some of the complications later, during birth and afterwards. Those are issues that we want to look at addressing.

Senator GIBBS—What are the reasons that they are reluctant to attend? Is it because their own people are not there or they cannot take someone?

Ms Cameron—Those are certainly two of them. Cathy, do you want to give some of the other reasons?

Ms Morgan—There are quite a lot of reasons. One is that past history and policies have created a fear of coming into hospitals in the first place. And, as I said, they do not view pregnancy as an illness and they see hospital as a place where you go when you are sick. Transport to the hospitals is difficult. The waiting time in public hospitals for antenatal care is often more than two hours, plus the travelling time to get there. There are all those sorts of things. Feeling isolated, sitting there amongst all these other people that they do not know, creates a sense of shame. If they have got children with them, it is difficult to keep them under control for that amount of time. So there are a lot of social reasons why they don't. Also they get stories from their families, from their mothers and sisters who have had children, and basically come in to confirm their pregnancy, have a scan, and the next time they come in is to have the baby, and anything else between they do not worry about at all. That is where the problems can arise.

Senator GIBBS—When I inquired about the higher rates of caesarean section, I was told poor nutrition, alcoholism—various things that when they actually came to give birth resulted in caesarean section. Have you found poor nutrition to be a factor, that because they do not come back they are not eating properly while they are pregnant?

Ms Morgan—The figures that we have show that poor nutrition is one factor. Gestational diabetes is another. Respiratory illnesses, smoking, drinking—there are quite a lot of risk factors there that contribute to low birth weight children, et cetera.

Senator GIBBS—Yes. That is what the committee has been told. I would imagine, if they kept going to antenatal classes, they would be informed of what they should do—that they must have so many vitamins a day, how they should eat and that they should give up smoking while they are pregnant.

Ms Morgan—It is a lack of correct information going out to them. That is why we are looking at some other way of getting the information out.

Ms Anderson—With young Aboriginal girls, a lot of the experience comes from the older women who have already had children. That influences the younger people as well.

Senator GIBBS—If they have had a bad experience in hospital?

Ms Anderson—Yes. A lot of Aboriginal people do not like the hospital environment or accessing the hospitals and mainstream services.

Senator GIBBS—I do not blame them.

Ms Bhatnagar—The women have commented to me that they are not sick, so they do not need to go. They do not see it as a reason to go, because it is a normal part of life—there is nothing wrong with you. I have some stats here from 1997, if you like. The total number of Aboriginal women who were delivered in South Australia in 1997 was 393. Of those, 107 had caesarean sections, which is a bit over a quarter. Twenty-four were elective and 83 were emergency. I have a list here of the reasons for those emergency caesarean sections, if you like.

Senator GIBBS—Sure.

Ms Bhatnagar—The reasons included: repeat or previous caesarean sections, seven of the women; failure to progress, 30, the biggest number; foetal distress, 28; malpresesentation, 14; hypertension or pre-eclampsia, 11; antipartum haemorrhage, three; multiple pregnancy, one; intra-uterine growth retardation, two; and other reasons not specified, 11.

CHAIR—Can you tell us how many of those were private patients?

Ms Bhatnagar—Not specifically. I can only give you the numbers of how many were delivered in private hospitals overall. Of the 393, 13 were delivered in private hospitals in that year.

Senator GIBBS—That is not a high percentage, is it?

Ms Bhatnagar—No.

CHAIR—Which hospitals were they mainly delivered at?

Ms Bhatnagar—On that list, 108 were delivered at metropolitan teaching hospitals and 200 were delivered at country hospitals.

CHAIR—That is broad. Do you know which country hospitals they would be?

Ms Bhatnagar—I have a list here.

CHAIR—Which is the biggest number?

Ms Bhatnagar—Mount Gambier had only two, Whyalla had 13 and Port Augusta had 92.

CHAIR—You have the figures there. Are we able to have those?

Ms Bhatnagar—We probably need to run it by the Pregnancy Outcome Unit. They supplied us with these figures. I do not think there would be a problem. It is a division of the Health Commission. They furnished us with these stats. I had not told them I was giving them anywhere else, so I will clear that with them. Is that all right?

CHAIR—I think you should feel absolutely comfortable about passing these over so, by all means, check. If they are not comfortable with that, I hope the photocopier works quickly.

Ms Morgan—Can I mention too that the recording of the Aboriginal identity of the patients is not that accurate. These could be underestimated. There would be many more women who have gone through the hospital who have not been identified as being Aboriginal Australians.

CHAIR—Where did you get these figures from?

Ms Bhatnagar—The Pregnancy Outcome Unit. In South Australia, the statistics from every birth—of the delivery and of the infant—are recorded and sent in. These are collated in this unit of the Health Commission.

CHAIR—Can I assure you that you must feel comfortable about whether you pass them on or not, okay? Otherwise, if that is not proper, we will go and get them ourselves. I do not want to embarrass you at all.

Senator GIBBS—In our travels, we have seen birthing centres attached to hospitals. That seems to be a choice that a lot of women are making. More would probably do so if they knew of all the services. With the feeling of the Aboriginal women, if there were birthing centres attached to hospitals which were for Aboriginal women, would they attend and would they then go to the antenatal classes?

Mrs Abdullah—One of the reasons why a lot of Aboriginal women feel very uncomfortable going to antenatal classes or hospitals is the stereotype from the past. We are in the process of educating staff within the hospitals about the value systems of the Aboriginal women as well. We are taking steps to put that in place as an ongoing program so the Aboriginal people will feel more comfortable and the mainstream workers within the hospitals will have a better understanding of how to approach the Aboriginal women.

Senator GIBBS—Yes. Apart from that idea, what is your solution to this? How are we going to educate and get across to Aboriginal women? We all know that pregnancy is not an illness. Women know that, anyway; I do not know about the men. It is not an illness. How are we going to get it across to them that they must go to the antenatal classes and that they must take care of themselves?

Ms Bhatnagar—As we said in the submission—after discussion with Aboriginal women—we need to have culturally appropriate services that are based in the community and that combine not just antenatal services but antenatal and postnatal services where they come in. We need services that are ongoing and where they educate each other. We need services where the elders are involved, where we are informing both our cultures of each other and where the women benefit through that.

Ms Anderson—The Aboriginal people themselves need Aboriginal health workers. They feel more comfortable with their own kind, basically, when it comes to health.

Senator GIBBS—Yes. Do we need to have extra training for Aboriginal people so that they can become doctors, nurses and midwives and work within their communities?

Ms Anderson—The Aboriginal community has to own it, do it, for themselves.

Senator GIBBS—Yes, I understand that.

Ms Morgan—But the other part is that, if we can get these groups happening, we would also have non-Aboriginal people there to provide certain information that the health workers may not have and to follow up immediately on any sorts of complications or concerns that the mother may have at that particular point in time. We are looking at a collaboration between non-Aboriginal and Aboriginal people on this, because we do not have enough out there already. It is going to take some time before we get enough to train to be qualified to go out as midwives, et cetera. They need to work together so that the non-Aboriginal people who are going to be part of the groups out in the community will have an understanding of Aboriginal people and their culture and will be sensitive to the issues that the women will be raising so that we develop this personal interaction. Those people would be the ones they would see in the hospital when it came time for them to be in there.

As you were saying with the birthing units, at Flinders Medical Centre where I am, a lot of the Aboriginal women have wanted to use the birthing unit but, because they have not attended antenatal care, they have not booked to use the room. They thought they could come in and say, ‘I want the birthing unit.’ It does not work like that. So it is a misunderstanding because they missed out on the education that comes with the antenatal side.

Senator GIBBS—Yes. That is interesting.

Ms Cameron—Two Aboriginal courses have been developed and have just started. There is the safe birthing course, which is starting in November. That is a course through Flinders University for Aboriginal health workers to learn practices to work alongside

midwives and GPs, pregnancy risk factors—normal pregnancy emergencies—and that sort of thing.

The second course that has been developed through what used to called family planning is the sexual and reproductive health course. The idea behind both those courses is that we are developing the skills of the Aboriginal health workers to work alongside mainstream workers, particularly the community midwives, so that they can actually go out and deliver appropriate antenatal care to the women so that they can have access to the services that the rest of the community have. By doing that, as you were pointing out before, issues like poor nutrition, addictions, poverty, unemployment can actually be addressed during the antenatal period and they can be put in touch with the mainstream services or whatever is needed so that we can increase birth weights and reduce mortality of infants.

CHAIR—One of the things that we have heard—

Ms Bhatnagar—I was going to add to that. The importance for Aboriginal people, apart from all women, is continuity of carers. It is important that they get to know the same person all the way through. It is really important for Aboriginal people that that person is there to either deliver them or be a support person and to follow them up afterwards.

There is actually a federally funded project running in the community in Adelaide called the Alternative Birthing Services project and those midwives provide that antenatal service and deliver the women at home or in a birth centre or be their support person in a hospital as the women choose and then follow up their care at home. They actually have delivered a couple of Aboriginal women already. Slight inroads have actually been made into providing services.

Senator GIBBS—To my way of thinking, that is important to any mother. Aboriginal and non-Aboriginal women have a lot in common in terms of what they actually want with their birthing process. I am sure the chair wants to ask some questions.

CHAIR—What was wonderful was that you literally took the words off my tongue. I wanted to say that we have had a number of witnesses talk about the importance of continuity of care. Can you tell us about this program? Is it Commonwealth funded?

Ms Bhatnagar—Some of the money is Commonwealth money and it is funded to run for two years. It is called the Alternative Birthing Services project and it is run through the Northern Metropolitan Community Health Service. We get together every couple of months to talk about how we are going to encourage services to meet the needs of Aboriginal women. They partake in those meetings. We faxed them a copy of the submission so they are part of that.

CHAIR—When does the money run out?

Ms Bhatnagar—It is coming up for one year that they have been going.

CHAIR—Is there any sense that it will continue?

Ms Bhatnagar—We are hoping. I do not know. They are getting blocked at the hospitals with getting permission to deliver. There is really only one hospital in South Australia that is encouraging them to deliver at their birthing centre.

CHAIR—Which hospital is that?

Ms Bhatnagar—Queen Elizabeth Hospital—the one they are trying to close down at the present time.

CHAIR—You are actually getting funding to fund Aboriginal midwives—

Ms Bhatnagar—These are non-Aboriginal midwives. I do not know at the present time—

CHAIR—They are midwives?

Ms Bhatnagar—Yes, but they are targeting providing services to Aboriginal women and people from non-English speaking backgrounds and low socioeconomic communities.

CHAIR—So these are women who are actually providing midwife services without having to charge the people attending?

Ms Bhatnagar—Yes, it is a free service.

CHAIR—They are actually on the books at the Northern Metropolitan Community Health Centre, are they?

Ms Bhatnagar—They are employees.

CHAIR—And they can actually do the antenatal care in the women's homes or at the health centre?

Ms Bhatnagar—Yes.

CHAIR—And then deliver them at home or in a hospital?

Ms Bhatnagar—As the woman chooses. If they want to go to a particular hospital all they can do is be their support person because those hospitals have not given them permission to deliver in these hospitals, except for one.

CHAIR—But they can go through the door?

Ms Bhatnagar—Yes.

CHAIR—They can stay with the mother but they cannot actually do any of the midwifery work?

Ms Bhatnagar—That is right.

CHAIR—No hands on work?

Ms Bhatnagar—There is one hospital, the Queen Elizabeth, where they are actually allowed to deliver.

CHAIR—Are you actually prevented from coming into the Women's and Children's Hospital?

Ms Bhatnagar—My understanding is that they have not got permission to deliver there. I think they can be their support person. I am wondering whether I have a copy of their project. Could I also point out the difference between continuity of care and continuity of carer? You might actually have continuity of care by a team—or some hospitals might even say that they provide continuity of care but the patient is not seeing the same person all the way.

CHAIR—That is a very useful point, and I think the committee is assisted by being reminded of that—thank you. When will an evaluation of this program happen?

Ms Bhatnagar—I am not quite sure. I could certainly approach them about information about that and send it to you.

CHAIR—If there is anything that you might provide to the committee, that would be very interesting. It certainly seems like it is filling a number of the gaps in the current state of play. Can I just ask you about this curious question of women's business? Does that mean Aboriginal men are not encouraged to be present at the birth of their children?

Ms Morgan—No, Aboriginal men can be present, can't they? In the treatment of any interventions in the antenatal stages, women are preferred—particularly over male health workers or doctors or gynies or whatever.

CHAIR—So they prefer midwives, nurses, attendants and obstetricians all to be women, if possible.

Ms Morgan—Yes.

CHAIR—This presence of fathers at the birth of Aboriginal babies: is that a cultural change? Has women's business in the past meant no men present at birth?

Ms Morgan—In the past, so that is a cultural change.

CHAIR—As Senator Gibbs said, a lot of what is changing for Aboriginal people is no different from the changes that are happening for non-Aboriginal communities, I suppose. Do you know anything and can you tell us anything about the Alukyra Centre for Pitjantjatjara people?

Ms Cameron—The one in Alice Springs?

CHAIR—Yes.

Ms Cameron—I know that it is an Aboriginal birthing centre that is run by Aboriginal workers and that they work very closely with the Alice Springs hospital. That is about all I know. I know that the Aboriginal women choose—

CHAIR—That is all right. I just wondered, because so many of the people are South Australian Pitjantjatjara people.

Ms Cameron—I think it supports the women to actually choose to birth at Alukyra or still have their bush births, if they so choose. The staff will actually go out and support them in the birth of their choice.

CHAIR—Do you know if there is already a difference from your programs, further to Senator Gibbs's questions, regarding the importance of antenatal care for Aboriginal women, particularly the younger mums? Do you see that already it is making a difference, or is it too early?

Ms Cameron—I think it is still very early stages. My feeling is that we do not have the staff to support the Aboriginal women with their antenatal care. We do not have Aboriginal health workers and community midwives who can actually go out into the women's homes. We do not have enough of them.

CHAIR—We are told in broad that the infant mortality and maternal mortality figures for Australia are extremely low but they are much higher for Aboriginal women and children. When a study was done in about 1984, I think the infant mortality was said to be about five times greater for Aboriginal people compared to non-Aboriginal people. That figure is now down to three times or high 2s. So there is certainly an improvement happening. Can you tell us about the figures for metropolitan Aboriginal women? Is there such a difference as I have just described or is the difference between Aboriginal and non-Aboriginal more confined to rural and remote Aboriginal people?

Ms Morgan—I think those figures were for all of South Australia. I think they were lumped in together for that two to three times higher likelihood of infant mortality. I think the majority of women are living in the urban areas anyway.

CHAIR—So that higher figure for Aboriginal women does refer to Aboriginal women in metropolitan Adelaide?

Ms Morgan—Yes.

Mrs Abdullah—A lot of the country women, the young women, have to move to Adelaide to be close to the professional doctors and midwives—especially if they are experiencing really bad pregnancies—to work in with the health workers and the doctors and keep their appointments up. They have to leave the country environment where they have lived all their lives and come into the city.

Ms Bhatnagar—On your last page of those statistics it gives figures for 1997 baby outcomes and the number of foetal deaths.

CHAIR—Which is it?

Ms Bhatnagar—It is the last one, referring to birth by outcome and race. There were nine Aboriginal foetal deaths and four neonatal deaths, which is 2.3 per cent foetal deaths and one per cent neonatal deaths.

Ms Cameron—Our feeling again is that if we can have better antenatal care delivered by community midwives and Aboriginal health workers we can actually address lots of these issues. We can get on to it faster.

Senator GIBBS—Yes, that seems to be one of the main solutions. I was a bit disturbed before when you were saying that you basically represented women in the metropolitan area, but you still have incidents of poor nutrition, smoking, drinking and you also said that they were influenced by their mothers or aunties or grandmas who had had bad experiences. Can you explain this to me just so that I can more fully understand it? I know that in Queensland the Aboriginal people who live on the communities—because of the system, which is pretty disgusting, and because the churches moved in—were all in dorms; they were taken away from being families. Most of them were taken away from their parents. They have had to reunite with their parents in later life, if they have found them. And because of that, they just do not know how to be parents, because they did not have the opportunity of being with their mothers and fathers and learning such things. So they have actually lost not only their culture but their family history—the whole thing. Is this a situation which applies in South Australia?

Mrs Abdullah—I think this is where the alcohol and mental health problems come into it and not being able to find their identity—where they belong, how they feel. We come across young mothers like that all the time. It is a struggle sometimes as to whether they are half traditional or half urban, half white and half black, and just finding out where they are. So we have to go through that process of supporting, encouraging and guiding them and referring them on to our link-up workers to actually find where they do belong and where the people come from, still supporting and encouraging all the time. I think that is one of the biggest issues; it is why a lot of our young women find it very uncomfortable, because they are really unstable themselves.

Senator GIBBS—In your metropolitan areas, is the Aboriginal community dispersed or do they live in certain areas? I live in Ipswich, where we have always had a high proportion of Aboriginal people. The Purga mission was close by—

Mrs Abdullah—There are different clan groups within the metropolitan area as well but, now that we are working in partnership and supporting and helping each other with all the health organisations and health workers, we have actually got different health workers from different backgrounds. A young woman from the Ngarrindjeri tribe feels uncomfortable without a health worker from that tribe to actually go and sit down with her.

Ms Morgan—Within the metropolitan region we have got three major areas where Aboriginal people are locating. There are about 2,000 in each population. One is in the Elizabeth-Salisbury area in the northern suburbs. Most of those are the elders. In the Parkes-Port Adelaide region we have got another large population. They are of the middle age

group, those that have had their children et cetera. In the southern region around the Noarlunga-Wilunga area we have our third Aboriginal population, and the majority of those are in the younger population. One thousand of those people are in the 0-19 age group. That area has cheaper housing. It is the southern region that is spreading out, so they are virtually living on the fringes where it is cheaper housing, but along with cheaper housing go less resources like transport, buses et cetera to get them in. Then you have got others who are just spread out around from there.

CHAIR—We have time for a last comment.

Ms Bhatnagar—Because of the lack of doctors with skills in the country, a lot of women are transferred down now. At Ceduna they do not do any first deliveries now or deliveries if there is any complication. Networking needs to be improved for Aboriginal women so that they are not isolated when they come down. There was a lady who came down. I provide a lot of support and was there for her delivery. She still keeps in contact with me although she is from outside Ceduna. We just need to be aware of those changes in birthing practices and that there are a lot of women transferred down to the city these days.

CHAIR—Thank you very much for your evidence today. I am particularly interested in your comment that the payment of senior women would recognise and acknowledge their skills, and also your earlier comment about some of the older women who are part of the traditional practice who sometimes may not have the knowledge or skills and there can be a two-way learning process here, but drawing on the older women network. It is really very helpful for us. I think you said you would look to see whether you had anything about the alternative birthing program. If you have got anything to offer us, we would be very pleased to get it.

Ms Bhatnagar—We have not got anything here now.

CHAIR—No, send it to the committee at your leisure. Do you want these figures back or can we keep them?

Ms Bhatnagar—I will make a phone call now.

CHAIR—Thank you very much.

[11.12 a.m.]

RESCH, Mrs Megan Lee, Member, Birth Matters

SHRIBMAN, Ms Vanessa, Joint Coordinator, Birth Matters

WATKINS, Ms Jennifer Anne, Coordinator, Birth Matters

CHAIR—Welcome. The committee prefers all evidence to be heard 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. 84. If you do not wish to make any alterations or additions to that, we might ask you to make a brief opening statement and then field questions.

Ms Watkins—I guess you understand what Birth Matters is. We are a group of consumers who have all either experienced birth as a wonderful life moment or are women or men who have not experienced that but feel that it could be. So we are a referral group primarily. We also follow up complaints. Our concern is that birth should be a normal process, a healthy process, and that the focus should not be on intervention. We see this as coming about in four ways. Firstly, we think that the whole culture around birthing needs to change away from this focus on the fact that it is fearful, it is terrifying. Every time you turn on the television there is a woman being rushed to have a caesarean but you never see a normal birth on television or read about it in the paper. So that needs to be a culture in the whole community that birth is normal.

Secondly, as the last groups have said, continuity of carer is really important. Studies show that women are more likely to achieve a normal birth with appropriate care from someone they know who knows them and knows their family. Thirdly, we think that the training of midwives and obstetricians and all health care practitioners who are involved in birthing needs to change to reflect the fact that it is a normal process. Finally, as other people have said also, there need to be some sorts of standards for best practice monitoring. We think this is a way of achieving normal birth.

CHAIR—This is a really useful submission. I thank you very much for it; it covers a lot of ground. When were you formed?

Ms Shribman—About six months ago. I would like to give you a little background and that might give you a bit more insight as to where we are at. All of the women from Birth Matters have attended prenatal and postnatal classes that empower them. They are classes that teach them how to use their own resources for normal birthing. They are classes that talk about birth as a normal experience and that empower them with information; there is a library. So the women that go through these classes are very informed.

CHAIR—Where is the library?

Ms Shribman—Within these classes. There is everything a woman could want to find out about what the current best practice is, what the current research is and also the best

possible ways in which they can have a normal birth. In the classes the women also share a lot of information about good practitioners and good places to birth, because of course the health practitioner you choose makes a huge difference.

The group grew out of a very large group of women who decided that the profile of birth and the fear around birth and the sorts of things that were happening in South Australia were just intolerable. It all happened quite spontaneously one morning after a woman had seen a program on television where a doctor espoused that an epidural was safe and wonderful and that a woman could not possibly manage without one. That morning we formed the group. We decided it was ridiculous that there was not one group in South Australia that was saying this information was not okay.

The other real concern we had is that women had no place to go to get good information. It is a struggle for women, even if they want to be informed, to be informed in South Australia and, I think, in Australia in general. There is no central childbirth education network or a setup so that women can go to a place and ask, 'Where can I go to get this kind of birth?' When they are recommended to an obstetrician, they have no idea of the practices of that obstetrician. They get recommended by their GPs and they say in the classes, 'But how do I know what to look for? How do I know what this person is going to offer me?'

We mostly found in these classes that women were not informed and that, even if they wanted to be informed, they literally had nowhere to go to be informed. We found through the classes that when women are informed they make great decisions. They are very clear about what they want. They are very clear about wanting the best for themselves and their babies. They feel confident and they feel strong in going through a process of normal birthing.

CHAIR—Do the other representatives wish to add some comments?

Mrs Resch—I joined this group through attending the classes. Without the knowledge that I had learnt, which was provided by those classes—and even though I had attended hospital antenatal classes—I would not have got through my first birth in the way that I did. The education provided by the hospital was completely inadequate as to what was the process of the birth.

Ms Watkins—I will add something about how I joined. In Canada I had been to a really beautiful birth with an independent midwife. My closest friend had her baby with her own midwife and when I fell pregnant I knew that was what I wanted. I wanted the same midwife all the way through, as everyone has spoken about, but I could not find an independent midwife in South Australia. I called all of the switchboards and all of the hospitals and ended up stopping someone in a health food store who had little kids to ask her. I found a midwife that way. So, even when you know about the care, it is still really difficult to find it. It is not promoted, and so that is very difficult.

Ms Shribman—The other thing that is really interesting is that many women think that they are going to get the best care in a private hospital—they have always had private health insurance so that they can birth there—but they have no idea that they are 50 per cent more

likely to end up with a caesarean section. I think they would be about 70 per cent more likely to end up with some kind of intervention than they would be in a public hospital. They go into this stuff very blinded.

Sometimes I hear from more informed women, 'Well, it serves them right if they chose that,' but the thing is that they are choosing without information. They erroneously think they are going to get great care and so, when they go in and have all these interventions, many women come out really rather traumatised by what they were put through and by feeling disempowered. They had felt very capable of having a normal birth but they had been hurried along. The policy of the particular obstetrician was to have them lying on their backs having episiotomies and so on without their consent, without asking them if that is what they wanted. Women carry those sorts of birth experiences and traumas with them for years and years afterwards.

We also run active birth workshops to which women come with their partners. They often bring their mothers to them and their mothers will take up a lot of time relating how traumatic their birth experience was, which is totally inappropriate but it is obvious so much of that is still there with them and that so much stays with them. So I think it is really important that we look at how deeply birth affects women. Yes, we are looking at safety here. All the research shows us that safe birth is normal. But we are also looking at being well cared for, being given compassion and care in the birth room—and there is not an awful lot of that at the moment. There is not an awful lot of compassion and there is not an awful lot of caring.

CHAIR—How would somebody find you?

Ms Shribman—Luckily, Adelaide is quite small, so through word of mouth.

CHAIR—So I do not have to line up in a health food shop to find out about you?

Ms Shribman—No. In fact these days all of the birthing centres recommend these classes to women. Interestingly enough, some of the very high-tech private hospitals recommend them although I do not know why.

The birthing centre midwives have said that women deal much better with birth and are much more self-contained when they have been through classes where they have been taught to breathe and feel focused and in control and where they believe that they can do it. That is why those midwives send them along.

CHAIR—Is the Child and Adolescent Family Health Service—the old 'Mothers and Babies'—not providing childbirth education anymore?

Ms Shribman—Nothing like that. The women go to the classes in hospital and the classes are focused on intervention. The classes are non interactive, you sit in a little audience, there are a lot of couples—probably about 40, I have heard—and some people talk at you from the front. All they talk about are the types of risks, the types of things that might go wrong and the types of interventions that are offered. Many women are actually

discouraged from trying to have a normal birth. They are told that it is just too difficult, too painful and that an epidural is the way to go, so many women feel very disappointed.

On one level, we are really wanting to change the culture but then we must change the education. For me, certainly education is the absolute basis that we need to look at changing.

CHAIR—Are you saying these antenatal classes happen in our large public hospitals and in our smaller private hospitals?

Ms Shribman—Absolutely. I have heard from women that in smaller private hospitals all they talk about are caesareans, epidurals and the kinds of drugs you can have. Women have told me they have become very upset at those classes and have said that they want to have a normal birth. The rest of the women there have said, 'How ridiculous! Why would you put yourself through that much pain? You must be absolutely masochistic.' So they get no support whatsoever in wanting to have a normal birth.

CHAIR—Do you have a sense of the history of the culture of childbirth? Maybe 20 to 25 years ago there were a number of fashions that were promoting natural childbirth. We had the Leboyer methods and a number of others. These seem to have gone off the screen again.

Ms Watkins—I do not think so. They are still around. Certainly people still talk about Leboyer's book in terms of gentle arrivals into the world, and I think that it is all coming back to it now; a lot of people are asking for this now. The birthing centres are overfull in Adelaide and cannot provide enough places for the women who want them. That is certainly what we have heard. We know of people getting turned away from the women's and children's birthing centre because it is too full. We know there are extreme problems with Flinders because we get complaints about the birthing centre there.

CHAIR—They cannot get into it?

Ms Watkins—It has not got adequate staffing and so, if they go into labour at night, they will be turned away because one room is already full. There are two rooms there but only one is working.

CHAIR—Is that all?

Ms Shribman—There is only one staff member on at Flinders at night at the moment.

Ms Watkins—And the ward next door has just been closed. These are the things we hear from consumers. I can hear things behind me which suggest that perhaps practitioners have different views, but this is what we hear from women about their births. I think the focus needs to be not only on morbidity and mortality but also on emotional outcomes of births. A lot of studies show that. I have a study here indicating that women can reiterate their birth experience, moment by moment, 20 years after the event. They do not forget it.

CHAIR—We started our questioning of you as witnesses a bit late. I am going to try to run a little bit into the next time, but I wonder if you could now try to keep your answers briefer and we will keep our questions shorter. Sorry. We will try to do it in three questions.

Senator GIBBS—From what we have seen of the birthing centres, to me they look very small. In your opinion, should they be larger? Should hospitals be making far more space and more staff available to these places? Is this the answer?

Ms Shribman—That is quite a complicated question on some levels. The Women's and Children's Hospital birthing centre is very full. It is very hard to get in. The program at the QEH, where a woman has the same midwife all the way through, is also very full and, again, it is very hard to get in. I think, if women had more education and less fear about birthing, more and more women would be demanding that type of service. We need to move towards that. Certainly, there definitely need to be more staff and more birthing centres at the Women's and Children's Hospital. I think there also need to be more programs of continuity of care. Then these programs would be bursting because that is what women want. They want to know their midwife.

Ms Watkins—And this should not apply just to low risk women. I think that is one of the focuses of this continuity of care. Only a small number of women who are low risk can get that type of care. If it was available to women of all risks, then the outcomes would be quite different.

Ms Shribman—I would add that there is—as you are probably aware—a very large percentage of transfer rate from the birthing centres. I think if midwives—and I have talked to midwives about this who work in the birthing centres—had more autonomy so that they were respected as an autonomous profession and did not always have to bow to obstetricians, there would be less transfer rate. Women are referred to these classes because they want to manage without drugs. They do not have to be transferred out for epidurals and so on. Again, we are looking at education for woman; we are looking at giving them good resources to cope with normal birth; and we are looking at midwifery as an autonomous profession. Then, I think, the birthing centres would be doing much better than they are.

Senator GIBBS—You obviously have a fair bit to do with midwives. One of our previous witnesses, when I asked him if there should be a Medicare rebate for private midwives so that more women could access them, answered yes. But his response was guarded with a comment that the midwives actually need far more training. In Australia, nurses do one year of training, but in the Netherlands and probably other places in Europe, they do four years of training. How do you relate to that?

Ms Watkins—Birth Matters is involved in helping to design a three-year bachelor course that is going to start in Adelaide. We have been asked what kind of midwife the consumer would want. It is going to be a three-year course and it does not require people to have gained nursing qualifications first, although nurses can certainly enter at higher levels through the course—there will be several points of entry. I think training is absolutely essential—that is, a different kind of training that is community-based and where there is more continuity of carer.

CHAIR—'A course starting in Adelaide' means what?

Ms Watkins—That they are talking about a university course that will start at Flinders University.

CHAIR—To train midwives who are not nurses?

Ms Watkins—It is called a direct entry course, but that is not exactly correct. It means that women can enter straight from school or other parts of life—they do not have to have done nursing first—but nurses can certainly enter at other points which will take their training into account.

CHAIR—I am still in the health food shop: where can I—or Mrs Average—find you? I do not know anybody in Adelaide. I do not have a network. How can I find you?

Ms Watkins—We are about to do a huge run of flyers which we are going to place in GP offices and everywhere we can think of—anywhere where we might come into contact with women who are pregnant.

CHAIR—If I went Flinders Medical Centre and said, 'I think I am pregnant; I am going to have a baby in about 10 months time'—or is it eight months time—would they give me your information?

Ms Watkins—If you went to the birthing centre, they would.

CHAIR—I didn't. I saw the doctor.

Ms Watkins—Normally, they would not. And they would still be telling you that you would probably need an epidural.

CHAIR—You speak on behalf of all doctors at Flinders Medical Centre! We heard from Flinders Medical Centre this morning that they offer a whole variety of options—probably more variety of options for antenatal, birthing and postnatal care than anywhere else. They were not actually wanting to say that they were the biggest and the best, but they did say that when you went Flinders you were provided with a number of options. You could decide to have an alternative birthing and meet the midwives and work with that group or you could decide to go through the outpatients and see a range of doctors—you could do a whole lot of things. Are you saying, 'Well, that might be the case, but they would not tell you about us,' except in the birthing centre?

Ms Shribman—There are a number of issues with Flinders. The birthing centre is run by a midwife called Julie Pratt, who was the main independent home-birthing midwife in South Australia. She is a very committed and very skilful woman. She took on that role so that she could access more women. Her philosophy is very different from the labour ward and from the ways that women birth there. The birthing centre is very different. She has been trying very hard to get in continuity of care, which is very much opposed at the moment at Flinders.

CHAIR—Who is the enemy? The state health department or the obstetricians?

Ms Watkins—I think it is the lack of information. I am on several government committees at the moment, as a consumer, that are looking at birthing services in the state. I

think that no-one is the enemy. The enemy is a lack of education and training and a lack of the culture of birthing.

CHAIR—A lack of education and training of whom?

Ms Watkins—Of everybody who is involved: of women, for starters, who have never heard a birth story that did not end in a caesarean section or an epidural. Very few women hear normal birth stories. There are midwives who are still intervention based and obstetricians who have not seen normal births either.

CHAIR—Is their contribution to undergraduate medical teaching? But they do not do undergraduate teaching at Flinders anymore, do they? Do people like you get to contribute to medical education?

Ms Watkins—We are speaking to the midwives tomorrow at Flinders.

CHAIR—We were told before that one of the best ways in which you can change a culture, or one of the very big influences on it, is financing—the way government funding might happen. You certainly seemed to suggest that you have been across just about every part of these issues. Would you care to comment on whether, if childbirth was funded as a package or in a different sort of way, it might assist this cultural change?

Ms Shribman—Definitely; by people going into schools to talk about women telling really good birth stories and about how wonderful birth can be. That is what we fail to mention: birth, for many of us, is the most amazing moment of our lives. It is wonderful and we forget to talk about that. As part of our group, we have talked about possibly going into schools, but I think it should be a government initiative providing really good antenatal education—and by 'really good' I mean that birth is a normal event and so on—talking about best practice and offering really good antenatal classes.

CHAIR—If I find out about you or other good antenatal classes, do I have to pay?

Ms Shribman—You do have to pay for these classes.

CHAIR—How much?

Ms Shribman—That is a bit confronting. It is $10 per class.

CHAIR—It is a real world, this.

Ms Shribman—And it is $8 concession. So, yes, there is a concessional price and, if women have a really hard time paying, I have been known to waive that. Usually women can afford it, but it should be government funded. Women should not need to come to a yoga class to find out about best practice. It is absolutely ridiculous.

CHAIR—If I went to an antenatal class in a public hospital, would I have to pay?

Ms Shribman—No.

CHAIR—Private hospitals?

Ms Shribman—You pay a lot to be there so, indirectly, yes, you do pay for your classes.

CHAIR—It is part of the package, so the whole cost for having a birth in a private hospital covers the cost of the antenatal care.

Mrs Resch—In some cases, they go to the point of almost telling you you cannot birth there unless you have done their classes. A friend is experiencing that at the moment.

CHAIR—Yes, we have been told that people have to pay, so your evidence is another variation on a theme.

Senator TCHEN—As a group, all the members of Birth Matters are mothers?

Ms Watkins—No.

Ms Shribman—And fathers.

Senator TCHEN—And do all the mothers have experience in natural birth?

Ms Watkins—No, we have had vaginal births after caesareans, we have had caesarean sections at all of the different hospitals, at home births, at private. That is the thing about our group that differs from other things: firstly, we are only consumers, so we have no other agendas; and it is a wide range of men and women who have experienced birth in many different forms.

Senator TCHEN—Men as well?

Ms Watkins—Well, they experience birth to some extent as well, they really do. They are a big part of it.

Ms Shribman—We really promote men being part of their partner's support. That is very important for us.

Ms Watkins—I hope someone has brought out the fact that there is not enough support for fathers. That is another one of our issues—that a birth is important for fathers too. And suddenly becoming a dad is—

Mrs Resch—I am aware that currently Flinders hospital are doing a study—I think it is a research project—where they are asking fathers-to-be to fill in a research document to see how they deal with birth as the father. That is set up by students, I would think.

Ms Watkins—We have sole parents too—there are different variations on a theme.

Senator TCHEN—You said hospitals' antenatal classes focus on interventions: is that all hospitals?

Ms Shribman—All of them.

Senator TCHEN—Is that all they tell you?

Ms Shribman—At the Women's and Children's birthing centre and at birthing centres generally they focus on birth as a normal experience but, again, the feedback is that there are too many people in the classes and they are non-interactive, and there are not enough classes to really make a difference. But the normal labour ward classes focus on birth as a high risk procedure. They talk about all the risks and they talk about the interventions you might have. The comments I have heard from women are that they are told that they will not be able to cope without drugs. So it gives them very little confidence to even try.

Senator TCHEN—Yesterday I heard that 60 per cent of births are totally normal. I was surprised; I thought the rate would be higher than that.

Ms Shribman—According to statistics by the South Australian Perinatal Outcomes Unit, 70 per cent of all women in South Australia have some kind of intervention. So that is not what I would consider normal.

Senator TCHEN—Without intervention, at least 60 per cent do not need intervention, right? I was a bit surprised. I thought it would be higher than that.

CHAIR—The evidence is that 60 per cent of deliveries are vaginal.

Ms Shribman—The World Health Organisation puts it at 85 to 90 per cent of all women being able to have normal births.

Ms Watkins—And vaginal births can also include forceps delivery, Ventouse delivery and things that we would consider to be surgical birth. They may be vaginal but they may still involve intervention.

CHAIR—I think Senator Tchen said it is the data we have been given.

Senator TCHEN—I want to get this point clear. So when a couple go into an antenatal class in a public hospital the first thing they are told is that it is going to be difficult?

Ms Shribman—Yes, that it is a risky affair.

Senator TCHEN—Not that 60 per cent of you will have no problem?

Ms Shribman—Or 85 or 90 per cent, depending on which statistics you look at. No, they are not told that birth is a normal event. And I would like to say this very clearly. Women are given a very hard time if they want to have a normal birth. They are called heroic if they want to have a normal birth. So it is actually very difficult for a woman to go out there, want to have a normal birth and achieve it. She has a huge number of odds against her—not only from her family, not only from her peers but also from the medical people that surround her, and the media. As Jenny said, we never get positive stories in the media; we just hear about how great caesarean sections are.

Senator TCHEN—They obviously pay a lot.

Ms Shribman—Exactly.

Senator TCHEN—This same thing happens even in a leading hospital like Flinders Medical Centre?

Ms Watkins—I think it is just the focus of it. It is certainly not their opening sentence that this is going to be the most painful thing you have ever experienced in your life. There is just not enough focus on the emotional outcomes of birth and on the natural things that you can do to help yourself. You are certainly not told about the long-term effects of things like caesareans. You might be told that there might be higher rates or morbidity, and mortality possibly, but you are not told that you may be less likely to breastfeed your baby, you may be more likely to have post-natal depression or you may not want to tell anybody about your birth experience.

Senator TCHEN—Just a final quick question: are midwives advertised in the *Yellow Pages*?

Ms Watkins—No. You cannot find them.

Ms Shribman—Recently a woman came to us and said that she went to her GP and was sent to an obstetrician who told her there was no such thing as an independent midwife in South Australia, because she had said that she wanted to have a home birth and an independent midwife. So, no, they are very difficult to find if you do not know where to go to look for them.

Ms Watkins—And you are told that you cannot have one for your first baby. That is a very common thing to be told.

Mrs Resch—When women are first pregnant they go to their GP—again, whether they have private health cover or public health cover. I spoke to a GP about a home birth—this was my experience and the experience of others I have spoken to—and was told, 'You do not have a home birth with the first baby. It is not safe. Find yourself a good obstetrician.' It is certainly encouraged that you avoid—

CHAIR—I think you are telling us that there are some extremely mixed messages out there. Possibly, what we also need to do is look not only at the continuity of carer but also at the comprehensiveness of the education and at what is being told. It is interesting too that sometimes what sticks in a person's mind is the one line that touched chords in them. I am not at all suggesting that the people who turn up to your group are telling lies about the impressions or the stories that were told to them, but I think it is important that we actually do research. We had some evidence yesterday that it would be very good to do some research not only with mothers but also with practitioners in terms of how they give the information and the advice, about what exactly is 'comprehensive information', and so on.

The line I think I like most in your submission is the one that suggests that some members of the Senate committee may also like to travel to the UK and Holland to see the

best maternity statistics in the world. I am not at all sure we can persuade the committee to fund this travel; I can assure you we cannot. But it certainly is terribly interesting. We have already availed ourselves of some of that information.

I thank you very much for forming and for putting in a submission and coming along. If there is anything further you think we should hear, please feel free to tell us. Or, if we want to ask you anything, we will get in touch. Maybe today's hearing will make more people in South Australia aware of your organisation. Thank you.

[11.44 a.m.]

BUTTERY, Mrs Lisa, Committee Member, Keep the Queen Elizabeth Hospital Delivering Community Action Group

HANNA, Mrs Carol Margaret, Committee Member, Keep the Queen Elizabeth Hospital Delivering Community Action Group

MOORE, Mrs Michele Carmel, Committee Member, Keep the Queen Elizabeth Hospital Delivering Community Action Group

NGUYEN, Mrs Lan Mong, Community Member Representing NESB Communities, Keep the Queen Elizabeth Hospital Delivering Community Action Group

WHITE, Mr Trevor John, Community Volunteer, Keep the Queen Elizabeth Hospital Delivering Community Action Group

CHAIR—I welcome representatives from the Keep the Queen Elizabeth Hospital Delivering Community Action Group. Do you have any comments to make on the capacity in which you appear?

Mrs Hanna—I am a committee member, consumer and midwife.

Mrs Moore—I am a consumer and a committee member.

Mrs Buttery—I am a committee member and a midwife at the Queen Liz.

Mrs Nguyen—I work for the Vietnamese community. I am here as a community member, representing non-English speaking background communities.

CHAIR—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 can ask to do so and the committee will give consideration to your request. We have before us your submission which is No. 103. Do you wish to make any alterations to that submission? No. I invite you to make an opening statement and then field questions. I notice some of you were nodding your heads about earlier evidence, so feel free to add a line or two.

Mr White—On behalf of our community group, I would like to thank senators for the opportunity of appearing today. The preamble to our written submission outlined how our action group arose in response to the announced intention to close the maternity section of the QEH. We clearly understand that it would not be appropriate for this inquiry to be involved in the issues of our campaign. However, there is by coincidence features of the present QEH maternity service highly valued by the women of the north-west Adelaide region that are the focus of this inquiry. We felt compelled to respond to your terms of reference (b), (e), (g) and (i).

CHAIR—I see that we have a camera crew from *A Current Affair*. We have received information about that, but we usually have to seek permission from the committee for you to film and/or record. There being no objection, it is so ordered.

Mr White—The Queen Elizabeth Hospital was the second teaching hospital to be built in the Adelaide metropolitan area. The service commenced with the opening of the maternity service in September 1954. So this department has provided 45 years of service to the women and families of the north-west Adelaide region. The QEH was built as a large teaching hospital, so over this period of time it has combined two interrelated functions—that of a university and of a hospital—that have been mutually beneficial in shaping and providing the community health care to our community, the form of which has changed over time with advances in medical technology and the needs of our community. From its outset, the character of the QEH has been described as 'heavily weighted to the care of people'. It has been said that, throughout its history, the Queen Elizabeth Hospital has attempted to avoid bureaucratic institutionalisation. They are important factors.

CHAIR—Does anybody wish to make a comment at the outset?

Mrs Buttery—No, I think we will just go with the questions.

Senator GIBBS—I notice that you say that QEH has one of the lowest caesarean section rates in Australia, 16.6 per cent, and we have heard from previous witnesses that South Australia has the highest caesarean section rates of all the Australian states. What do you put this down to? Why is this particular hospital lower?

Mrs Hanna—I started asking the doctors and midwives. What we have come up with is that there is a different philosophy—when you come into hospital you are not treated as if you are going to be a potential problem, you are treated as if you are going to be a birthing unit client. That is on the labour ward and in the birthing unit until things are shown to be otherwise.

Senator GIBBS—It was quite disturbing to hear from the last witnesses that the antenatal classes now do not teach how to breathe, how to do exercises, and do not gear you for a natural child birth rather than intervention. How are your antenatal classes conducted?

Mrs Moore—I will answer that, as a consumer I went through all the antenatal classes. The QEH antenatal class actually starts from the premise that you will deliver your baby naturally without drugs.

Senator GIBBS—I am pleased to hear that.

Mrs Moore—That is how it starts. In the course of the antenatal class, which runs over six weeks, you also have a whole section of the class which is devoted to relaxation. It is taken by a physiotherapist. It is a designed course where you go into one of the physiotherapy theatres. You use large inflated balls, you look at different positions that you can use and you practise positions with your birthing partner. From day one it is based on the premise that you are going to have a healthy pregnancy and you are also going to deliver your baby naturally.

They talked about intervention in the class, but intervention and epidurals were discussed on a level of that is what happens, this is how the procedure takes place and, if you have an induction, these are the outcomes of the induction most of the time. So you actually have a feeling that you know what the consequences of a particular action will be. We discussed how an epidural was performed and the risks involved in epidurals. I think a lot of times women are not told the risk of epidurals until they are actually in the most traumatic stage of their labour. You need that information beforehand so that you can make an informed decision on whether you are going to proceed through your birth with or without an epidural. The antenatal classes at the QEH are designed for women to have as natural a birth as possible.

Senator GIBBS—Thank you. Obviously you have a birthing centre there. I see here you have that one study quoted in a report found 35 to 40 per cent rate of transfer out of the birthing centre, 30 per cent occurring during pregnancy. Is this rather large because other hospitals that we have visited say that they have about 20 per cent rate of transfer because of complications and it is not a low risk birth. Is this because your centre is larger than other hospitals? Is this why the percentage is higher?

Mrs Buttery—I do not think that study was actually referring to Queen Elizabeth's figures, it was dealing with the children's.

Senator GIBBS—Sorry, I think that was the Women's and Children's.

Mrs Buttery—And it was outlined in the Barclay report.

Senator GIBBS—Right.

Mrs Buttery—Have you been able to get your hands on that?

Senator GIBBS—I am not sure.

CHAIR—Have we been provided with a copy of the Barclay report dated 28 June 1999? We must certainly see if we can get a copy, thank you.

Mrs Buttery—From the health commission or Department of Human Services.

Senator GIBBS—How does the hospital feel been independent midwives?

Mrs Hanna—We do have independent midwives delivering at the Queen Elizabeth Hospital. At present we are the only hospital that has given accreditation to the midwives from the Northern Community Midwifery Group to come and deliver and care for their patients.

Mrs Buttery—Not just be support people.

Senator GIBBS—Do you have a large percentage of mothers who have their independent midwife?

Mrs Buttery—I am not sure of the statistics of independent midwives coming in. Certainly it happens, but whether they are accredited to formally be the midwife responsible for that woman's care, I am not sure of. I need to find that out. But I do know we are the only hospital in Adelaide to have accredited the midwives in the northern community project.

CHAIR—Can you just give us a breakdown on your figures? Do you have any private patients delivered at Queen Elizabeth?

Mrs Buttery—Yes.

CHAIR—Do you have those public and private figures?

Mrs Hanna—I think it is somewhere around 20 per cent private. Dr Pridmore who is coming up later will be able to give you those figures.

Mrs Buttery—I actually have the figures—you might be interested—for caesarean section rate this year up to 31 August. I was able to get my hands on that.

Senator GIBBS—I was going to come to that.

Mrs Buttery—It is currently at 14.6 per cent of a total of 911 deliveries. We have done 133 sections. I do not have the breakdown of emergency and elective. But that is another reason which is a bit more measurable as to why our caesarean section rate is lower. And Dr Pridmore will also speak to this. We have a lower elected caesarean section rate than the national average. We are about five per cent elective, and the state average is about 10 per cent. But, again, if you ask the question: why is that elective rate lower? That is not so measurable. I think it is like Carol said, it is to do the culture and the ethos of the place. It is to do the team of midwives and doctors trusting each other and respecting each other in their slightly different roles. Doctors are prepared to trust the midwives that they will notify the doctors if there is a problem, and it works the other way as well in that the midwives can work with the doctors. They are all aiming for that ultimate goal of a normal vaginal delivery.

Senator GIBBS—This is very interesting, because we have previously heard that there has been a lot of tension between obstetricians and midwives and a lot of professional jealousy and 'you should not be here' attitude. Your culture is trying to change that.

Mrs Hanna—We have been very fortunate at Queen Elizabeth Hospital not just with the medical staff but also with our assistant directors of nursing. We have been encouraged to develop and respond to community needs and we have worked well together. It has taken a lot of years—it was not always the case—but I think it is something that is very precious that has been encouraged to develop.

Senator GIBBS—That is really encouraging. We have also heard that women these days simply demand to have a caesarean. They make up their mind that this is the way to go and they demand it, so of course the obstetrician just says, 'Yes, sure, not a problem.' Obviously this is not happening in your hospital?

Mrs Hanna—Every hospital gets women who demand to have a caesarean section, but whether they get it or not is another thing. But as Birth Matters pointed out, the type of education and the books that you are referred to—Michelle can probably talk to you more about that—in your antenatal classes, if you want to read them, is very important because there is a wide range of books on birthing out in the community and some of them really just need to be put in the dustbin.

Mrs Moore—I would agree with that. When I had my first child, I was quite committed to natural birthing practices. I have also come from a background where I have a sister who is a midwife and all my family delivered naturally. I was just so sure in my mind that I was going to deliver my child naturally but I wanted to have a birth as naturally as possible. I did a lot of reading, and the discrepancies in books is amazing.

Not only that, the discrepancies in the way the medical staff approach your birth is amazing as well. I remember asking a doctor who was training to be a gynaecologist and obstetrician what books did he think I should read. We were talking about my birth. He said, 'If you just go into the hospital and within the first hour that you are there you will demand to have an epidural anyway.' This was a training doctor when my first baby was born only four years ago. So there has not been a great change in the way doctors perceive women birthing naturally.

CHAIR—What did you say to him?

Mrs Moore—I was dumbfounded. I actually just said, 'Oh, yes,' because it was a social occasion and that was his job. I did not want to bring it up too much, so we left the conversation as it was and I walked out. I said to my husband, 'What did you think of that?' He said, 'I know now that you will definitely have a normal delivery just to spite him.'

CHAIR—This I think is another criteria of not optimal practice, but we understand it. Have you written to this doctor?

Mrs Moore—No, I have not. He was a close personal friend of a very close friend of mine, so to keep the waters smooth it just seemed like it was best to leave it as it was. But I did tell him my birthing story—

CHAIR—But the interesting challenge is that if we leave the waters smooth we may never change the culture.

Mrs Moore—He knew that my birth proceeded perfectly well. I had a perfectly natural normal birth. In fact, it was so textbook it was just amazing.

CHAIR—The right textbook.

Mrs Moore—That is right. It went very smoothly and I was fortunate that there were no clinical reasons why I had to have any intervention as such.

Senator GIBBS—This inquiry has been quite an eye opener. It is one of the most interesting ones I have been on. It seems to me that the culture has changed since Senator

Crowley and I became mothers years ago. You just assumed that of course this will be a natural birth and if one has to have a caesarean in it is because I am going to die or the child is going to die, but it is the last resort. But there seems to be a culture now amongst mothers or people in society, and I do not know whether this has been propagated by the doctors because it is an easy solution. We have been told by obstetricians that women these days want the perfect birth, the perfect child, it is that sort of society, and they are actually demanding these procedures. So obviously this culture has changed and we really need to get back to the culture of natural things. Do you think this is because it is the easy way out for doctors to conduct a caesarean? Let us face it, most people out there just think that to have a caesarean they cut open your belly, take the baby out and stitch you back up. They do not realise that this is a major operation and can cause so many problems and do so much damage to your body. How do you think this culture has changed and how can we get it back?

Mrs Buttery—I think it is to do with litigation. There are far more cases of litigation for a baby that has been compromised because it was not rescued by caesarean section than the other way round. I have heard of a few cases of women suing because a caesarean section was performed but it is nowhere near as frequent as suing because you did not do a caesarean section, you did not save my baby from cerebral palsy or death or whatever the outcome was. That is just a legal thing, and I do not know how you would get around that.

Mrs Hanna—I may be hypersensitive to this but in the *Advertiser* in the last couple of months there were quite a few articles on caesarean sections putting it in a positive light. In yesterday's *Advertiser* there was a picture of a woman and her final comment was that there was no pain. It was easy and there was no pain. That is not correct. You are limited in what you can do for some time afterwards, besides all the other things that can go wrong. Yet it is presented to people by the media as well as by other people who have had caesareans that it is the easy option, because they see hours and hours of being in pain as something horrendous and they do not hear about the continued pain of a woman for quite some time after a caesarean section.

Mrs Buttery—Lan has had conversations with me about how Asian women feel about caesareans.

Mrs Nguyen—I work in the Vietnamese community, so I am able to talk to quite a lot of women who have given birth at the Queen Elizabeth Hospital. I have heard quite a few stories. In Vietnam the caesarean is a major operation and it may result in death for both child and mother, so there is a lot of stigma and people really feel bad. When we come here we still keep that idea, and I think most Vietnamese women prefer to give birth naturally rather than have a caesarean. I talked to a couple of women who gave birth at Queen Elizabeth hospital. One woman had her first child in Vietnam and they had to do a caesarean on her because of the position of the baby. When she came here she gave birth to a second child. The position of the baby was very similar to the first child and she expected she would have the same thing happen to her and she was so afraid of that. However, when she came to Queen Elizabeth Hospital the doctor was able to help her and somehow they turned the baby. I do not know what they did, but she was able to give birth naturally to her second child, and she was very grateful for that.

The second woman's case is similar. It was her first child, she came to Queen Elizabeth Hospital and there was some complication with the position of the baby. That woman had been so afraid. Eventually they had to do a caesarean on her. As for the procedure, everything was explained to her so that when she had to go through that she was not very afraid of what was going to happen to her. So I think the results and outcome from that were very good.

Senator GIBBS—We heard yesterday that the high rate of caesarean sections in Australia was put down to the fact that we are a multicultural society in which Australian men marry Asian women. Therefore, if the child's head size reflects the head size of the Australian man and if the child is rather large, the woman will have to have a caesarean section. I know this sounds bizarre but this is what were actually told yesterday. This was given as one of the reasons why we have such a high rate of caesarean sections. I am sure you have not come across that.

Mrs Nguyen—A personal friend of mine is as small as me. She is married to an Australian, who is big. She has had two babies, each of them about four kilos. She gave birth naturally.

Senator GIBBS—There you go.

Mrs Moore—I still think that the demand for caesareans is in the minority rather than in the majority. Maybe with more education women would really know the risks associated with having a caesarean, in comparison with the joy that can actually be experienced through a natural birth, which you cannot get at any other time in your life. A lot of women will talk about their births as just being the epitome of their lives, so taking that away from women is almost denouncing the fact of what they are as such.

CHAIR—I think the question that Senator Gibbs is just coming to is very important. I understand that Queen Elizabeth Hospital has a very large Vietnamese community and that it has established, in response to that population, a significant interpreting service and a community backup service for Vietnamese families including parents. Is your group at Queen Elizabeth larger than any other group anywhere else in South Australia?

Mrs Nguyen—I think ours is the largest group of Vietnamese women who come to Queen Elizabeth Hospital. The population is not just of the Vietnamese community but also of most of the non-English speaking background communities. That population around the Queen Elizabeth Hospital is the largest such community in Adelaide.

CHAIR—So QEH actually provide an interpreting service?

Mrs Nguyen—No, they actually have midwives who can speak Vietnamese. As well they employ a social welfare worker who is also a Vietnamese speaking person. So in terms of language and appropriate culture, they can provide that to women.

Mrs Buttery—We also have antenatal classes in Vietnamese.

CHAIR—And in any other languages?

Mrs Hanna—Yes, on an individual basis. If you are non-English speaking, your antenatal classes are given with an interpreter in your language on an individual basis.

CHAIR—Can you tell us whether the fathers participate?

Mrs Nguyen—I am not so sure but my impression is that, yes, the fathers participate in that.

CHAIR—Is that the usual pattern in Vietnam, for example?

Mrs Nguyen—Not really, because in Vietnam the father would be separate from the birth. Here fathers are encouraged to participate in the birth of the children. This makes me very happy because we would not be able to do that in Vietnam.

CHAIR—What would happen if Queen Elizabeth Hospital's maternity ward ceased to exist?

Mrs Nguyen—I am not speaking just on behalf of the Vietnamese community, because there are about 10 or 11 other communities surrounding Queen Elizabeth Hospital. We all feel the same in that most of the women from non-English speaking backgrounds would be most disappointed because they have lived very much in isolation.

They might have either no car or no drivers licence. They cannot speak English. If they had to travel about 10 or 20 kilometres away from home to give birth to their children, I think that would be very hard, especially as public transport in Adelaide is not adequate, given that they might have to wait one hour before another bus comes.

If you were to close Queen Elizabeth Hospital, they would have to go to another hospital far away from home. Normally these women have no support from extended family. The only family they have is maybe their husband, who might be working all day and having only a little time in the evening. It is very hard if they do not have that kind of support.

CHAIR—Say I am the government and I have to close you down because you are costing too much money. Please persuade me otherwise.

Mrs Buttery—Ours is an institution that highlights best practice in many areas. We are the only metropolitan hospital to be accredited under the 'baby friendly hospital initiative' of the World Health Organisation, which means we promote breast feeding, and our breast feeding rates are reflective of that. We have to maintain that accreditation so we have to maintain good breast feeding rates.

Mrs Hanna—We are the only hospital to have a mental health midwife, who sees all the women, talks about some of the feelings that they may experience and gives them information about where they can click into if they start feeling depressed or if they are not feeling the correct feelings.

Mrs Buttery—Let us tie all of that into costs. It is a common thing for governments to look at just the top level of how much something costs. But, in relation to breast feeding, if

we were to close, how many fewer women would out there without breast feeding support? Their babies would be formula fed and there would be all the problems that go along with that: the allergies and the asthma. How much would those problems cost this institution as far as children are concerned? If support is not given through the mental health midwife right from the onset of problems, how many women are going to be out there needing crisis care because they have postnatal psychosis? There are all those underlying costs.

Mrs Hanna—Although we are continually assured that community services will be provided for women, we have had a recent experience otherwise. The Western GP Service had a lactation consultant. This was supposed to tie in with early discharge so that women could have help within the home with breast feeding. The priorities have changed and there is now no lactation consultant. So we would not feel really comfortable with that sort of thing being ongoing.

The other thing we have been promised is that a lot of our programs would be integrated into those of other hospitals. Some of our programs for physically and intellectually disabled women have been going for 15 years. Not only their antenatal care and birthing but also their postnatal care is tailored to their individual needs. No other hospital, even though information about this has been published, has picked it up. In fact, other hospitals refer to our hospital because it is really time consuming.

CHAIR—From what you are saying, it seems to me that there is a kind of community ownership of the Queen Elizabeth Hospital. Is that fair to say?

Mr White—Certainly. Most of the older generation, especially the grandmothers, were appalled to hear that the maternity service would close. That group was the most outspoken of the ones that I heard from. There was a sense of outrage.

CHAIR—I am not suggesting that is not to be taken seriously, but tough decisions do have to be made. One of the things that I find contradictory is the evidence all sorts of people have given us about the importance of continuity of carer. I am wondering how continuity of carer could be provided if people had to leave the western suburbs and come across town. Is it possible to provide that?

Mrs Moore—For my second child I actually went under the 'mothers with midwives' through the QEH, which means you have one midwife who sees you through all of your visits, except for your initial visit and your 36-week check-up visit. For me, that was ideal. Continuity of care is about knowing not only about the physical side of the birth but also about the mental side of the birth. I had a lot of problems associated with my first child. When I brought her home I had a lot of problems with feeding. From about my fourth month my midwife sensed that I had a lot of resounding problems that I needed to address. She directed me and talked me through a lot of issues that I needed to—

CHAIR—But what if she worked with the women's hospital? Why wouldn't you get the same continuity of care from the same splendid person?

Mrs Moore—I think you probably would, but the difference would be that your family would be disrupted in the travel aspect of it all. What they are planning for the QEH is that

we will have a basic low risk birth area. You will see your midwife and you will have a continuity of care, but if a problem arises you will be transferred. You can go right through your pregnancy, have a risk-free pregnancy, get into your birth and have complications. Nobody wants to be transferred out in the middle of the birth to have a medical procedure done. They are saying that your midwife will go with you, but I think there is also a problem with accreditation between the hospitals.

CHAIR—We ran out of time about 20 minutes ago, unfortunately. This is just proving too interesting, and it is too difficult to try to get as much information as we want. I think what you have told us today is that your hospital has the lowest caesarean section rate in this town. It would be interesting to see what would happen to the statistics if you closed. Maybe you could take your good figures to some other place. As I pointed out—and I appreciate that Mr White said this at the beginning—this committee's work is not to save the Queen Elizabeth Hospital. But the arguments about the culture and the approach at the Queen Elizabeth Hospital certainly seems to be somewhat singular. It has a significant non-English speaking background support group—and particularly from the Vietnamese community—but, for us, one of the things that stands out in capital letters is that very low caesarean section rate. That is something that we will certainly take up this afternoon. Please forgive us if we rush you offstage. Thank you very much for coming. If there is something further we wish to ask, we will contact you. Or, if there is something you want to put to us, please feel free to contact us.

[12.18 p.m.]

ANASTASSIADIS, Ms Kay, Principal Policy Officer, Policy and Planning (Health), Department of Human Services

BROWN, Mrs Judith, Executive Officer, Obstetric Review, Department of Human Services

CHAN, Dr Annabelle, Senior Consultant, Pregnancy Outcome Unit, Department of Human Services

JELLY, Dr Michael Thomas James, Chief Medical Officer, Statewide Services, Department of Human Services

CHAIR—I welcome representatives of the South Australian Department of Human Services. The committee prefers all of its 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 can ask to do so and the committee will give consideration to your request. We have no submission from you.

Ms Anastassiadis—No, that is still to be submitted. We have basically been very behind in our work program. We give our apologies to the Senate committee, and we hope to provide that by early next week. We are taking, in part, this opportunity to provide you with as full a submission as possible, taking on board some of the comments that have been made here today, so that you have a clear picture of the services that are provided in South Australia and the issues around those.

CHAIR—Thank you for coming. I know that you are here ahead of the submission. We will not have an opportunity to come back to a public hearing in South Australia, so it is very useful for us to have the opportunity to have you as witnesses today, even though we might want to follow up your written submission with questions. I gather from your nodding that that would be okay.

Ms Anastassiadis—Definitely. We would be very happy to do that.

CHAIR—There is a number of questions that I think the committee would be very pleased to put to you today. Do you wish to make an opening statement?

Ms Anastassiadis—We do have a lengthy opening statement. We could address many of the terms of reference, if you would like us to do that. It may be useful for us to do so, because that covers a lot of the information that you have already heard and probably provides a clearer context for much of that information.

CHAIR—What do you mean by 'lengthy'?

Ms Anastassiadis—About 15 minutes.

CHAIR—No, that is too long. Can you pick the highlights out for about five minutes or so? Then, if there are points that you really want to put on the record today, you can do that in answers to questions or you could ask to do so at the end.

Ms Anastassiadis—Okay. I will pick the eyes out of it.

CHAIR—Can you cope with that?

Ms Anastassiadis—Yes, I think so.

CHAIR—We can receive what you have written there as a submission, if that is a help.

Ms Anastassiadis—I have written all over this one.

CHAIR—At a later date.

Ms Anastassiadis—It will form the basis of our written submission, in any case, so you will get it. The department undertakes a significant range of activities to monitor and report on pregnancy outcomes in South Australia and to contribute to improving health and wellbeing outcomes for women who are pregnant through the provision of appropriate antenatal, intra-partum and post-partum care with a range of birthing services and options whilst ensuring the best possible perinatal and maternal outcomes.

We have a well-developed policy context, and we will be providing you with a copy of the operational guidelines and standards for maternal and neonatal services in South Australia. This document is to be reviewed shortly, but it provides the current policy context for service provision and outlines the levels of care and significant detail on type of care, quality of care and levels of care. It also refers to standards and strategies for monitoring quality and outcomes for care. So it will give you some important background information about how we manage services in this state.

There is a number of other state and national initiatives that we try to respond to, and I note that we have supported the NHMRC report *Options for effective care in childbirth*. We see that as a very important context report. We also have produced two state reports that also provide a context for care. One of those is the report of the South Australian Models of Maternity Care Working Party, which was produced in 1995. The other is the report of the South Australian Birthing Service Working Group, which was produced in 1994. We also note the national partnership on Aboriginal health, which is a critical background framework for service development. That has high priority within the department.

We have a Pregnancy Outcomes Statistics Unit based within the epidemiology branch—a state-wide division of the department—and this forms the basis for what the department sees as the outcomes for perinatal and maternal. Our unit produces a report on an annual basis, with the most recent being the 1997 report. Again, these key reports will be provided to you to give you the background to the state of work being undertaken by this department.

We have, for starters, this relatively comprehensive data and, in association with that data, we collect sociodemographic data and data on various procedures performed in

childbirth. South Australia has also established a maternal, perinatal and infant mortality committee that reports annually on maternal, perinatal and postneonatal deaths and makes recommendations on issues to be addressed to improve outcomes. So we have a quality context to monitor outcomes across the state.

In these reports it is noted that the perinatal mortality was 4.0 per 1,000 births in 1997, with a neonatal rate of 0.7 per 1,000 live births, which was the lowest ever recorded in the state. Those rates are used for international comparisons.

CHAIR—With those rates, what is described as neonatal?

Dr Chan—In this respect it refers to rates used for international comparisons. In this context neonatal is the death of a baby within the first seven days of life.

CHAIR—And perinatal?

Dr Chan—In this context it is stillbirths of 1,000 grams or greater. I think Kay has quoted to you the international rates. In 1997 our rate for babies of at least 400 grams birthweight and for neonates of 28 days was about 10. In 1998 it was 8.9 per 1,000. That is the perinatal mortality rate for all births in the state. Our rate—for international comparison—fell even further last year.

CHAIR—We will have a look at that in detail when we get your submission. It is confusing sometimes with perinatal, neonatal, infant mortality. So South Australia has very low figures in all of those categories?

Dr Chan—Yes, that is right.

CHAIR—Are they the best in the world?

Dr Chan—We could say that, but not every country has provided the most up to date rates to the World Health Organisation. If you look at the rates that are reported to the World Health Organisation, we do have the lowest neonatal mortality rate.

CHAIR—That would be the deaths of babies within the first seven days?

Dr Chan—Yes, that is right.

CHAIR—Infant mortality in the first month?

Dr Chan—Infant mortality is within the first year of life.

CHAIR—How do we compare there?

Dr Chan—It is difficult to get international rates. Our rate last year was 3.9 per 1,000 live births, which was also the lowest we have ever had.

CHAIR—Within that very good figure, is there an Aboriginal figure?

Dr Chan—The Aboriginal figures are not as good. Last year they were much better than usual, but they were still about twice the rate of the non-Aboriginal population.

CHAIR—So that makes it about 7.8?

Dr Chan—It is about 7.5.

CHAIR—Is that 7.5 figure for Aboriginal people included in the 3.9 figure or is it scored separately?

Dr Chan—It is included in the 3.9 figure.

CHAIR—So if you took the Aboriginal figure out of the 3.9 figure—

Dr Chan—it would be less than that.

CHAIR—That would make it extraordinarily low.

Dr Chan—It is very low.

CHAIR—That is infant mortality?

Dr Chan—Yes.

CHAIR—That is, deaths within the first 12 months after birth.

Dr Chan—That is right.

CHAIR—Does that include the tiny little babes that are born at 24 weeks?

Dr Chan—Yes, even those that just gasp once and die or have a heartbeat for a few seconds. It is all live births. It is births that have any sign of life at all.

CHAIR—Thank you, that is really very useful. It is very encouraging that the figures are so low.

Ms Anastassiadis—We would like to comment on the first term of reference. We would like to start from the opposite side of this term of reference and I think we should focus on what is quality of care in childbirth. There are a number of factors that contribute to that.

We provide a range of antenatal care services in South Australia, and they include general practitioner/obstetrician; antenatal care combined with birthing and post-natal care; specialist obstetrician care; shared care, primarily between general practitioners and hospital obstetrics services; hospital based midwifery care; and birthing unit care. It has already been noted that these birthing units are well subscribed. There are two models of birthing unit care operating in South Australia, with some emphasising midwifery based care or a combination of medical management and midwifery care.

CHAIR—Where would we find one of those?

Ms Anastassiadis—The three midwifery based birthing units are located at Flinders Medical Centre, the Lyell McEwin Hospital and the Women's and Children's Hospital. The other one is located at the Queen Elizabeth Hospital. The last one was the first to be established in South Australia, and the first three were established under the Alternative Birthing Services Program with additional resources being provided by those hospitals. We have had a significant increase in the use of those services since their establishment, progressively since 1992.

CHAIR—Could I interrupt and say at this point that we are pressed for time, so I will just ask you three questions. The caesarean rate: does it concern the department that you have got the highest caesarean rate in Australia?

Dr Jelly—The simple answer is yes. It is always subject to scrutiny as to whether that is an appropriate rate or not, and it has to be linked to outcomes at the end of the day in some way or other. But the simple answer is yes, it does concern us that it is such a high rate and it does require further evaluation as to whether that is reasonable or unreasonable.

CHAIR—Does it concern you that privately insured patients are far more likely to have a caesarean?

Dr Jelly—Annabelle may be better placed to answer that, but just to comment: one of the difficulties in looking at any of the figures is the client base in any particular scenario. For example, the major teaching hospitals pick up the high risk patients, and therefore it would not be unreasonable to expect that they may have a higher caesar rate than a lower level hospital which transfers out the high risk patients. So it is very difficult to know, but the fact that the private sector appears, at least on the surface, to have a higher rate is a matter of concern, yes.

CHAIR—It does not appear. The figures show it beyond any doubt. The South Australian figure is 23 point something, so it is getting up to not quite, but nearly, one in four on average. But if you are, for example, between 35 and 39 and privately insured, the figure is 40 per cent. And that is a significant increase.

Dr Jelly—It is indeed.

Ms Anastassiadis—The caesarean section rate has been stable for the last four years in South Australia—

CHAIR—At about 23.5 per cent?

Ms Anastassiadis—Yes.

CHAIR—Dr Chan, can you tell us the figures for private patients?

Dr Chan—For private patients it is 29 per cent compared with 22 per cent for public patients. And the rate last year was 23.9 per cent, but it has been between 23 per cent and 24 per cent for the last five years.

CHAIR—Given that you are anxious about it, or at least concerned, Dr Jelly—I do not mind who answers this—if the figure is at that kind of rate, what are you doing to see that the figure gets lowered?

Ms Anastassiadis—We think that there is a range of contributory factors to those caesarean section rates, as in all procedures. Because it is so difficult to identify what is the critical contributing factor, we have adopted a broad based approach in South Australia, looking at a range of strategies and approaches to reduce those.

CHAIR—But it hasn't worked.

Ms Anastassiadis—We are adding to the range of strategies on a continuous basis. Dr Jelly, do you want to add anything?

Dr Jelly—Yes. I do not know that you can draw that conclusion. Maybe it would have been harder if the strategies hadn't worked to a degree. You just cannot draw that simple conclusion.

CHAIR—You cannot, except that the only things we have got to go on are the statistics that are available, and they are from your perinatal unit. I think you would have to say that one of the reasons South Australia sometimes gets punished is because it is very good at providing good data. I acknowledge that the scores are there, but, whatever way you look at it, the figure remains around 22 per cent, 23 per cent, as an average. We have also heard that the Queen Elizabeth maternity unit, which is under threat, has the lowest caesarean rate. Does the department look at what is going on in Queen Elizabeth—why the women down there are so much fitter?

Ms Anastassiadis—Annabelle can probably answer this in more detail, but the demographics have a lot to do with it.

Dr Chan—Perhaps I should say first of all that we have to look at this historically to some extent and the statistics that we have for comparison with other states. The first year for which we have statistics is 1981, when the National Perinatal Statistics Unit was established. Even then we had the highest rate out of the states that could contribute data. We had a rate of close to 17 per cent, whereas some of the other states had about 14 per cent—the ones with a higher rate. So we have traditionally had a higher rate. We cannot go further back than that, so it is in a way difficult for us to ascertain why our rate has been so high.

CHAIR—Why is Queen Elizabeth much lower?

Dr Chan—I am afraid you will have to ask Queen Elizabeth about the strategies that they have put in place, but similar strategies are in place in other hospitals. Could I just say that we have traditionally had a high rate, and once you have got a high rate it is quite

difficult to reduce it—not that that is an excuse. For example, last year was the first year in which we collected statistics on women who had previous caesareans, and the rate is 13 per cent. So 13 per cent of women entering labour have had a previous caesarean section, and the rate of caesarean in women who have had a caesarean previously is much higher. For example, for women who have had one caesarean, about 62 per cent of them end up having another caesarean.

CHAIR—Flinders Medical Centre told us this morning that they did, over the years, drop their caesarean rate to 18 per cent, and it has since crept up again. There seems to be, as much as anything, a culture within a hospital and a habit of practice.

Dr Chan—That is true, but we also have these predisposing factors. Firstly, because historically we have had a higher rate, the proportion of women with a previous caesarean is probably higher in our state than in other states. Secondly, if you look at our caesarean rates, we do not have a higher elective caesarean rate than the other states. In fact, our rate for elective caesarean is very much in the middle compared with all the other states. It is in our emergency caesarean rate that we are higher than all the other states, and that is something that we are currently looking into. We are currently undertaking a study on caesarean section rates, on the risk factors—

CHAIR—Do you have a sense that the fear of litigation is encouraging doctors to do caesarean sections?

Dr Chan—I think that is prevalent everywhere, without a doubt, in Australia as well as overseas. It is also, in some cases, women's concern about the outcome for their baby, thinking that a caesarean may provide a safer outcome. So a lot of information needs to be given to women about this to help them to make their decision. This has been undertaken in a study that was recently published.

CHAIR—Can you, as a department, comment on whether you think the funding for the process of childbirth may be encouraging certain practises rather than others?

Dr Jelly—There have been changes over recent years in the Medicare Benefits Schedule, which for a time included caesarean section as one item. We do not have any evidence that I know of that says that the changed practices are due to changes in the Medicare Benefits Schedule funding arrangements. Our fee for service arrangements in country public hospitals in this state mirror the way that the CMB scheduled fees are paid. There does not seem to have had an impact in terms of practices of delivering babies in the 25 per cent of our deliveries which are done in rural hospitals. I cannot identify any particular changes that may have occurred because of changed funding arrangements.

CHAIR—What about early discharge from hospitals?

Dr Jelly—That certainly has increased substantially, and that brings into question the postnatal care of the patient at home and whether domiciliary services ought to be provided from hospitals. That is a growing feature of most hospitals, including private hospitals, in this state. Certainly the length of stay in public and private hospitals has come down very considerably over the last decade for both vaginal and caesarean deliveries.

CHAIR—I will call my colleagues for questions, but I have a last one. We were advised that South Australia has the highest number of obstetrician and gynaecologist specialists and that the high caesarean section rate correlates with the high number of specialists. Would you care to comment?

Dr Jelly—The first part of your statement is true: we do have a high number of obstetricians and gynaecologists—some of whom, of course, do not deliver babies; they are more gynaecologists than obstetricians. The AMWFAC report on obstetrics and gynaecology showed that we were well-off for obstetricians and gynaecologists, and we actually identified a need to reduce the number of trainees in this state by one in the next three years. Whether that then correlates with the high caesar rate, I do not know.

CHAIR—It does correlate with the high caesar rate.

Dr Jelly—It is true that we have a high number of obstetricians and gynaecologists and a higher caesar rate, but whether you can actually link the two directly, I do not know.

Dr Chan—I think one of the factors in reducing the rates is to encourage women that it is possible to have normal vaginal delivery after a previous caesarean. That is something that needs to be encouraged in both the community of women and the community of obstetricians. The hospitals that have managed to reduce their rates have possibly been able to achieve this result by advising women that it is possible to have a normal delivery after a previous caesarean section and also that it is possible to have breech deliveries delivered vaginally. There are approaches in place to try to reduce the rates that can be attributed to those.

CHAIR—That is true, and that is a thoughtful, reasonable and deliberative contribution to our thinking. But to go back to Dr Jelly, only obstetricians do caesarean sections. I do not know of any midwives in South Australia who are allowed to do caesarean sections. It is only the specialists who are qualified to do them. Are you saying that you know of no causal connection between high rates of specialists and the high rates of caesarean sections?

Dr Jelly—I do not know of any evidence that says that. Yes, the two coexist—there is no doubt about that—and one would have to question whether that is causal or not, but I do not know that the evidence says it. One of the issues that Dr Chan has raised with our last statement and what information is provided to women with respect to consent to have a caesarean section. The advice given by those obstetricians and gynaecologists who are proposing a course of action is critical in the decision making, as well as the women's attitude to the caesarean section and what might be the outcomes. Those exchanges are usually one on one, so it is very difficult to judge the information that is provided to women.

CHAIR—Do you think it is an important question?

Dr Jelly—I think it is a very important question.

CHAIR—Will you find the funds to research it?

Dr Jelly—I do not control funds, Senator.

CHAIR—Do you think it would be a good idea if funds could be found to research it?

Dr Jelly—I think it would be a very worthy subject of research in this state.

Dr Chan—If the Senate could provide us with some funds, that would be very suitable.

CHAIR—That is a very good answer too, Dr Chan, but we are also not responsible for funds. In fact, a department is probably closer to the money than the Senate or a Senate committee. All four of you have nodded at that point, suggesting that informational research about what is told to mothers would be a matter of significant importance if we were looking at reducing caesarean rates. Would you have any idea of what percentage of caesareans are done, because we are told in the papers women are demanding them?

Dr Chan—It is difficult to gauge that. We do collect reasons for caesarean section. We have places to insert two reasons. It is not very often that it is stated that it is for social reasons. Usually, there is some other reason as well and those reasons are quite valid.

CHAIR—How has this myth and legend got legs? How do you think the view has been formed now out in the community that the caesarean rate is high because women are demanding it? It seems to me it is contrary to the evidence that we have been provided which is that if there are women demanding caesarean sections they are a small number. Yet that tends not to be the climate or the atmosphere that is being talked about—caesarean rates have gone high and now suddenly it is women who are asking for them, not specialists who are doing them.

Dr Jelly—If you take that out of context it can look like we are saying, 'All women demand to have caesars.' That is not so. But it depends on the information given to the woman when the decision is made to have the caesar. There may be some women who are told, 'We could go through a trial of labour and see whether you can progress, because the reason last time for having your caesar was failed to progress. We might leave you labouring for 12 or 18 hours to see if that will work, at which point we then make a decision if you are not progressing to have another caesar.' Or the woman could be told, 'Or we could go straight to a caesar.' The exchange that goes on over the consent for having the caesarean section is critical, but you cannot say that is a woman demanding a caesarean section.

CHAIR—That is a very important point, Dr Jelly. We would be very pleased and assisted if we had that kind of information and that kind of approach. Early on you gave evidence that you are concerned about the very high caesarean rate in South Australia—you collectively, that is the South Australian department—and you are looking at a number of strategies that can reduce it. Are you setting figures or quotas such as 'we will have it down to 20 per cent by'?

Dr Jelly—We have not set those figures.

Ms Anastassiadis—No, we have not.

CHAIR—Would you?

Dr Jelly—We could look at doing that in a review of obstetrics and gynaecology process and of the health service agreements with the hospitals, which is about the outcomes we expect for our dollar.

Ms Anastassiadis—It requires a broader range of strategies and you are really looking at things running at the same time. For example, the quality of information that women have independently. One of the things we wanted to talk to you about was the trial of a woman-held pregnancy record card. We trialled that at the Queen Elizabeth Hospital, the Flinders Medical Centre, the Lyell McEwen, and in a couple of rural practices as well as private GPs. This record provides a standardised care package basically.

On the document we record social demographic details and previous birth history. The woman carries the document with her and also writes in the document. It is her pregnancy record while she is having antenatal care. We are looking to have it developed across the state so that all women have that. It seems a point of communication between the care provider—whoever that care provider might be, it might be an independent midwife, it might be a general practitioner, it might be a midwife in a hospital—and the woman and the woman and her family. It provides a focus for discussing and raising issues with that care provider. We ask them to record any questions that they might have on that document and also to write their birth plan so they look at what options they might have. We also have other information with that in an information booklet about choices in care. We are looking to expand the information that is available to consumers so that there is a more equitable basis for that information being available in the community.

CHAIR—I hate to cut across you, but we are way beyond time.

Ms Anastassiadis—We want to note that there is a very inequitable base of information provided to women. In respect of their access there are some women who are very literate—

CHAIR—Who and will get it. Can you answer yes or no to this question: do you have the figures for caesarean sections in every hospital in South Australia?

Dr Chan—Yes, we do.

CHAIR—Can you provide them to the committee, broken down by public and private and including all the private hospitals?

Dr Chan—Not unless you obtain the approval of all the hospitals to release them.

CHAIR—So you have them but you cannot give them to us?

Dr Jelly—One of the things we have to do is to have cooperation in collecting the data. The identification, especially of each private hospital, would be counterproductive in terms how we do it—

CHAIR—Do they put those figures in their annual reports?

Dr Jelly—I think we can give you grouped data.

Dr Chan—Some do. The Queen Elizabeth, for example, provides reports to all the hospitals for quality assurance—

CHAIR—The public hospitals seem to do it very well but with the private hospitals we seem not to get the same access to data. If you can provide us any further information on the breakdown—I guess it is called non-identifying—in those hospitals, it would be extremely useful.

Dr Chan—The rates for hospital categories are in our report for teaching hospitals, private hospitals and country hospitals.

CHAIR—We keep talking about the information available to mothers. Another point that has been raised with us is that some people are very concerned about the information that is available to obstetricians and to general practitioners. For example, lots of doctors whom women may go to see first of all to confirm that they are pregnant or what have you are the people who provide no information to the mothers about antenatal classes or about a range of options for childbirth. I am wondering if you would perhaps take on notice the question: while it sounds fantastic that you are providing lots of information for mothers, are you also providing it for the doctors?

Ms Anastassiadis—That is the beauty of the South Australian woman-held pregnancy record card because each provider potentially provides it to the woman at her first visit so that the range of information that is being provided at that initial visit is the same whether you are visiting a hospital or a GP. There is a package of information about those things in there, although we want to improve that.

CHAIR—I am afraid we are out of time. I am very sorry. It is a terrible pity that we do not have your submission here, because I can see you have done a bit of homework. I do thank you again for making the effort to come. After looking at the *Hansard* that will be available to you, if there you want to tell us further about any answers or if you want to pick up on what earlier or later witnesses have said we would be happy to receive it. If there is anything further that we would like to follow up after we have seen your submission, I hope that would be all right if we contacted you.

Ms Anastassiadis—That would be perfectly fine. Thank you very much for having us.

[12.56 p.m.]

LITTLEJOHN, Ms Anne, Member, Midwives Act Lobby Group and Community Midwife, Northern Metro Community Health Service

LITTLEJOHN, Ms Sally, Member, Midwives Act Lobby Group

PRATT, Ms Julie, Member, Midwives Act Lobby Group, Flinders Medical Centre Birth Centre and South Australian Midwives Association Inc.

CHAIR—I welcome the representatives from the Midwives ACT Lobby Group and the South Australian Independent Midwives Association. We have spoken to midwives in other places so please understand that we are squeezed for time, but we very much welcome your attendance today. We have received submission No. 99 from the South Australian Independent Midwives Association and No. 61 from the Midwives ACT Lobby Group.

The committee prefers all its 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 can ask to do so and the committee would give consideration to your request. If you would like to make a very brief opening statement and then I will ask my colleagues for some questions.

Ms A. Littlejohn—I will shorten what I have to say so that we have more time for discussion. In the little time we have here we would like to emphasise the need for accessible, affordable and culturally appropriate maternity care for women and their families in Australia. We would like to talk mainly about childbirthing as a normal natural event in healthy women, not a medical event, and that women have the right to make informed choices around the style of birth which most suits them and their families and their life culture.

The emphasis we want to highlight today is in talking about best practice models of care for safe and effective births and looking at ways to establish a model of care which provides a continuum of care, with women and their families accessing high quality community based maternity services with obstetric and neonatal support where necessary. We feel it is essential that there should be a collaborative relationship between obstetric and other services with midwives so that these sorts of models of care can be provided in a way that is appropriate for both the carers and for the women that we are looking after.

The continuity of care models should be localised in the community, should be directed by the specific community needs and it is extremely important that they should be culturally appropriate. We believe that at the moment models of care are very white Australian centred. We need to be looking much more to the sorts of communities that we are providing these services to and asking those communities what services they would most need.

Without going into details, we have looked at the United Kingdom's maternity services and at how they are being redirected from hospital based to the community, with GP sometimes and with midwife-led care for healthy women. There is an increasing body of evidence, which you have probably heard of already, to support this move with particular

emphasis on the reduced costs of maternity services, the improved clinical outcomes, the reduced morbidity for women and their babies, and the fact that women are more satisfied with this type of care.

So we think that services should be women centred rather than focusing on the needs of the service provider. At this point, I would like to say that the Medicare rebate that is given to providers for more complex births would seem to me the wrong way round. In other words, we should be providing the women with the money to make the choices for the type of care that most suits their needs, both culturally and within their environment, rather than money going to the providers where they can actually provide that extra money for complex births. We think this is the wrong way round. Emerging evidence suggests that obstetric models of maternity care are not only financially and socially unsustainable but they do not always necessarily produce better health outcomes when compared to more women centred and midwifery models of care which are primary health care focused, culturally appropriate and with due attention to social justice, access and equity issues.

I would like to mention that the various alternative birthing service programs, which have been publicly funded pilot projects in Australia, have demonstrated highly successful cost-effective outcomes with midwifery continuity of care models. However, despite the success of these innovative projects in Australia, many have not received ongoing funding and there are structural and professional issues that require urgent resolution. I am at present a community midwife working on such a project in the northern suburbs of Adelaide. It is the second such alternative birthing service project that I have been working on and I would say that it is hard work, it is underfunded, underresourced and undersupported. It would seem to me that, if these sorts of continuity of care projects and models work so well, why can we not get together and start looking at a women centred care that really gives women the kind of care that they are asking for?

Just to finish, I would also like to say that on our project we have quite a lot of women who call us asking for VBACS, in other words, vaginal birth after caesarean section. We have to tell them that we cannot help them, simply because they do not want to have a trial of birth, which is what it is called obstetrically; they want to try to have a baby vaginally after a caesarean section but there are only two hospitals in Adelaide where the women can have that kind of care. They are the birthing centre in the Queen Elizabeth Hospital, which is the one hospital which is under threat of closure simply because its practices are so brilliant, and Flinders Medical Centre.

Ms S. Littlejohn—Or they can choose to have a vaginal birth after caesarean section at home with an independent midwife.

Ms A. Littlejohn—So what often happens is that women will choose to have a home birth because they know they can have safety with a midwife and have their baby vaginally at home. We think it is a shame that we cannot work collaboratively with obstetricians.

CHAIR—I hate putting pressure on you, but we are so squashed for time. I just want to signal that we need to follow it up anyhow. Could you provide us on notice, not now, with any of the information about the funding for the alternative birthing program? And only if it is not too major an effort. I think you probably have a few other things to do each day. That

alternative birthing program seems to be an idea that is often not spent. So I would like to know what has happened to the funding.

Senator GIBBS—I noticed in your submission that these pilots were carried out quite extensively around Australia and that one was in the Mulla Mullas in Queensland. I am a Queensland senator. What is the funding? Is it state or federal funding?

Ms A. Littlejohn—It is Commonwealth funding. It is federal funding with the hope that at the end of the program there would be state funding for the continuing of that program.

Senator GIBBS—Sorry, I have not had a chance to read this because I was only given it a few minutes ago. How long has this pilot been going on?

Ms A. Littlejohn—The one that I am working on at the present?

Senator GIBBS—In the hospitals where there is no funding.

Ms A. Littlejohn—The one that I am working on at present is not a hospital centred program; it is a community based program.

Senator GIBBS—No, they are all different centres, aren't they? So did they all start at the same time?

Ms A. Littlejohn—No. In 1989 an alternative birthing services working party got together, and I think 1990 would be when the first project would have started. There was one in Tasmania, one in Perth and a small one at the women's health centre in Adelaide.

Senator GIBBS—Tasmania home birth, yes—I have got all that. So that is definitely Commonwealth funding. Good. How many independent midwives do you have in South Australia?

Ms A. Littlejohn—That varies according to when they get paid. That is the truth. The payment is so small that independent midwives in South Australia probably—

Ms S. Littlejohn—There are about seven actually practising.

Senator GIBBS—And you are paid by the mother?

Ms S. Littlejohn—It is private, yes.

Senator GIBBS—And you have a good relationship with the Queen Elizabeth Hospital, obviously. We have heard that. It sounds like a wonderful hospital to me. What other hospitals do you have a good relationship with?

Ms A. Littlejohn—I do not work as an independent midwife at the present moment. I am working as a federally funded community midwife on a publicly funded project in the north.

Ms Pratt—The independent midwives can ask for accreditation rights at any of the three major public hospitals in Adelaide.

Senator GIBBS—And they will be given it?

Ms Pratt—If they meet the criteria they will be given them, and that will allow independent midwives to then work within that hospital with their clients—still as private practitioners.

Senator GIBBS—So that means they are actually in there for the birth?

Ms Pratt—Yes.

Senator GIBBS—Good.

CHAIR—They are in there, or is it that they can be?

Ms Pratt—They are. If that is what that woman wants and that is their contract, they will be in there with that woman for the birth.

Senator GIBBS—We have heard evidence that there is a lot of tension between obstetricians and midwives in other places. I raised the question about the Medicare rebate for independent midwives—that there should be a Medicare rebate—and one of our witnesses said, 'That is fine, but midwives should be trained a little bit better. At the moment they are nurses who do a year's midwifery, and overseas they do four years of training.' How do you feel about that? Do you think our midwives are up to scratch or should they have far more training?

Ms Pratt—I guess it is very hard to say about those midwives who are now practising that they are not up to scratch but I think that, yes, their education could be improved if it was much more a midwife focus, a wellness focus and a woman centred focus rather than being nurses first with midwifery as a postgrad one-year course. I would have to agree. If midwives do have a direct entry four-year course they should be then more entitled to Medicare rebates, to prescribing rights for various drugs and for tests and for normal pregnancies. I think it would help them have a more collegiate relationship with medical professions rather than a more submissive dominated one that tends to be historically nurse orientated.

Senator GIBBS—I have two sisters who are nurses, and I think they are more knowledgeable than most doctors. Do you think it is necessary for a midwife to have some sort of medical background like being a nurse first, or do you think it is okay not to have these qualifications before you receive the qualification of a midwife?

Ms Pratt—I think that, if the midwife course is appropriately designed, which it will be, it will definitely incur some medical as well, but it will be that medical that pertains to midwifery and not things like heart attacks or pneumonias and things that maybe do not pertain to midwifery.

Ms A. Littlejohn—It is just the same as a physiotherapist never being considered to be subservient to a doctor but also having to learn a medical knowledge to be able to work as a physiotherapist. I cannot think of another analogy but it seems to me that that is parallel. We see ourselves equal to but different from obstetricians. I think that is one of the difficulties—that there is this idea that an obstetrician does the big stuff and the midwife follows. In fact we believe that we have a separate body of knowledge with a clear definition, and midwifery has its own scientific body of knowledge which is different from but respectful of. And I think that is the difference.

Senator GIBBS—Good point, thank you.

CHAIR—Ms Pratt, I think your name was used this morning as having moved from one institution to another. Is that true?

Ms Pratt—I have actually moved from being an independent midwife into an institution.

CHAIR—And you are at?

Ms Pratt—At Flinders Medical Centre.

CHAIR—What is your role exactly?

Ms Pratt—I am the clinical midwife consultant of the birth centre at Flinders.

CHAIR—Can you do outreach or is your work all done with women who come to Flinders?

Ms Pratt—It is all done with women who come to Flinders.

CHAIR—Do you see that there would be any role for midwives in a hospital, that is on the books of a hospital, and being able to do a lot of what independent midwives do effectively—that is, move out from the—

Ms Pratt—Yes, I think it would be excellent. That is maybe part of my motive in moving into the hospital—to help educate hospital midwives to be able to move out into the community.

CHAIR—So we should be able to talk about midwives and not about whether they are independent or not—as though an 'independent midwife' is somehow a different beast from a 'midwife'.

Ms Pratt—Yes.

Ms S. Littlejohn—We need to bear in mind that women should make the choice of where they want to birth. In Britain the midwives, who are based in the community or attached to a hospital, facilitate that. The women themselves make the choice of where they are to birth, and the midwives will then follow and give them the care where they want to receive it.

Senator TCHEN—Ms Littlejohn, you said earlier—if I may quote you—that you think the Queen Elizabeth Hospital is under threat of being closed because it is so brilliant. Can you substantiate that? Because, if you cannot, you had better withdraw it.

Ms A. Littlejohn—That is a slight superlative from me. I have had connections with most of the major maternity hospitals in South Australia, except for the Lyell McEwin because I have not worked in the northern suburbs. My experience is that the Queen Elizabeth Hospital has the most women centred approach of all hospitals—in other words, the women's choices are respected within the structures within which the staff have to work. The collegiate relationship—this is a personal opinion—that exists between midwives and obstetric staff is the best that I have ever come across. This, of course, means we work together well and the women benefit, and this is what our aim should be.

Looking at social justice issues, the women in the western suburbs of Adelaide have great difficulty in being able to have a voice, simply because of the environment that they work in. I think it says a lot for that hospital that it works with all of the culturally different groups of women—including Aboriginal women—with such skill. They have skills in that hospital which will be lost entirely, skills which have been built up over many years because they want to work well with the community. As a midwife—either as an independent midwife or now as a community midwife—I see that every time I go into that hospital. The mutual respect is something to be spoken of.

Senator TCHEN—It is okay to say that the Queen Elizabeth Hospital is brilliant, but I suggest that you withdraw what you said about it being closed because it is brilliant.

Ms A. Littlejohn—I will withdraw that. What I am trying to say is that it needs to be noted that, if there are less caesarean sections and less interventions in a hospital, then they get less Casemix funding.

Senator TCHEN—That part is fine.

Ms A. Littlejohn—I withdraw the statement.

Senator TCHEN—Hearings are on the public record, so I think you had better withdraw that. You have been an independent midwife.

Ms A. Littlejohn—Yes.

Senator TCHEN—So has Ms Pratt.

Ms Pratt—Yes.

Senator TCHEN—Why are you not listed in the *Yellow Pages*?

Ms A. Littlejohn—Because the word 'midwife' is not recognised by the people who run the *Yellow Pages*. There is no such thing as a midwife in the *Yellow Pages*.

Senator TCHEN—I think that is something that we can do something about.

Ms A. Littlejohn—We have tried for five years and have not succeeded.

Ms Pratt—It is listed under 'nurses'.

CHAIR—One of the major concerns of this inquiry has been the variable caesarean section rate across the country, the fact that it is higher in South Australia than in any other state and that it is much higher for privately insured patients than for public patients. Can you comment on whether or not you feel your work in alternative birthing, either in a hospital or through independent midwives, will make a difference, or is it just that you are offering a more women centred focus and, indeed, the caesarean section rate may finish up the same?

Ms Pratt—I do not have statistics here to back this up, but I think statistics would already show that midwife care does result in less caesarean sections. As an independent midwife, I know that my caesarean section rate was only about seven per cent amongst women I looked after. I am not sure what our caesarean section rate in the birth centre is, but I am sure it is very low. I think that the emotional support that women feel they get from midwives helps them get through a labour with fewer interventions.

CHAIR—This is rather awful to say but we are so crowded for time: can I ask each of you if there is something that you passionately want to put on the record or that you think the Senate committee must know? Now is your chance.

Ms A. Littlejohn—As a midwife I believe that the only way that women will get better care—because after all we are looking at women, not me as a midwife—will be if everyone believes that, aiming for women as being the centre of attention, we work collaboratively, rather than having the polarity that exists at the moment between obstetricians, midwives and whatever the carer is. Collaborative work together is what will provide the best care for women.

Ms Pratt—To support Annie in that: yes, collaboration is one of the most important things. What needs to be done to assist that to happen is the formation of some sort of national guidelines that direct both obstetricians and midwives as to how they work.

CHAIR—So you think that best practice guidelines would be better, coming with national leadership?

Ms Pratt—Yes.

CHAIR—As I understand it, you would suggest that those best practice guidelines should apply to both obstetricians and midwives?

Ms Pratt—Yes.

CHAIR—And Ms Sally Littlejohn?

Ms S. Littlejohn—I would like to say that, from a consumer point of view, women must have choices and options available to them. In order for them to know that options exist,

there must be education of the community as to those options. That includes, as was spoken about before, the education of GPs, who are usually the first point of contact. Information must be given about all options, including homebirthing as a safe option, that hospitals are not the only places where to give birth, that obstetricians are not the only birth carers and that midwifery care has been shown to be the best care for pregnant women with the best outcomes.

CHAIR—I have one last question for all of you. We have been told one of the reasons why caesarean sections have increased is that women are now demanding them. I think we would now distinguish from the evidence two groups of women. There are women who, having had a previous caesarean section or upon hearing what the risks are, say, 'I am not going to worry with the trials of labour. I will decide to go to a caesarean straight away now.' I think the women who make that decision—or about a breech delivery, for example—will be counted in as women who are asking for caesarean sections.

But we are also told that there are other women who are demanding caesarean sections because it will be less inconvenient for them and they will—according to yesterday's article about 'How I had my baby by caesarean section so as to have no pain'—have no pain.

Ms S. Littlejohn—I think that is a part of our culture of wanting it. It is an immediate culture of wanting it fast, when we want it and how we want it. Childbirth just does not fit into this idea of our fast, immediate culture. There needs to be a re-education of our expectation of this part of life. It is not surprising that women think that they should have birth with no pain and that at 10 o'clock on a Monday morning that is when they want it, because that is what our culture directs everything to. I think there needs to be a cultural shift to the normalcy and the naturalness of birth as a life event, as an event our body has and that it is not something that just happens to us.

CHAIR—Has any of you found that you have had to talk with women about the idea that having a baby vaginally is preferred to having a caesarean?

Ms Pratt—No, I have never had to actually discuss that it is preferred. I find that women come to me already with that opinion—'That is what I want.'—and I support them in that. As Sally says, there does need to be a cultural shift and I think the media, as you say, are saying all the time, 'Caesarean sections are okay—they are really just another way to have a baby,' instead of saying the opposite, 'Caesarean sections are not another way to have a baby, they are a major abdominal operation and vaginal birth is the normal, natural way and that pain is okay.'

CHAIR—It seems curious to me that you could say having a baby by caesarean section avoids pain. I guess it may stop you grunting and shoving for a couple of hours but, on all good authority—as Senator Gibbs has said—we are not born with zips and stitching people up after an abdominal operation carries with it some days—if not a week or so—of considerable readjustment.

Ms Sally Littlejohn—I find so surprising this culture that there is more adversity in somebody choosing to have homebirth than in somebody choosing to have major abdominal surgery. Someone choosing homebirth is looked upon as being dangerous and stupid—there

are all kinds of judgments made for that decision—as against somebody who elects a caesarean.

CHAIR—It would be interesting to finish on that, because we had evidence given to us yesterday that, if women are asking for a caesarean section, doctors say, 'Of course we would do it,' because of the fear of litigation and because women are now able to have a right in making decisions. If women ask for no intervention, they are regarded as slightly off the planet. They are far less likely to have their request for no intervention taken seriously but the request for a caesarean is taken seriously.

Ms S. Littlejohn—With caesareans you are seen to have done everything possible whereas, if you do nothing and are very hands off, then you have done nothing; there is nothing written down to show that you have done everything possible.

CHAIR—It is actually called fear of litigation. We do have to finish and I think we have been assisted by your being bothered to come and give us evidence. That fits with what the midwives were saying in evidence in Melbourne yesterday. I thank you very much. If there is anything that you have not said and passionately want to say, please feel free to contact us. We will no doubt follow up with you anything further that comes to our attention.

Proceedings suspended from 1.22 p.m. to 1.49 p.m.

REDDIN, Sister Edith (Private capacity)

TURNBULL, Dr Deborah, Senior Lecturer, University of Adelaide

CHAIR—I welcome Dr Deborah Turnbull and Sister Edith Reddin. The committee prefers all evidence to be heard in public, but should you 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 would give consideration to your request. We have before us your submission No. 19, are there any alterations or additions you would like to make to that?

Dr Turnbull—No.

CHAIR—Can we ask you to make an opening statement and then field questions.

Dr Turnbull—Our submission is twofold. Firstly, we wish to report on the evidence for a particular model of maternity care and that is midwife managed care or continuity of midwifery care. We are going to present the results of a systematic review published late last year in the *British Journal of Obstetrics and Gynaecology* which presented data indicating the benefits of this model of care as well as the risks. Secondly, we wish to refer to the reference on information on choices for women and our recent paper in the *Medical Journal of Australia* which talks about choices and information with respect to caesarean section.

CHAIR—Do you wish to talk to that or did you want us to ask you about it?

Dr Turnbull—I am happy for you to ask us about it, if you would prefer?

CHAIR—Could we start then with the information provided to women and the caesarean section rate. One of terms of reference for this inquiry is the very different caesarean rates across the country, between states, between hospitals and between public and private patients. It has been very interesting today in South Australia, where we have the highest caesarean rate, to find all that information confirmed. I do not believe we yet have a good handle on the sorts of steps people might take to lower the caesarean rate. Though, we have had a commitment from a number of people today that it would be a good thing if it were lower. I wondered whether you could tell us whether the information provided to women makes a difference and what sort of difference it makes?

Dr Turnbull—The paper which we published in the *Medical Journal of Australia* in the last two months indicates several things. We did a survey with 278 women who had caesarean sections here at the Women's and Children's Hospital. Thirty per cent said that they had not been involved in the decision making. We found that between 20 and 50 per cent were not entirely satisfied with their input into the decision making, the decision itself or the information provided.

Very interestingly, we found that approximately 25 per cent of women told us that they had some sort of preference for caesarean section. This was indicated by two particular items which said, 'I was very keen to have a caesarean section or I told the staff right at the start that I was keen to have a caesarean section.' Also, very interestingly, we found that, in about

one-third of the cases, where the doctors presented an alternative to caesarean section, such as external cephalic version, the women declined the alternative.

Senator GIBBS—Can you tell me what that actually is?

Dr Turnbull—It is when there is an attempt by the clinician to turn the baby in utero. When the baby is in the breach position there is an attempt to turn it so that it is head down and engaged and ready for delivery.

CHAIR—That evidence is a little confounding. On the one hand about one-third of women felt as though they were not involved in the decision to choose a caesarean section and, on the other hand, 25 per cent said that they wanted a caesarean and go away with alternatives.

Dr Turnbull—Yes, it is very confounding and for that reason what we did subsequent to that study was a qualitative study with 10 women where we spent time doing more in depth interviews with them. They confirmed the results—that is, that it is a very complex issue and when women talk about it they will not necessarily discuss their views and their choices in consistent ways.

CHAIR—I think my committee colleagues and I are struggling to deal with a very paradoxical piece of information—that is, women, who for 200 years if not 2000 years, have been completely powerless and ignored at child birth have suddenly become all powerful and if they ask for a caesarean section they will get it. Could you care to comment on this rapid change in women's power at the time of child birth? We do allow a streak of irony in a question.

Dr Turnbull—One thing that I can comment on from the data is this: our study showed that women who seem to have a preference for caesarean section are no different from those who do not. I know that a lot of individual clinicians talk about articulate middle-class women having stronger preferences, wanting to plan the event and, therefore, demanding it more. Our research with a consecutive group of women, sampled in a systematic manner, does not indicate that that is so. The women who have preferences for section are no more likely to be educated women, they are no more likely to be older women, they are no more likely to English speaking women.

CHAIR—What is it do you think that is encouraging women to be inclined to caesarean section if not directly choosing it from the word go?

Dr Turnbull—The study shows that that very much depends upon whether they have an elective or emergency section. The women who have an elective section talk about things like being able to plan the event. I think that they probably feel they are going to recover better, whatever that means. They often think about the issue of pain. They probably feel that it is going to be less painful. On balance, when we interviewed the women, both in a quantitative and qualitative sense, they very much talked about or thought about caesarean section as being less risky for the baby. They very much couched their reason in terms of safety to the baby.

CHAIR—Have you done any comparable interviews with the doctors or midwives who were providing the information and/or do you think that would be a useful addition to the research and information you have?

Dr Turnbull—We have not spoken with those two groups, but I think it is imperative that it be done. This particular study was funded by a very small grant from this hospital, which, I think, indicates the support that they are giving to this particular issue and trying to address it. I think the other two groups need to be addressed as well.

CHAIR—It seems that there is an agreement on what the figures are—a 23 per cent average caesarean section rate in South Australia. That is a bit higher than anywhere else in the country and nobody is boasting about that. Nobody is saying, 'Isn't that beaut and if there is any luck we will get it up to 50.' In fact, most people are saying, 'We would prefer to see that rate lowered.' It is a bit difficult to know what is going to be done to lower it or what sorts of things make it effective, but no-one is cheered by such high figures. Does your research give you any clues about what sorts of things we can do to lower that rate?

Dr Turnbull—We have done a fairly extensive review of the evidence to find out the potential for different interventions. So far, all we have been able to do is identify things that do not work. We know that restructuring the payments system does not work. We know that other kinds of structural interventions do not work. On the other hand, we think that one thing that may work is improving women's access to information. What we have proposed more recently is an intervention package which would be integrated and multifaceted and which could be controlled in a proper, randomised, controlled trial. This may not go towards reducing the emergency rates, which are the ones that account for the largest proportion, but it may well address the elective rates to a certain extent. We have been attempting to pursue funding for that particular intervention.

Senator GIBBS—Do you think that if we had best practice guidelines on a national basis that they would bring down the rate of caesarean sections?

Dr Turnbull—No, I do not. The evidence to date is that those sorts of guidelines can be developed. The first author of one of the papers included in our submission, Dr Chris Wilkinson, who could not be here today, created a set of guidelines for Scotland alongside a group of Scottish obstetricians. They were able to create the guidelines, but after implementing the guidelines they had no impact at all on the c section rate. If anything the rate subsequent to publishing the guidelines has increased from about 16 per cent to a little bit under 17 per cent.

Senator GIBBS—It is interesting what you say because most of the evidence we have heard so far from the medical profession—obstetricians and the like—is that the women who are demanding the elective surgery are the educated, wealthier, middle-class women as opposed to women who cannot afford private health care, cannot afford private hospitals and are in the public hospital system. Basically, your findings are the reverse of what they are actually saying.

Dr Turnbull—Yes, in my view they are saying that because they are the women that they are seeing. It is an issue of selection bias. They are seeing a select group of women so

they have no points of comparison. Our study was based on a complete, population based sample, representative of the women who were delivering at this particular hospital. I think it reflects the fact that they are seeing different women.

Senator GIBBS—We have heard from quite a few midwives in our inquiry that the constant care that the midwife gives to the mother on a one-to-one basis results in the women being less stressed and less likely to actually go for the caesarean birth. How do you feel about that? They go to the midwife first because they want the natural birth and they want that ongoing care. They believe that if all women were educated on natural child birth and on having the epidural, the caesarean and the so-called pain free birth and they knew about the side effects of pain and so on, more women would actually go back to the old ways.

Dr Turnbull—I think they feel that because the women they see are more likely at the very beginning to have preferences for vaginal deliveries. One thing that our study confirmed is that there was a tendency for women that had those models of care have different preferences at the outset. The systematic review, which we have included in the submission, involved over 9,000 women in five industrialised countries and was conducted over eight years and that indicates that when you do this sort of study and implement midwife managed care in that way it has absolutely no impact on c section rates.

The models of care have got lots of advantages. For example, they can result in reduced induction and reduced augmentation; they can reduce episiotomy; they have better continuity of care; they produce more satisfied women; they are safe for the baby. But, on the other hand, they do not improve the c section rate.

The other thing is that this systematic review indicated that, whilst these models of care have got a lot of advantages, one thing that needs to be drawn to your attention is the fact that we found that women who had this model of care had an odds ratio for perinatal mortality of 1.6, which indicates that they were 60 per cent more likely to have this particular outcome than women who had traditional models of care. And that particular statistic was bordering on statistical significance. With the exception of only one study they were all in the same direction; that is, they indicated elevated risk, albeit very minor elevations in the midwife managed care.

I think it does indicate the fact that these particular models cannot necessarily be implemented in a cart blanche manner, and they certainly cannot be implemented in a manner which means that they are totally isolated from the major tertiary setting. What we found with a sensitivity analysis, which is not included, was that those models of care which had the worst perinatal mortality were those that had the lowest rates of intervention.

Senator GIBBS—That is interesting. So with the midwife care, if I can understand what you are saying, you would prefer to see the birthing centres actually attached to the hospital as opposed to being outside the hospital so that, if the women need the medical care, it is actually there?

Dr Turnbull—What I am saying is that, in my understanding of the evidence, the models of care which produce the best outcomes, both at a psychosocial and a clinical level,

are those whereby they are integrated within the main hospital setting—irrespective of how you might define that.

CHAIR—In your submission you say on page 3 that a Scottish study found that 20 per cent of caesarean sections were conducted at maternal request rather than for medical reasons. Do you think it is the same in Australia and what does 'maternal request' in that sentence mean? Does it mean that they arrive wanting one out of the blue or at the beginning or, given options for best management, they then say, 'I will have a caesarean'?

Dr Turnbull—I think you can define it fairly loosely, because in that particular study the data were collected through a computerised audit whereby the doctor input the data after they had done the section. So the chances are that 'maternal request' could mean any of those things.

What I can tell you is that our study confirmed those data. We found that at this hospital, as I said, about 25 per cent of women express some sort of preference; that is, those women who have had a section. Very interestingly, for those women who had had an elective section, it was as high as about 45 per cent. Overall, we found that approximately 10 per cent of women who had had the sections very strongly agreed that they had some sort of preference. Those data have been replicated in a study from Perth by a woman called Julie Quinlivan, who used a different method to ours but came up with somewhat similar results. There are also British data indicating that similar things are happening in Britain.

CHAIR—Do you have any data or any research that you can refer us to that collaborates the complete reverse of that evidence that was given to us yesterday in Melbourne, which was that if women ask for a caesarean section they are extremely likely to get it; if they ask for a non-interventionist birth, they have a very low likelihood of getting it?

Dr Turnbull—No, I am sorry; off the top of my head I cannot think of any study which has looked at that systematically that would help you.

CHAIR—Do you think it would help you to know about that?

Dr Turnbull—Absolutely.

CHAIR—It is really like the other end of the equation, is it not? Women who seek an independent midwife or an alternative birth, as it is called, find quite often, from the evidence given to us, that they are being pressured to have some kind of intervention or they are told very early on about the interventions that they are likely to need. But if you choose to have a home birth or an alternative birth, you are a bit odd as a woman and you have then got to sort of fight the system. Whereas it seems that if you say, 'I would like a caesarean section,' you are welcome. Do you have a sense that the evidence we have been given along those lines is consistent with what you know?

Dr Turnbull—No, I do not, I am afraid.

CHAIR—What about you, Sister Reddin?

Sister Reddin—I can only answer that anecdotally, from my own personal experience. I think that there is a very real culture of women who want to do things the natural way as perhaps being a bit odd and going for those alternative fringe type things. I work in both the public and the private sector, so I see both extremes. The perception that I get is that when women are paying good money to have a doctor look after them, they want the doctor to look after them. If they want a certain thing—for instance, a caesarean—they feel that they are paying him or her and he or she ought to do it. I think they put as much pressure on the doctors perhaps as the doctors put on them, in some cases.

Senator GIBBS—Our witnesses have actually said that that is the case, that women do pressure them, and litigation is a big problem with the doctors.

CHAIR—That is a separate question though, is it not?

Senator GIBBS—Yes.

Sister Reddin—Studies show that there is more litigation regarding having not done a caesarean than having done a caesarean. There are very few cases up and running in terms of doctors who have done caesareans, whereas there are doctors that have not done caesareans that the litigation is against. That is an American study, however, even so—

Senator GIBBS—That was their reason why they said that, if the patient wants a caesarean, they will do the caesarean because, in the back of their minds, they are thinking, 'If I do not do it and something goes wrong, I am going to be sued.'

Sister Reddin—I think the nail was hit on the head when it was said that women put the baby first and they do not think in terms of the risks to themselves, as long as they get a healthy baby at the end. I think that that, more than anything, is the thing that really drives women.

CHAIR—So claims like, 'I had a caesarean section and I felt no pain' do seem to suggest that she has got herself at least in the frame?

Sister Reddin—We talk about modern women and being in control. I think the fact that you can say, 'I am going to have my baby on this day, I am going to be recovered in six weeks, I am going to be back at work,' whatever, gives you a certain amount of control. If you have never laboured, you do not know what labour is like, you do not know whether you are going to cope or not and the fear of that unknown can be overwhelming in some women. I do not like to put people in pigeon holes, but a lot of the more career orientated women are very in control people and do not like to not be in control. I really do believe that that is a driving force. I have no evidence for that; that is just an anecdotal thing, but I do see that quite often amongst the women that I look after.

CHAIR—Would either or both of you care to comment on a lively tension between an assertive woman asking for a caesarean section and best practice and/or whether or not an obstetrician would be abandoning his or her professional objectivity, professional status, to just say, 'Yes, sure, you want a caesarean section, that is okay, I can do that'?

Sister Reddin—One interesting study I found from the United Kingdom that actually was successful in reducing the caesarean rate was where doctors basically had to have a peer review regarding why they chose to perform caesareans. That actually did have an impact on the caesarean rate. They had to say, 'Okay, this is why I did this.' When you have to come to your peers and say why you did it, I think that is probably making them accountable for that.

CHAIR—An obstetrician saying to his peers, 'Mrs Jones asked for it' suddenly does not sound sufficient. That is what the evidence suggests.

Sister Reddin—Yes.

CHAIR—In your report from the Scottish study, do you have any evidence of how consensus was reached amongst the clinicians on strategies to reduce the caesar rate?

Dr Turnbull—The first stage was to collect data about what was currently happening in the country as a whole. That was done by putting a computer into every labour ward in the country and getting the doctors to prospectively audit what their practice was. That data was presented to a group of obstetricians who were named in the back of the report, and the decision about the guidelines came about through a consensus.

CHAIR—Do you think peer review was an element of that?

Dr Turnbull—I am sure there was an element of that kind of thing in that particular process, yes. But at the same time what they were taking into account was the evidence about safe alternatives to caesarean section that were presented in that particular paper. They made four recommendations about practice. Despite those recommendations, it has had absolutely no impact on the rates which continue to rise in that country.

CHAIR—I am not sure if your study picked up on this—please help me: we have been told in other evidence here that the information provided to women is very patchy, very uneven and often a woman will have to seek it for herself. Mrs 'Modest' and not Mrs 'Middle-class assertive' will have to chase it down. Most women front their GP for confirmation of pregnancy, and the GPs are, as described to us, pretty poor at providing any information about antenatal classes, childbirth education or anything of that sort at all. GPs are not likely to say, 'Of course, you can ring Miss so and so, the local midwife.' People are not steered that way. They are probably guided to a hospital—which hospital will you have your baby? Then they might pick up some more information from the hospital. So the information that is provided to women is very patchy and very uneven. Quite often they do not get to have a serious talk about the options until around about the time of birth.

Dr Turnbull—Our study definitely confirms that. We found in our study that there were varying degrees of dissatisfaction with women who had sections. Information in particular was an issue that they were not happy with. For example, they were not happy with the extent of information they were provided on safe alternatives—different choices that they may well be able to make.

Sister Reddin—If I can just give an example. In putting together this pamphlet, we discovered that the highest caesarean rate is in repeat caesareans so that if you can reduce the primary caesarean rate then obviously that is going to have an effect. But there is a huge area for reducing the caesarean rate by having a vaginal birth following a caesarean. There are certain reasons that you might need a caesarean the first time round, but that does not necessarily follow for consecutive pregnancies.

Just recently, we had up at Flinders a lady who rocked up to the labour ward feeling a bit unwell. She had had three previous caesareans. By the time they assessed her, she was pushing and had her baby. If she had come along normally early in labour, there is no way that they would have let her have a normal delivery because they would consider that not to be safe. There is probably a huge area out there of women who are having repeat sections—maybe because they choose to but maybe because the pressure on them. I believe that that could cause our caesarean rate considerably.

CHAIR—That might also be a case for staying home for a longer time and come in late. I am very interested the basis of your research which is so powerful, and that is it very much depends on the information that is provided and how it is provided. I think the evidence that 25 per cent want caesar and 30 per cent did not think they had a say in it is an astounding piece of contradictory or conflicting evidence. What are you planning to do next?

Dr Turnbull—What we are embarking on now is developing an intervention which will provide women with the kinds of information we have discussed. It includes the pamphlet that Edith has developed, a video, a peer support system. It is an integrated package that women can access—really importantly—not just from the hospital but also from home. I would like to report to the committee that this particular idea has been met with a degree of scepticism, and attempts to have it funded have not been successful.

CHAIR—Scepticism from?

Dr Turnbull—From the broader public health profession. I think they are sceptical because the evidence is that just providing people with information is not enough to change. We are trying to design this particular package so that it is not only information based but also attempts to deal with effective or emotional issues. For example, a very interesting Canadian study came out late last year which indicated that one of the main predictors for a woman have having a caesarean section was to do with motivation. The women who had vaginal deliveries were the one who were the most motivated to have a vaginal delivery, and that was irrespective of whether they had been randomly allocated to a particular intervention group or not. It is not just about providing information but also providing it in a way where you are addressing motivational or emotional issues.

CHAIR—In light of what you have said earlier about the importance of providing that kind of information to the providers of information—to the obstetricians and midwives—would you make this package of information available for them or would you make sure that it were directed to them or would the college suggest that you keep your nose out of their business?

Dr Turnbull—Ideally, I think the intervention should include the professional groups. They need to be primed for those situations where women come to them with our information pamphlets so that they will at least have a position on them. In the first instance though, we are devising the intervention specifically for the women.

CHAIR—If we are told that there is a culture that needs to change—a culture in our hospitals, a culture in our society that says, 'When you are pregnant, women, go to hospital and you will have your baby there with more or less intervention,' and that is being good, that is getting a good baby with a high likelihood of success out of it all—what you are saying is almost that, in a sense, the culture can stay the same but women will feel differently about it? Or are you saying that, with that information, the process of getting that happy baby might be different and the numbers of caesarean sections might fall?

Dr Turnbull—The intervention should operate on a lot of different levels. In an ideal sense, any intervention like this would probably aim to have an outcome whereby the section rates were reduced. But in my view that is very problematic. It is very problematic about what we say the ideal rate is—what level should we reduce the rate to? That is very complex. You cannot make an arbitrary decision about that.

CHAIR—The WHO has a figure.

Dr Turnbull—They have a figure of 15 per cent, yes. But, on the other hand, we have to include psychosocial outcomes. It is no good in aiming for arbitrary rates if all it is going to do is result in a group of women feeling guilty and inadequate if they themselves do not achieve vaginal birth. I think that we need to aim for some sort of reduction in interventions, whatever that might be, but not at any cost and particularly not at any cost to the psychosocial wellbeing of the women.

CHAIR—Last question: do you have a view, either or both of you, about a thing that I think is quite remarkable and that is the culture of acceptance of such a high rate of caesarean section? It is really back to the question Senator Gibbs asked in the first place that, compared with a little while ago, we now find newspaper articles and stories—

Sister Reddin—My input into the study we have been doing has been to create a pamphlet that explains alternatives that are available. What I find from women is that they want that baby to be healthy and they do not care what they have to go through to get that healthy baby. They do not appreciate that, by having a vaginal delivery, their baby can be or will be as healthy as the baby born by caesarean and that the differences are not that statistically significant in terms of the mortality or morbidity rate. So they tend to think, 'At least if I have a caesarean, the baby is going to be all right,' and they do not look at the effects that it has on them. I think they are not even aware that the effects exist.

CHAIR—But are they being told that in fact a vaginal delivery may be safer for the baby than a caesarean section and that there are risks for the baby in having a caesar?

Sister Reddin—I think there is not enough information out there. One of the things that we discovered through doing this was that the information about caesarean section is very sparse.

CHAIR—There is a whole lot of mystery and mumbo jumbo that surrounds childbirth, but there is emerging evidence that a vaginal delivery is helpful in helping to establish breathing in a baby. This is not possible through a caesarean section.

Sister Reddin—The physiology of birth is such that, as the lungs are squeezed out through the vagina, that first breath expands the lungs maximally, so that sort of dries them out; whereas in a caesarean birth that fluid is still within the lungs and that can pose some breathing problems.

CHAIR—It is interesting. I can see that women would want to have a safe baby but to me it is still quite breathtaking that, somehow or other, people are equating 'shove it out or cut it out' as being comparable. That to us on the committee was astounding. How has this happened? We have had evidence provided to us that in some private hospitals in South Australia and in other places in Australia the caesarean section rate is 50 per cent—one in two women will be delivered of caesarean section as private patients. It is a cultural change that is sweeping around the place. I must say that the evidence is not there that I know of which says the caesarean section is comparably as safe as a vaginal delivery. If women are saying, 'All I want is a happy baby, let us cut it out and we will be right,' then somebody is giving those women a very strange misrepresentation of the facts. Would you agree?

Sister Reddin—I would agree.

Dr Turnbull—Yes. I think our second study, the qualitative study, suggests that the women say that they are making the decision but they are making the decision frequently on the advice of the doctor, and sometimes they say that the advice is presented as though the section is really the only alternative. Even though the decision is theirs and they say the decision is theirs, at the same time they report that they are responding to information provided by the broader system.

CHAIR—We have probably gone beyond our time again. Thank you very much for your submission, to say nothing of your excellent research, and best of luck with the next section.

[2.31 p.m.]

VNUK, Dr Julia (Private capacity)

CHAIR—Do you have any comments to make on the capacity in which you appear?

Dr Vnuk—Yes. I am a general practitioner working in Port Augusta.

CHAIR—We prefer 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 can ask to do so and the committee will give consideration to your request.

Dr Vnuk—I was involved with the submission from the Maternity Advisory Group, which is a consumer provider group in Port Augusta which has been operating for the last five years. I suppose I represent the views of some consumers and the GPs in the region because I work for the Division of General Practice. In the country there are quite limited options for choices of care. We have heard about a lot of different choices of care that women have in metropolitan areas. In the country we have quite limited options, particularly in terms of midwives, antenatal and postnatal care, the option of having a woman practitioner at the birth, and homebirth. This particularly disadvantages Aboriginal women who do not access mainstream care very well in the country.

We have a low number of GPs and obstetricians. We have doctors all the time stopping doing obstetrics; there is a lot of concern about that in the country. The main causes are fear of litigation and the cost of medical indemnity.

We have talked about best practice guidelines, which need to be national. There needs to be support and assistance in implementing these in the country because the situation is quite different. There needs to be assistance in how these can be implemented where there are not the facilities that there are in metropolitan hospitals.

We have talked about whether or not women demand caesarean sections and whether or not they make informed decisions, particularly Aboriginal women. I cannot give you recent statistics in the country—25 per cent of births at our hospital are Aboriginal babies—but several years ago the caesarean section rate for Aboriginal and non-Aboriginal women was more or less the same, except that there were more emergency sections and less elective for Aboriginal women, compared with non-Aboriginal women. Whether women are asking for it, whether it is for the convenience of the doctors or the doctors are making that decision, it is difficult to determine. With Aboriginal women, as in a lot of aspects of their care, the communication barrier is so great that it is really difficult to say who is making the decision. The doctors feel that they are consulting with Aboriginal women, but the Aboriginal women say that they were not consulted adequately.

CHAIR—Which might confirm some of Dr Turnbull's evidence. Do the Aboriginal women in your neck of the woods speak English as a first language?

Dr Vnuk—No.

CHAIR—Almost none of them?

Dr Vnuk—A lot of them do speak English as their first language, but some of them come from remote areas. The Pitjantjatjara women in the north of the state go up to Alice Springs but the other women mainly come down to Port Augusta to have their babies.

CHAIR—It is a long way from Port Augusta to Alice Springs if you are a Pit woman.

Dr Vnuk—Yes; women in the Pitjantjatjara lands right up the top. Women in the Yalata and Maralinga lands come to Port Augusta. The Oodnadatta, Ceduna and Cooper Pedy women all come down to Port Augusta.

CHAIR—So Port Augusta is really the hospital for the north.

Dr Vnuk—Yes.

CHAIR—Do you know roughly how many babies are delivered there each year?

Dr Vnuk—About 300.

CHAIR—Is that right? That is not very many—one a day for that whole area. About 25 per cent of those deliveries are Aboriginal?

Dr Vnuk—Yes, and there is a very high teenage pregnancy rate among Aboriginal and non-Aboriginal women.

CHAIR—And a high caesarean rate for teenagers?

Dr Vnuk—Yes.

CHAIR—Do you have any other data that you could provide, if not now at least later?

Dr Vnuk—Yes, I may be able to provide some.

CHAIR—Particularly concerning caesarean section. If there were a breakdown of public and private patients at the hospital, that would be helpful, if you could provide it.

Dr Vnuk—Yes. I will see whether I can provide all that.

CHAIR—And the difference between Aboriginal and non-Aboriginal.

Dr Vnuk—Yes.

CHAIR—Do you know how many people who might otherwise attend your hospital choose to come down to metropolitan Adelaide for birth?

Dr Vnuk—Yes, we have a so-called leakage rate, people who come down to Adelaide. Not many Aboriginal people at all would come down, unless they transfer down in labour or

antenatally. Aboriginal women prefer to be as close to home as possible to give birth. Even coming down to Port Augusta is not appreciated by a lot of them and some women will remain in the home community and have their baby there, even though the hospital is not set up for that. Some of the non-Aboriginal women do come down, particularly women from Roxby Downs and places like that. They come down because they want a different type of care.

CHAIR—Thank you. If there is anything further, in particular things like how hard it is to get a doctor into the country, let alone an obstetrician—

Dr Vnuk—Yes it is hard and it is hard to keep them there.

CHAIR—We have run out of time. If you were to write something for us, even just dot points, that would be good. We do not want you to write a philosophical essay, just any data you could provide would be really very useful. We will conclude there, unless you have one last thing you are busting to say.

Dr Vnuk—I just want to say that our caesarean section rate is very high but any attempt to decrease the caesarean section rate must be supportive of the practitioners because the precariousness of the situation, because if rural GPs pull out, then there will not be services.

CHAIR—Thank you very much.

[2.38 p.m.]

PRIDMORE, Dr Brian Roy, Director Obstetrics and Gynaecology, Queen Elizabeth Hospital

CHAIR—The committee prefers all evidence to be given in public but should you wish to give evidence, part of your evidence or answers to specific questions in camera, you can ask to do so and we will give consideration to that request. Would you like to make a short opening statement and then we will ask some questions? We will be visiting with you later.

Dr Pridmore—I look forward to that.

CHAIR—Thank you.

Dr Pridmore—I would like to comments on two issues which I know you have heard a lot about in the last two days. One is the size of public obstetrics units in the future and the other is the caesarean section rate. I am sure you are aware that in South Australia our delivery rate is dropping. We have data about this. Partly in response to that there is a report before the South Australian government suggesting that five public obstetric units in Adelaide will be reduced to three. Needless to say, the community are unhappy with this, particularly those who may lose their unit.

However, because of economies of scale, casemix funding, shorter doctors' hours et cetera, smaller units can no longer function within the budget allocations from government, particularly because of casemix funding. For instance, our own unit requires five registrars for 1,200 deliveries; we would require five registrars for 600 deliveries and we would require five registrars for 1,600 deliveries, with obvious differences in the amount of funding we get. In addition, smaller units do not have the numbers of women who would benefit by extra help—such as teenagers or Aboriginals—to justify special clinics for them, as do larger units. I refer particularly to Monash, which I visited recently.

In Britain the maternal mortality committee looking purely at maternal deaths advocated there be fewer, bigger units across England, with at least 18 hours—preferably 24 hours—of in-house consultant cover, as distinct from in-house registrar cover. On the other hand, smaller units can be closer to the target population and can provide a more personal service with opportunities for doctors and midwives to work closely closer together and to appear to the women less rushed. In fact, one woman described the smaller services as 'boutique, as distinct from supermarket'. However, just as in retailing, boutiques will offer a more exclusive range and perhaps more personal services but at a greater cost. Therefore, if smaller units are to survive—as the community wishes—someone has to pay for them. That is a problem for governments.

I will turn my attention to caesarean sections. Our hospital has a caesarean section rate of around 15 to 16 per cent in a state where it is normally 23 to 25 per cent. I have spent a number of years looking to find why our rate is different from that of other hospitals and the only factor that I can come up with is that we have a very low elective caesarean section rate—about five per cent—whereas the state average is 10 per cent, which suggests we are prepared to give more women a try in labour. When you look at the indications for caesarean

sections, the actual percentages are the same, whether it is a 16 per cent caesarean rate or a 25 per cent caesarean rate.

I have tried to put down, from my experience, what I think are the reasons for the high rate. I have put three reasons down for doctors. One is that we trying to train more doctors in Australia on fewer deliveries, making doctors less confident about abnormal presentations such as breeches. Hence they advocate caesarean section, the skill level drops and therefore they advocate more caesarean sections. This applies even more in country areas, where if you are only doing 50 to 100 deliveries you might be faced with one breech a year; no doctor in their right mind is going to continue doing one or two a year.

Medico-legal concerns—which I know you have been bombarded with—weigh too heavily, I suspect, on our minds and are probably often used as an excuse. However, to support what the lady here said a minute ago, I can say I have been involved in some 20 or so cases of obstetric litigation—not on my own; reporting on, I should say—and 19 of those would have been for not doing a caesarean section or not doing it quickly enough and one would have been for doing a caesarean.

The third reason is time constraints. Doctors are no longer able or willing to wait the longer times often required to achieve a safe vaginal delivery. This was indicated by a study in South Australia some 15 years ago where the highest rate of emergency caesarean section was between 6 o'clock in the evening, when people finish consulting, and 10 o'clock at night, before they went to bed.

From the woman's point of view—and by 'woman' I include family because men often have an input into the decision—I have suggested that some reasons might include a desire for more input into their management; concerns about outcomes particularly with conditions such as breeches, which has women—having read the *Women's Weekly* in the 1970s about how dangerous they are—now saying, 'We will have a caesar,' so there are fewer breeches for us to train younger doctors on. A lot of women are now giving as a reason the protection of the pelvic floor, particularly as we move towards smaller families. We recently had two professors from China visiting us and they said that, with their country's one-child policy, their section rate was 50 per cent because women said, 'If I am only having one baby, why should I risk incontinence?'

Women no longer want long labours. Most women would now consider 14 hours as a long labour; when I was a registrar, it was two days. Some women want control over the timing of delivery. There is a certain amount of natural selection in this, I feel, because women who want a caesarean will often seek out a doctor or a hospital who will do it on request, just as women who want a vaginal delivery with, say, a breech presentation will seek out a doctor or a hospital sympathetic to their cause.

I believe there is no such thing as a right caesarean section rate. I would suggest that the ideal rate is the one where the maximum number of women and carers feel happy about their decision, with satisfactory outcomes. There is probably no optimal way to reduce the caesarean section rate but I would suggest that caesarean section police, as I saw advocated in today's *Advertiser*, is not the way to go. That would guarantee the closure of most country obstetric units and reduce its availability in other areas.

From our experience at Queen Elizabeth Hospital—and these are anecdotes; there is no science, I am sorry—I think the following points are important. There must be a commitment by all staff to achieve a vaginal delivery without compromising the woman's and baby's safety. There must be a close working relationship and a build-up of trust between doctors and midwives; neither group should be prepared to go it alone. I believe there should be more midwifery-led care with rapid and consistent medical backup as required. This care can be virtually nil by the doctor, for women when everything is going fine, up to a significant output in conjunction with midwives for women who have medical or other obstetric problems.

We should allow more women to go for a vaginal delivery if they wish to try for it. This means we should see a higher emergency section rate and a lower elective section rate. There must be joint decision making with the woman, her family, the midwife and the doctor. Thank you.

CHAIR—Thank you very much, Doctor. You used the very interesting expression of women seeking out 'a doctor who is sympathetic to or a practitioner who is sympathetic to' vaginal delivery or vaginal delivery of breech. That sounds contrary to best practice guidelines. Would you care to comment?

Dr Pridmore—We do not have a lot of best practice guidelines. We are in 1999 and the Canadians are currently running a worldwide trial of randomising women to have a vaginal breech delivery versus caesarean section. They would not be doing that if we knew what was the best way to deliver a breech. We do not have best practice guidelines to guide us in many things in obstetrics.

CHAIR—That is interesting. Last Friday in Canberra we were given data by Dr Paul Lancaster from the Australian Institute of Health and Welfare. He said much of what happens in pregnancy and particularly in childbirth really amounts to large uncontrolled experiments. You are effectively saying the same, that there is no controlled examination of whether three days post delivery is any better than four days or five days or one day and we do not know whether we have should breech vaginally or by caesar.

Dr Pridmore—We do not know. I think that somewhere like Canada, with its litigation, still being prepared to run a controlled trial tells us that we do not have the evidence.

CHAIR—Can you please comment for us on why Holland has got such a low caesarean section rate?

Dr Pridmore—As you know, we have two professors of obstetrics and gynaecology in Adelaide from Holland. You have met one, I believe, Professor Keirse, and we have Professor Dekker. We have obviously talked about this, and they do not have easy answers either. They think there is a culture where there is much more midwifery led obstetrics. Whether this makes a difference we do not know. We believe it probably does. Holland is a fairly small place and no person ever lives more than 50 kilometres from a hospital, which makes it easier to set up a home birth delivery system. And maybe there is something different about Dutch women, although nobody has shown it. Again, none of this has ever

been subjected to a controlled trial, which I guess would be having thousands of Dutch women deliver in Australia and vice versa.

Senator GIBBS—We did hear yesterday that one of the reasons for the higher rate of caesars is that men are now attending the birth and the obstetricians are saying that they start to panic and say, 'Come on, Doc, she is in a lot of pain here. Can't you sort of hurry it up?' That is not only caesars but any intervention at all, and they are not prepared to stick it out. Have you found any evidence of that, where the men are the ones who are motivating this?

Dr Pridmore—I cannot say that I have ever felt pressured by relatives to do a caesarean. There is no one explanation, and I do not think it is possible to say that it is because of the woman, the doctor, the midwife, the husband or the next door neighbour, who often has a view too. The whole culture in Australia seems to be that caesarean section—I hesitate to suggest that there is a badge of honour but I think sometimes it seems like a good thing to do. 'I went to Dr So-and-so and he said that I must have a caesarean section,' so a lot of your friends go to the same doctor if that is what they want to have.

Senator GIBBS—It really is a culture, isn't it?

Dr Pridmore—Yes. It is like businessmen who regard having a bypass as an indication that they are hard-working people. One told me once that you had to have this scar up here as a badge of honour that you were a hard-working businessman.

Senator GIBBS—It could not be genetic at all!

Dr Pridmore—Racial, I think!

Senator GIBBS—You were talking here about screening and the increase of ultrasound and other screening and overordering. You have obviously got evidence of this—

Dr Pridmore—Only that I guess the government is spending $70 million or $80 million a year just on obstetric ultrasound.

Senator GIBBS—Too much.

Dr Pridmore—Well, I think it is time somebody looked at it. My suspicion is that it is too much; it may not be. Again, it is difficult to get good controlled studies now because women and doctors find it difficult to move in obstetrics without an ultrasound.

Senator GIBBS—And maybe too much there but not enough in other screening. I know you are recommending screening for HIV and hepatitis C.

Dr Pridmore—I do not know that I recommend it. I said that I think we are coming to the stage where hepatitis C is sufficiently common that we should be screening for it. Obviously it depends where you are practising, but in our own hospital we probably do not see more than one case of syphilis a year now in our obstetric population, whereas we are probably seeing 20 cases of hepatitis C a year.

Senator GIBBS—I was just interested in that, because one of my pet interests, I guess, is the use of illicit drugs. In our investigations, one of the things that has disturbed me a little is the speed with which women are let out of hospital, such as, within a couple of days. They have the baby and, say, three days later they are home. One of the witnesses said that maybe it is advisable for some women but not for others. Maybe that mother is a substance abuser, and the child could be addicted down the track. Most substance abusers usually have some sort of hepatitis, don't they?

Dr Pridmore—I do not know about most.

Senator GIBBS—They will get it eventually.

Dr Pridmore—I hope not.

Senator GIBBS—That has just been my experience anyway. Is there any sort of screening for substance abuse in mothers?

Dr Pridmore—Only in that we ask direct questions in the antenatal period, such as whether they take drugs—prescribed drugs, over the counter drugs, illicit, whatever you want to call them. While I am not pretending that there will not be some women who deny it, most women are sufficiently interested in their babies that they will tell us about it, I believe. If they are not going to tell us antenatally, we are not going to pick it up because the mother stays in four days instead of three days.

CHAIR—If the baby starts showing signs of withdrawal?

Dr Pridmore—I believe they usually start showing signs within one to two days. I am not an expert, but the other point I would make is that it is very important that women are not sent home early without some sort of support in the home. You will find my last comment in my submission was the disappointment that you tend to stop at childbirth. I think the area that is grossly underserviced in Australia—and it is improving—is for the birth to one-year-old. This is where our greatest benefits are likely to come, not whether the caesarean section rate is 20 per cent or two per cent.

Senator GIBBS—That seems to be the thing now. We have heard that quite a lot. That has been the whole theme through this: once they go home, that is basically the end of the story for the hospital and the carers.

Dr Pridmore—Our own hospital some years ago was able to close a ward and use the money we saved by sending women home early to set up a domiciliary service—and women are at least followed through. They get a minimum of one visit up to a maximum of about 10, depending on what they need. Those midwives are very attuned to trying to plug these women into the appropriate system, depending on what their problem is—from lack of housing, lack of education, help. So I do not have a problem with people going home early, providing they are supported at home. Some evidence we have from our own hospital is that, when we first set up the domiciliary care and sent women home earlier, the breastfeeding rates at six weeks actually rose. What women were telling us was that what they preferred was to see the same midwife each day for four or five days, albeit for half an hour or an

hour a day, rather than stay in hospital and in 24 hours maybe see four different midwives who might give them five different opinions. I do not think we need to be obsessed by length of stay in hospital. There are enough women who want to go home early to balance out those who perhaps need a few extra days in. What we must not be in is the regimented American system where, if you deliver at 12 o'clock, you go home at 12 o'clock two days later, regardless of how you are.

CHAIR—Just to finish, because unfortunately we are pressed for time, the very low rates of infant mortality, peri-natal mortality, morbidity and so on that we are dealing with mean that we are trying to make distinctions about a very small percentage. If you like, the main game has been won in Australia, and we are dealing with the small percentage that is difficult. But the figures are not so good for Aboriginal women. We have a factor of about three, which means that there is more opportunity to have a look at the things we do that might reduce those Aboriginal figures to non-Aboriginal figures in the next short while. Are you aware of anything that you could do or that is being done to tell us what is making and/or will make a difference in reducing the mortality figures for Aboriginal women and their children?

Dr Pridmore—Julia might have told you more because, as you heard, they have a very high rate of Aboriginals. The Aboriginal rate in our hospitals is about two per cent of 1,200 deliveries, and most of them are probably what we might call from the urban population, who perhaps behave—that is a terrible word; I mean to use whatever the correct word is—more like a lot of our caucasian population. Just looking at where we have been successful in reducing the mortality rate for caucasians, whites, or whatever the correct word is, women being in their maximal healthy state prior to pregnancy is important. It is also probably a reduction in the number of teenage pregnancies and a reduction in very big families, I suspect. A lot of these women are quite sick with diabetes, heart disease and things even before they get pregnant, and they are often related to lifestyle. There is still a certain amount of rhematic fever in the Aborigines that we are not seeing in our own population.

CHAIR—There are some very big differences that have to be improving the morbidity and mortality across the board, from antibiotics to blood transfusion. You almost flinch a little, but I am sure in your lifetime you can go back to a time when RH babies was a major concern, or on the cusp of ceasing to be a major concern. Things like blood transfusion and antibiotics have been very big contributors to reducing mortality, or at least morbidity.

Dr Pridmore—They have had a role to play, but I dispute a little how big is big.

CHAIR—Okay, please dispute.

Dr Pridmore—An interesting study came out of Aberdeen back in the 1950s in a population where women were of the barefoot pregnant style and where they hardly got home before they were pregnant again, and it was popular in a lot of the large cities in England—Aberdeen, Newcastle, Liverpool and those sorts of places. Professor Baird had the most success in reducing peri-natal mortality by the central expediency that, after four babies, he would tie their tubes if they requested it, at a time when sterilisation was an absolute no-no. He was pilloried quite severely in England for his liberal approach and yet, when you looked at his data, he had the best peri-natal mortality because he was not having

these poor undernourished and iron deficient women having eight or nine children in quick succession. I am not decrying antibiotics and blood transfusions; I am saying that the healthier the woman who starts the pregnancy and the more time she is given to recover between pregnancies will have a bigger effect on mortality and morbidity than blood transfusions. That is like dealing with the ambulance at the bottom of the cliff instead of putting a fence up to stop people falling over.

CHAIR—I take those points. Can you tell us, just to close, why your figures are so much lower than your those of your cousins in town.

Dr Pridmore—I cannot tell you exactly. But we have three obstetricians—because we do 1,200 deliveries—in charge of all the public hospitals and all three of us have a commitment towards a low caesarean section rate. We believe in giving women a try, so we think alike. We have managed to have an excellent team of midwives, many of whom have been with us for many years. It is trite, I suppose—and you would have to ask the midwives if they agree—but we do work together very well. We trust each other's judgment. If they say that they think it is all right to proceed, we will listen and, if we say no, they will listen to us. The other thing we do is to imbue this into our new registrars, who often—I have to say—come from other hospitals. We have to watch them very closely because they have this idea that a caesar is the answer to all the world's problems. We have to make sure that they ring us regularly. So it is not something that you set in place and then go off and have a couple of beers. You have to be doing it the whole time. I think our data since we opened shows that there were a couple of times when we got a bit slack and the section rate jumped up. We monitor very regularly on a monthly basis.

CHAIR—You seem to be suggesting—if I said that was the last question, sorry; it was the nearly last question—that you reckon there is a place for the Queen Elizabeth Hospital maternity unit. It is not a fair question—'I am in charge of this hospital: do I think it is a good thing? Have I got the lowest caesarean section rate? Yes'—but, if you were trying to fund the optimal, most efficient delivery of childbirth practices, what would be your arguments for why you should stay open? Do you at this stage wish to be in camera?

Dr Pridmore—I do not think, just because we are at the Queen Elizabeth and we have this commitment, that we could not do it in other hospitals or other hospitals could not do it. I do not think it is peculiar to the Queen Elizabeth. I think it is peculiar to the staff and it shows a sense of commitment by all of the staff, and I just happen to be in charge of them. It is not me. Yes, obviously, we would like to stay, but if in their wisdom the government chooses otherwise and there are good strong economic arguments as to why we should not stay, then I would see it as a role of our staff to go and educate the masses in the other hospitals about our philosophy.

CHAIR—What strength do you put on the fact that many of the people from the western suburbs are not just eight kilometres away but in another country? It takes them two bus rides to get here and more of them, rather than less, will have to take public transport.

Dr Pridmore—I agree but, equally, 600 people in our area choose to come to this hospital to deliver and 200 people from the Lyell McEwin area—which, as you know, is at Elizabeth—choose to leave the Elizabeth area and come to the Queen Elizabeth. I feel very

sorry for these people—it is the economics versus the rational, the economic versus what people want. People in Hobart, if they do not like Hobart, have to go to Launceston—that is where the next public hospital is.

CHAIR—I appreciate that. If you live in Saskatchewan, it is a different place to go, too, but we are actually talking about the good old downtown heart of Adelaide.

Dr Pridmore—As director, I do not want it to close.

CHAIR—Are there any economies of smallness or, at least, modest size—or shared administration or something of that sort—which you could recommend?

Dr Pridmore—I think the biggest difficulty is the requirement to have staff in-house 24 hours a day. Even surgeons now do not necessarily have a surgical registrar in-house. They might be on call from home, which is a cheaper way of paying people. But in obstetrics, I believe that we need people in-house and the best economies are to have as many people delivering in one place, under one roof, as possible. We believe that you probably need around 2,500 deliveries to have any hope of breaking even under the way things are funded under Casemix.

CHAIR—We have had a lot of evidence given to us that the Casemix DRG funding arrangement for obstetrics is really hopeless—

Dr Pridmore—Yes.

CHAIR—and that it may well be that the funding provisions as they are are not the best criteria on which to decide which hospitals stay or which go.

Dr Pridmore—This is where I feel it is the government's and the community's decision. If they want smaller units to remain, one would like to think we have a lot to offer. Somebody is going to have to be prepared to pay slightly more for it.

CHAIR—I think that is probably not a good note to finish on! It is interesting because, as Dr Vnuk was saying, too, sometimes women in Port Augusta have to be brought at a rapid rate from country Australia to urban Australia for assistance, procedures and so on. Has any thought been given to an obstetric bus? We have a beeline bus or whatever it is, so we can have an obstetric bus or a baby bus.

Dr Pridmore—I think the flying doctor provides a very good service in South Australia for women who need to be transferred. The biggest reason women need to be transferred is for very premature babies. There is no way any state can support premature baby units for 300 deliveries a year.

CHAIR—No, I am not asking about that one. I am just suggesting that transport is one of the problems. Early evidence that witnesses gave us here was that one of the things that Queen Elizabeth Hospital has that most other hospitals do not have to the same extent is a community commitment. It belongs in the community like other hospitals do not.

Dr Pridmore—Yes, I was brought up in a country town, and my father was a general practitioner, so I know that. I think there is more of that there than perhaps there is in other areas. Unfortunately, a lot of it seems to have surfaced since we have been threatened with closure.

CHAIR—That is a good note on which to finish. Thank you.

Committee adjourned at 3.12 p.m.