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COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Childbirth procedures

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SENATE
COMMUNITY AFFAIRS REFERENCES COMMITTEE
Wednesday, 8 September 1999

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

Senators in attendance: Senators Crowley, Gibbs and Knowles

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 9.14 a.m.

CHAIR—Good morning. In opening today's session I want to put on the public record the committee's appreciation of the hospitality shown to us yesterday by the Women's and Children's Hospital in South Australia. We thank them for all their assistance. Today we thank the King Edward Memorial Hospital for Women for allowing us to hold our hearing here and for the hospitality we have experienced. It is of huge assistance when inquiring into childbirth practices to be able to have a look for ourselves. We already have a very good body of information on the best birthing centres in large hospitals in parts of Australia, and we will be publishing this information in a small booklet. We hope to cast our eyes over the services here today, even if it is only very briefly.

The committee acknowledges the presence of some officers from the Health Department of Western Australia. If you are driven to despair when listening to the hearing, please feel free to drop us a note. We appreciate your interest and participation.

[9.15 a.m.]

TURNBULL, Dr Hilda, Member, Legislative Assembly, Western Australian Parliament

Dr Turnbull—I am here as the chairman of a committee which reported in 1995—the Select Committee on Intervention in Childbirth.

CHAIR—You are an ace witness then. 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 consider your request. I note we have a camera rolling. Just to make it official, is it the wish of the committee that we approve the presence of and recording by the TV cameras? There being no objection, it is so ordered. Dr Turnbull, I ask you to make a brief opening statement, and we will then proceed to questions.

Dr Turnbull—Thank you very much. Firstly, because we have started at this time, am I still allocated 45 minutes?

CHAIR—Approximately; we will do our best.

Dr Turnbull—In that case, I would like to thank you very much for coming to Western Australia. It is most important that from time to time the issue of childbirth is brought before health department people, the general public and mothers in particular. Before I start, I would like to ask what the impetus was for your holding this inquiry, because when responding to questions I would like to focus on the issues that you see as the most important. I have read your terms of reference, and I do not want to take up more than a minute or two. Could you tell me very briefly what you feel is one of the most important aspects of promoting this inquiry?

CHAIR—It is fairly unprecedented, but I am sure the committee can cope with being asked a question to start with. We ask the questions, Dr Turnbull; we don't answer them! The Senate has approved the terms of reference that you have before you, and that is the most important thing to say. Some of us have had a concern for a long time that the particularly high intervention rate and high caesarean rate have not changed and perhaps are increasing. While we do have very low maternal mortality and infant mortality, it is a matter of some concern that we have such a high intervention rate. That is the priority concern. There are other ongoing concerns about what is best in the way of maternal involvement in the process of childbirth—some people have already criticised our terms of reference because they are not holistic enough.

Dr Turnbull—Those are exactly the same concerns that led to the formation of our select committee back in 1994, and I do feel that they are very important issues. Although it is not an issue that many parliaments would address—we also had the same problem in Western Australia when we set ours up—it is important that the public knows that people who develop the policy and provide the funding also recognise that this is an issue. I will be pleased to talk along those lines.

Before I finish, I do also want to touch on a few items with regard to the actual funding of certain programs, et cetera. The most important thing we found during our select committee inquiry was that the management of a person's pregnancy and childbirth must be focused on the mother. At the moment there is a clinical attitude, a clinical model that focuses on all the people who are involved. It is focused on the doctors, the midwives, the specialists, the hospitals, the facilities, the government, the budget—all of that is what it is focused on at the moment. In fact, childbirth has become a clinical issue; it has become a clinical episode. What has happened is that it has actually become a treatment.

Our opening summary in our select committee report was that we must change this focus on to the mother. This is not something that the government can do. This has to be an attitudinal change which is supported by the government. It cannot be driven by the government. There has to be an attitudinal change in, firstly, the mothers. In our current society mothers are focused on the fact that they want a birth that is without too much mucking around, is at a time that suits them, is not too painful, is not too messy or too bloody and that does not cause too much disruption to the rest of the family. That is one of the attitudes that many people now have.

That attitude has developed from a number of things. It has developed from the promises that the medical fraternity are giving people. They are saying, 'Come to us and we will look after you. We will give you these things. We will give you a pain-free delivery and we will provide you with a perfect baby.' Of course, one of the problems is that, when they do not get a perfect baby, they sue people and the insurance rates go up and drive doctors and specialists out of business. So the problem is a totally attitudinal one. How are we going to turn around the attitude? The most important decision that a mother makes after she has become pregnant is how her pregnancy and delivery are going to be managed. She usually makes that decision as she walks out of the doctor's surgery after her first visit. That visit will be to a specialist, to a general practitioner or to a midwife. Many of them pick a specialist, partly because we have lots of specialists available in our society and partly because she believes—and her mother, her friends and everybody else tell her—that picking a specialist is the right thing to do. The other problem is that the general practitioner tells her that as well. So she needs information and the general practitioners need information on which to make these decisions.

So the most important thing that came out of our report was that we would develop this booklet which would have all the information in it. There will be other speakers who will speak to this today, I am sure. We launched this booklet last year. It took a very long time to compile because the information in it had to be absolutely accurate. Before we could even do that, we had to actually categorise all of the birthing places in Western Australia, from the Kimberleys to Esperance to Perth, and all the different services that could be provided—the competencies and what could safely be provided in that area, et cetera. So we had to produce this booklet with all the information, and it is to go to all general practitioners and all mothers.

All mothers need assistance in going through the pregnancy process. This booklet reassures them that, if they are a low risk patient, they are safe to be delivered by a midwife or a general practitioner/obstetrician. That is part of the objective of this book. The objective is to get out the news to people that safe delivery for low risk patients can occur in any one

of these establishments in the whole of Western Australia. Your guarantee of having a good delivery of a baby that is as perfect as can possibly be managed in our society is excellent in any one of these facilities throughout the whole of Western Australia. The assessment as to whether you are a low risk or a high risk patient will be made by your general practitioner, in conjunction with some specialists and with the assistance of the midwives. That decision can be made through your antenatal period. So the very first and most important step is this booklet, and although it looks like a very small thing, and although people may say, 'That is pretty small in coping with intervention in childbirth,' it is not. It is the fundamental platform of helping to change the decisions that mothers make at the very beginning.

The next point that comes with it, of course, is the separation of high risk from low risk. The high risk patients have to go to the specialists, and they have to have the procedures which result in caesarean sections. The caesarean section decision has to be made by the patient's own doctor or specialist; it cannot be made by anybody else. So that is a very important thing. But, it has to be done in the management of the program of the mother. So the antenatal period is the most important one of all. I see the principle that you put forward in your first term of reference as to what could be done in the antenatal period as being very important, and the wording there says, I think, 'screening programs'. Screening programs are important, but they are only a small part. That is part of the decision as to whether a mother is a high risk or a low risk.

The most important part of the whole of the antenatal program is for the mother to recognise that she can be comfortable with being designated as low risk and that what will happen is that her management through her antenatal period will prepare her for a birth which is going to be low risk, where she will not land up with a caesarean section, where she will not land up with intervention and where she will not land up with some medical system taking over her pregnancy and delivery. The evidence that we had in our select committee hearings and the inquiries that we made in a big survey that we sent out to all mothers who had recently had babies within a six-month period was that, if a mother is comfortable, secure and confident about what is going to happen during her delivery, she is far more likely to get through that delivery without having to have intervention. The sorts of things that lead to intervention are lack of pain control, lack of confidence or an induction at a time which was not the natural commencement of the birthing. We had a very interesting statistic presented to our select committee by Professor John Newnham, who is the professor here at the King Edward Memorial Hospital, on the effect of epidurals on the intervention rate. The effect of an epidural on the intervention rate is enormous. If you make the decision to have an epidural, if the mother makes the decision or the clinicians make the decision, your chances of having intervention are exceedingly high—more than fivefold has been proven, and it is really quite a lot higher than that. Part of the reason the research is showing that is that the epidural interferes with the natural progression and natural action of the labour. So, when you have these protocols that have been set up in the medical model that you have to progress labour at a certain rate and that it has to reach certain stages in a certain time, the impetus or the cascade, as we call it, as to whether you land up with intervention and eventually a caesarean is set, and you are on the way down that path. So, if we can keep low risk mothers away from the medical setting and keep them there with the confidence that they are going to have a successful delivery and that their pain is going to be managed—they are going to have pain but it is not going to be excessive—and that they will

have an exciting lifetime experience that they will appreciate at the end, we can keep mothers away from caesarean sections.

One of the most important things that our select committee found was that part of the reason for this increase in the number of caesarean sections is related to the fact that the age of mothers having their first babies is increasing. That was another factor. Older mothers having their first babies have a totally different attitude and mind-set. They choose the specialists, the managed system and all those factors which eventually put them into the medical model and set them down this cascade of events which leads them towards having a caesarean section.

CHAIR—Thank you very much for those opening comments. Do you have a copy of that booklet or is it not launched yet?

Dr Turnbull—It has been launched. They will be presented to you. We have 20 copies to leave with you.

CHAIR—Wonderful. It might save a lot of other people in Australia doing all that hard work too. It certainly confirms evidence that has been given to us both in Melbourne and in Adelaide yesterday about the importance of information.

Senator KNOWLES—I actually have very few questions because I am one of the people who believe that this inquiry is probably superfluous to Commonwealth government requirements. I do not see where the Commonwealth actually fits into the decision making process. I notice that you made two comments: firstly, that outcomes must be focused on the mother; and, secondly, that any intervention decisions must be made only by the doctor. Therefore, I ask you this question in your capacity not only as a medical practitioner but also as a member of parliament: do you see any role for politicians in trying to change clinical practice and decisions that are made between doctors and patients?

Dr Turnbull—I do not see that the politicians can make those decisions. But I see a very important factor as far as politicians and budgetary matters are concerned. In Australia at the moment we have a severe shortage of GP obstetricians and midwives. Part of the management of the low risk mothers is that they must have the GP obstetrician and the midwife as a shared care team. If we do not have enough of those, they will automatically drift into the specialist section. You know from the statistics that you have that, once you get into the specialist section, your chances of intervention are very high. It should be remembered that a lot of specialists in Australia deal with low-risk patients. So we have to try to keep the low-risk people with the shared care and the midwives and the GPs.

The training and remuneration of midwives and GPs are federal government issues and are related to how the Medicare money is allocated. At the moment, for the services that a midwife delivers to a mother, which are not under the direct direction of the GP or the specialist, there is not a payment section. So how do we manage the payment of high-class professional midwives when they are managing these mothers?

The objective of keeping the low-risk mothers managed by midwives and GPs is to reduce the intervention rate; it is to give the mother a much better experience of her birthing

process. But we cannot do it at the moment, partly because we do not have enough midwives and GPs. One very good thing has been done: there has been a change in the Medicare schedule—and Dr Innes will talk about the payment to general practitioner obstetricians—and that has been a help. I think, Senator Knowles, that that is a very important part.

Senator KNOWLES—But is it not also fair to suggest that there are many general practitioners who do not want to take on the added responsibility of obstetrics because of the world growth industry in litigation—and, therefore, their indemnity premiums becoming outrageously high—and that they are more happy to hand a pregnant woman to somebody else than take on that responsibility themselves? Don't you think it is fair to say that it also comes down to a personal decision of that doctor as to whether to practise as a general practitioner obstetrician or to say, 'No, I'm not prepared to take on that risk,' considering that there have been so many claims made 10 and 20 years down the track?

Dr Turnbull—You are absolutely right. That is exactly what we found in our inquiry, and we do have a chapter addressing that. There are two things to do with that. The Western Australian government had to take on the cost of subsidising the insurance requirements of general practitioner obstetricians in country areas of Western Australia because we need those people out there in the country. We have to encourage them to be there. Paying that for them is very important.

CHAIR—Did that reduce the indemnity of the insurer or increase it?

Dr Turnbull—No, this is sheerly paying the general practitioner a complement to his insurance.

Senator KNOWLES—Helping with his insurance payment.

CHAIR—Exactly so; but we were given evidence just two days ago that one of the insurance companies, on seeing that addition paid on behalf of doctors in another state, promptly added to the amount that the doctors had to pay and whacked the premiums up even more. I just wanted to know if this same pattern had happened in the west.

Dr Turnbull—No. I am afraid that the insurance rates are increasing sheerly because of the payouts.

CHAIR—Not in this case; they went up exactly. This evidence was provided to us by college experts.

Dr Turnbull—Maybe that is something that you people can address, and that would be very good.

Senator KNOWLES—But, once again, that is not something that the federal government can intervene on. It is a commercial decision of an insurance company to increase their premium. It is not for a government to say, 'You, as a commercial entity, will not increase a premium.'

Dr Turnbull—You are right to that certain degree, but I think that we have to address this issue. If we are coming to a situation where GP obstetricians are essential, we as a government have to look at how we can manage it within the commercial setting.

At the time we did this inquiry, we had the Jenny Macklin inquiry into professional indemnity in all other issues related to medicine. There were some very interesting outcomes from that in relation to how to manage the possible transfer of the medical costs of payouts as compared with the current situation. If you do want to look at that issue, I would suggest that you look at the relevant components of that. We did not recommend any of those, but we found them extremely interesting, and they are a federal government issue.

Senator GIBBS—Dr Turnbull, I was very impressed with your submission. I have 5,000 questions but I am going to have to limit them. How far down the track have you succeeded in having your recommendations implemented within the medical services in Western Australia?

Dr Turnbull—There have been quite a few interesting ones. There is the booklet, which was our chief one. When doing the select committee reports and recommendations, I felt that we had to concentrate on very distinctly enunciating what we could achieve and what the outcomes would be. So the booklet was the most important one of the whole lot. Now we have to make sure that that actually operates. That is the hard bit—to get it out there and make the GPs aware and make sure that all the people interact.

Another very important one, of course, is the provision of, particularly, things like the birthing centres within the hospitals, support within the hospital system for GP obstetrician rosters, support within the hospital system for midwives having access to hospitals in relationship with a medical practitioner—

Senator GIBBS—Is that happening here?

Dr Turnbull—Yes, it happens in Western Australia. I think you will hear good examples of that from the other witnesses today. Woodside Hospital and Swan District Hospital are good examples. The best examples of the whole of the shared care model are in the country. That is where you have a specialist, but that specialist has too much work to be taking on the low risk, and they focus on the high risk. I refer, for example, to Geraldton, which Kathy Innes will speak on today, Kalgoorlie, and Collie, which is where I come from. We have a population of only 10,000. We do not have a resident specialist, but we have three GP obstetricians, a general surgeon and anaesthetists, and our intervention rate is low compared with that. It is currently about 10 per cent. A few years back it was seven per cent, with only a few sent to Perth. So it can be done, and it can be safely done. As Kathy Innes will say later, that model is working well.

What we are trying to do is bring that into the metropolitan areas. One of the policies of the Western Australian government of decentralising our metropolitan services is very important there. We must continue to have the central tertiary. We must have the specialists in the central tertiary. In Western Australia we are very fortunate that there is only one, and that is King Edward. That way the King Edward hospital can adjust their policies. I think you will hear from them about that today.

Senator GIBBS—You were talking about midwives. We have heard a lot from midwives in this inquiry. Yesterday we were in South Australia, and we were informed that there is going to be set up in South Australia a four-year training course for midwives; whereas at present the midwife is a nurse and the nurse does one year of midwifery. Would you agree with this? The whole thing is that you do not have to be a nurse to do this four years of study to become a midwife. Could you see this being implemented in Western Australia?

Dr Turnbull—We definitely looked into that in our select committee inquiry. We had presentations from a person from England and another one, I think, from Holland talking about this. We also communicated with a region in Queensland; I cannot remember where it is in the report. Yes, we tentatively gave that support. We felt there was certainly a place for a midwife who was trained in that manner. So, if South Australia is doing it, I think that is fantastic.

Senator GIBBS—Well, they are going to implement it, which is very encouraging. I want to ask you about Aboriginal women. I come from Queensland, and the Aboriginal population is spread out there. In South Australia yesterday we heard that a lot of Aboriginal women do not go to antenatal classes. They do not like going to hospitals. Basically, they become pregnant and they go to the hospital once, but they do not go back until they are ready to give birth, because they do not consider themselves sick. And, of course, they are not sick. But they see hospitals as a place where you go when you are sick.

There are high intervention statistics for Aboriginal women, particularly teenage ones, because they are not getting the care. They are not finding out what is good for them. How are you in Western Australia trying to help these women change this sort of culture? What the Aboriginal women were saying was that they need birthing places where they have their own people. Others can be there; whites can be there too, of course, but they are comfortable with their own people. Their culture is particularly different from ours. Actually, it wasn't much different when they spoke about it, because I think all mothers wanted the same continuity of care.

Dr Turnbull—Yes. We found the same thing entirely. It is very difficult to deal with, though, in practice. It is extremely costly. Let us take the example of Halls Creek in Western Australia, where Aboriginal mothers are shipped out to Derby, which is hundreds of miles away. They go by plane and then the poor things are dumped on a bus with their babies to bring them back to Halls Creek. It is really tragic.

The trouble is the cost of it and the lack of personnel, et cetera. In health care terms, I think money spent on the antenatal period is the best spent money that we can possibly spend in the whole of Australia. Kathy Innes and others will tell you more about the details of the Aboriginal ones, but I would like to focus on this one point: in Western Australia at the moment at King Edward hospital Professor John Newnham has been involved in research which indicates that low birth weight is related to about five mid-life medical conditions—diabetes, hypertension, heart disease and a number of others. That research shows that it is actually the birth weight that is the predicting factor. The birth weight is associated with the stresses that the mother has in the antenatal period. So it is really your foetal life which is the most important component. The amount of cortisol that a foetus is subjected to while in

utero determines what happens to you when you are 50 years old. In health care terms, this is where we have got to focus the money.

I would like to put to you people, as federal senators and as people who have control over how budgets are structured, that in the Medicare agreement with the states there should be a substantial increase in or a substantial focus on the amount of money spent on the antenatal period. The antenatal period will save us not only caesarean sections at birth but also health problems when people turn 50. Professor Newnham is proving that here in Western Australia.

Senator GIBBS—That is very interesting. Thank you for that. We have heard that in our investigation. We have also heard that it should not just chop off when one gives birth and leaves hospital. That first year is so important as well for the health of the mother and the child.

Dr Turnbull—That is right. I agree with you entirely. We must focus on the antenatal process, give mothers enough confidence to be able to have a low risk delivery without any intervention and then support mothers in the postnatal period. Again, King Edward research, which they could mention today, shows that postnatal depression is related to two things: it is related to the amount of intervention that you had during your birthing process, and it is also related to whether you had an experience that corresponded to your belief of the experience that you were going to have when you had the childbirth.

So this business of having an unreal expectation of what is going to happen during childbirth can lead to postnatal depression. Mothers who think it is going to be all beautiful, it is going to be reasonably pain free, the doctor will give them this perfect baby in their arms, they will sit up there two days later and welcome everybody in the world and everything is going to be rosy, are much more prone to postnatal depression.

Senator GIBBS—Thank you very much.

CHAIR—Why did the Western Australian Legislative Assembly decide to do their inquiry?

Dr Turnbull—Thank you very much for giving the question back to me.

CHAIR—In three seconds.

Dr Turnbull—As I said at the beginning, it was very much the same as yours. We were horrified by the statistics for caesarean sections. We set out to see if there was some way of changing this assault upon women; an assault which women are willingly letting themselves in for. Our select committee showed that it is an attitudinal thing. It has to be addressed in giving mothers a good antenatal experience; an experience which prepares them for a realistic, low risk delivery. But in the process we clearly recognised that there are low risk patients and there are high risk patients. Those decisions have to be made by the shared care team as you go through, and then their doctors have to assist them at the time of delivery in what happens.

CHAIR—There are a couple of questions that I really want to put to you. One concerns alternative birthing funding to Western Australia. Commonwealth money used to be a direct line to that, and it has been a terrible challenge to get any state to spend it until more recently. Can you talk about that funding in Western Australia?

Dr Turnbull—Yes. I cannot tell you the exact amounts at the moment. Maybe some of the later witnesses can. I think the programs were quite good when they were trialled and they were targeted. I think the program has to be recognised in the Medicare agreement between the Commonwealth and the states. I think recognised in the Medicare agreement should be antenatal care and all the costs that go with that, because I honestly do not see any other way of making sure that this happens. In Western Australia the state government has a very real commitment to this. I can assure you that it does. It is more a matter of how you share the money under the terms of the Medicare agreement.

CHAIR—Alternative birthing funding, as I understand it, has now been rolled into a broadbanding to public health agreements with the state governments.

Dr Turnbull—I am sorry, I cannot comment on that.

CHAIR—That is all right. I will talk to the department about that. You suggested that a lot of women must change their attitudes about birth—and I am paraphrasing; I am not intending to diminish or put down your argument—and that decisions for a caesarean section can only be made by a doctor.

Dr Turnbull—Yes.

CHAIR—We have had evidence to the contrary on both of those points, and I would welcome your comments on them. One is that essentially some people have suggested that, if we say it is up to women to change their attitudes, it could come out as a victim blaming exercise. But are you arguing that we should be leading women to a different participation in the birthing process? You are nodding; you are in agreement with that emphasis?

Dr Turnbull—Yes. I thought in my introductory remarks I tried to cover that. This is an attitude which is developed by a whole society at this current time. Quite a bit of it is related to the fact that women are older when they are having their first babies. They have this concept of preciousness and specialisation and all the rest of it.

CHAIR—So you are suggesting there is a need for women to have good information so that they can, at whatever age, proceed through pregnancy with—

Dr Turnbull—Yes.

CHAIR—One piece of evidence that we have been given that varies vehemently from state to state is that decisions for caesarean section are being made by other than doctors: ‘Women are demanding them.’ I might say there is a certain irony in women who have been powerless for 2,000 years who have suddenly leapt to be the absolute power behind the caesarean section throne, but you will allow a heavy irony from time to time. Can you talk about who does make this decision? Did your report find out how much of the increased

number of caesarean sections can be put down to women's demand, if that is a real estimate at all? And is the fear of litigation when women ask for a caesarean section a package that we need to look at?

Dr Turnbull—There were a few anecdotal comments along that line. We did have one letter from a woman who said that she had requested a caesarean section because she was a model, I think, or something like that.

CHAIR—Please continue, Dr Turnbull. That is too much to leave us hanging. She was a model and she preferred to have a scar down the front of her belly.

Dr Turnbull—Well, it had to be under the bikini line, but it just meant that she did not have to go through all the absolute pushing. But, anyway, that was the letter.

I think, unfortunately, that those exceptions are highlighted. Some women—and particularly career women; we had a number of these people involved in our select committee—say to their specialists, 'My delivery needs to be at this time and, therefore, Doctor, I want you to assist me to have it at that time.' Inductions can often be more painful than a normal onset delivery so, as the pain builds up so does the demand for pain relief, and then the epidural comes in. The epidural can lead to a distortion in the labour pattern and eventually the caesarean section.

CHAIR—I am sorry to push you along, Doctor, but I have three or four questions I would like to ask before we move on. Do you know whether the funding in Western Australia for antenatal education services is the same, is increased or is reduced?

Dr Turnbull—No, that is one good question I do not know the answer to. I will ask whether it has increased since we did our inquiry.

CHAIR—That is very kind of you. If you could find out and assist us with that, that would be really good. Do you know whether the levels of intervention are the same or have increased since your inquiry? We have figures for 1996.

Dr Turnbull—Vivien Gee will present those figures. Last year when I launched *Your Birthing Choice*, and also when I went to Woodside and launched a special shared care program down there, the figures had not shown any change. Vivien will be able to explain that far more clearly to you.

CHAIR—Did your report look much at antenatal screening? Can you tell us very quickly what you meant by antenatal screening? For instance, did it include mother and foetus or just mother or just foetus?

Dr Turnbull—No, we did not focus on screening; we only addressed screening as being an important item in helping the general practitioner to decide on what is low risk and what is high risk. There is a very important piece of research that has come from Professor Newnham's unit at King Edward hospital—that ultrasounds must not be used more than twice or four times in a pregnancy unless there is some particular issue to be addressed.

CHAIR—‘Must not be’ or ‘it would be good if that were the case’?

Dr Turnbull—They should not be used, because multiple ultrasounds are associated with low birth weights. Further research, as I mentioned before, shows that low birth weight is a predictor for midlife disease.

CHAIR—If we get the chance, we will ask whether it is a causal connection or just a correlation.

Dr Turnbull—It has occurred twice in the world, and no ethics committee will allow a double-blind trial to test whether multiple ultrasounds are detrimental to the foetus.

CHAIR—Dr Turnbull, the day’s inquiry has been opened up with your very excellent assistance. Thank you very much for running us through your report and some of the points that are of interest, particularly your booklet. We will look forward to getting a copy. If you could provide us with any information about antenatal education service funding—how many women can get it, where it is provided, whether they have to pay, and whether there are still free services, et cetera—it would be very useful.

Dr Turnbull—I know there are still free services. Our community health system does provide a very good one, but I would not be able to tell you the details of how much money is spent, et cetera.

CHAIR—If you could do that easily, that would be fine; otherwise, we could ask the department.

Dr Turnbull—I think it would be better to put it to the department.

CHAIR—Thank you very much indeed.

[10.00 a.m.]

COLLINS, Ms Robyn Patricia, Midwifery Director, King Edward Memorial Hospital

NEWNHAM, Professor John Phillipps, Professor of Maternal Foetal Medicine, King Edward Memorial Hospital, and Head of Department of Obstetrics and Gynaecology, University of Western Australia

ROBERMAN, Dr Brian David, Medical Director, King Edward Memorial Hospital

CHAIR—I welcome representatives from the King Edward Memorial Hospital for Women. The committee prefers all evidence to be heard in public, but should you wish to give your answers, part of your answers or any of your evidence in camera you can ask to do so and the committee will consider your request. We have before us your submission No. 155. Is there anything you would like to add to that at this time?

Ms Collins—Not at this time. There are a couple of documents that I would like to submit along with the submission, which is our evidence based on clinical practice guidelines.

CHAIR—Thank you very much. It is very welcome. Would you like to make a brief opening statement and then field

questions?

Prof. Newnham—I was not included in the original submission, but I was invited to come along. One of the reasons I did not submit anything was that when I read your terms of reference and the point of the inquiry, I regret to say that my heart sank. I see the emphasis of looking at childbirth, episiotomy rates and forced rates, et cetera, as being something that is very important. It is something that the three of us have devoted our working lives to up until now—we have spent our days and nights doing it—but it is not the future; it is not where we will be going in the next century. I am here to try to convince you that this is not where we should be putting our efforts. Our efforts should be going into stacking the deck; in other words, not accepting the hand that is dealt to us when women arrive in the labour ward.

Our intervention rates are partly for social reasons, partly for trade reasons and partly for professional reasons. The big thing that we have to start to address is the quality of the pregnancies at the time women arrive in the labour ward; in other words, we should no longer accept that foetal anomalies could arrive in the labour ward undiagnosed, we should no longer accept the fact that one in 500 of our babies at the time of presentation of labour probably already has cerebral palsy. We should no longer accept the fact that seven per cent of these births will occur pre-term. We now have to accept the fact that we need to do more research earlier in pregnancy.

We and our predecessors can be excused for not having done adequate research in the field of foetal medicine and foetal surgery up to this point in time, because the technology did not exist for this area of research to flourish. But that excuse is no longer sustainable. The technology now exists for us to investigate the foetal origins of childhood disease and the foetal origins of adult disease and to address this issue properly.

Funding for research in the prenatal period in this country, like most developed countries at this time, is increasing rapidly but is very poor in relation to the wealthier cousins of adult medicine. The United Kingdom and the United States are looking at the possibility of making foetal research a priority area of funding. Our NHMRC has priority areas of funding, most of them beginning with 'A': asthma, AIDS, allergy, Aboriginal health and alcoholism.

CHAIR—Or alternative birthing.

Prof. Newnham—But there is no reason for us not to address the true origins of disease in humans at a time when prevention would be most effective, and that is prior to birth.

If the first point has been made, there is a second point that I would like to raise. Your first area was antenatal screening, and I think the area in antenatal screening that is in most urgent need of attention at a government level is prenatal diagnosis. We have a divergence of protocols in place around Australia. There is maternal serum screening—what used to be known as the triple test, which was originally just for screening for down syndrome but we now know it can predict many other things as well. There is a divergence of practice on neucal translucency screening at 10- to 14-weeks gestation, which is predicting not only down syndrome with much greater accuracy but also a variety of other foetal anomalies and other high risk states which we are only just discovering.

In the world of foetal research, this was very active over the last few years. It is now very active at a college level and at a Medicare funding level, and it is time for us to have a national coordinated approach for metropolitan and rural dwelling women to benefit from prenatal diagnosis. If we want to alter what happens in our labour wards we need to be looking much earlier, and we can now start at 10-weeks gestation.

CHAIR—I will just intrude with one small question. Could antenatal screening indeed lead to much more intervention?

Prof. Newnham—It depends on what you are screening for. If you are trying to diagnose foetal cardiac anomalies at 10- to 14-weeks gestation by looking at neucal translucencies and then confirming the diagnosis at 18 weeks, you will produce intervention in some cases prior to 20 weeks but you will not be left with undiagnosed problems at term in women who are not suspecting problems and who then present with an abnormal foetal heart rate, trace meconium and an emergency caesarean section for a problem that has been there for many months which had been unsuspected. The same thing goes for chromosome abnormalities. If we do not diagnose these sorts of disorders, they usually present to us with surrogate signs at the time of labour and lead to inappropriate and unnecessary intervention.

CHAIR—Did anyone else wish to make an opening statement?

Ms Collins—I would like to add that not only is it the antenatal period where the intervention needs to occur—which includes the scientific side—but intervention is also required for women who are at risk of postnatal depression or do not have support to breastfeed, which also includes the important factors which lead on to adult life. We at King Edward Memorial Hospital for Women have been able to implement a screening tool which—whilst it has not been proven, there is nothing better on the market—can identify in the antenatal period those women at risk of postnatal depression. We have had a huge increase in the referrals to our psychological medicine department to the point where we need to modify that referral process to cope with the influx.

Secondly, statistics from our breastfeeding centre show that 92 per cent of women breastfeed upon discharge. At about two months of age that percentage drops to something like 60 to 70 per cent, and at six months of age it is somewhere between 40 and 50 per cent. Our breastfeeding centre was opened with no increase in funding to do so.

Dr Roberman—I have a few things that I would like to say. I presume that most of this time should be taken up with you asking us questions, but one of the things that I wanted to mention was that the perinatal mortality rate in this country has been steadily going down.

CHAIR—Could you remind the committee what perinatal means?

Dr Roberman—That relates to the number of babies who die during the pregnancy and also those who die in the early period after birth—the first 28 days after birth. This rate has been steadily going down, and some of it has been due to intervention and some of it has been due to better quality of health care and health of the community. But we have reached the cost-ineffective end of the spectrum where we have to spend more time, effort and money on doing things to save few. I always liken it to buying a hi-fi set: you have to spend a little bit of money to get something, but the more you spend the better you get, up to a point where you have to spend a lot more money to actually get a better quality.

The medico-legal climate in this country certainly has been shown to be one of the reasons for more intervention. I suppose that, whilst we still have the adversarial system in this country, it is going to be the fact that doctors, midwives and others who provide health care are going to feel safer doing things. People do not get sued for doing something; they get sued for not doing it. That tends to lead to more things being done, and it is sometimes difficult to prove that they are beneficial, as has been shown in the past. When Hilda Turnbull was talking, you mentioned that the patient's choice is sometimes seen as something that leads on to interventions. We have two things here: we have a push for more intervention from some people who are demanding caesarean sections; and, on the converse side, we have people who are demanding no intervention—both of which are dangerous. Unfortunately, they do lead us to certain pathways, which should not be the case.

There are a number of things that I could mention, but I think we should leave it up to the committee. The one thing that I would like to say is that there has been a manpower study conducted by the College of Obstetricians and Gynaecologists. We in Western Australia have the least number of obstetricians per 100,000 women, but unfortunately they are all around Perth and the outer metropolitan area. They are not well represented in the country, rural and provincial areas, and Western Australia is the most centralised of all the

states. I would like to see the government somehow or other putting money into providing health care in the areas where perhaps it is most needed, and that is in the Aboriginal population.

Senator KNOWLES—Professor Newnham, as you know, I am aware of the fine work that you have been doing in terms of research. I think it might be useful for the committee to know a little bit about your research and the extent of it. I join with you: my heart sank when I saw the terms of reference, too. I feel there is a danger—and I would be interested to hear your comment—in trying to promote a theory that says that intervention is bad at all costs; that these interventions are going up and therefore they have to somehow be artificially pushed down. I think Dr Roberman was alluding to that a moment ago. Much of the fine research that people like you are doing throughout the world is, as you say, causal of interventions and desirable for the outcome that you are getting. Would you be kind enough to inform the committee of some of that work that does in fact cause an intervention and what the outcomes generally are?

Prof. Newnham—I think it is an evolutionary thing. The world of science and research is ahead of the thinking of the community, the government and the health department. The world of research and science 20 years ago was talking about operative deliveries, caesarean section techniques and best ways to induce labour. There is a little bit of that going on today in research terms but not very much—it is old and it is pretty tired. What we talk about now is ways of improving the lives of humans by diagnosis and treatment well before the time of birth.

So our research has really left labour wards and has gone to much earlier periods in time. Five years ago I would have said that it was down to 28- to 30-weeks gestation; now it is down to 10- to 14-weeks gestation. It is just getting earlier and earlier in timing. That is where science and research is going. What is driving it? The big thing that is driving it is the knowledge that there are associations between events during pregnancy—in particular, birth weight—and subsequent risk of adult disease. Those risks are hypertension, coronary heart disease, cerebral vascular accidents, adult onset diabetes and a proportion of behavioural disorders in adolescence. We know that there are associations there, and the aim now is to see if they are causative. The Western Australian pregnancy cohort study—we know it as the Raine study—has shown relationships between foetal growth and blood pressure as early as one year of age in the child. We would expect these to amplify. They have amplified by the age of five. We are now looking at the age of eight. We expect that, as those children get older and become adults, those effects will amplify.

What is the mechanism underpinning the origins of adult disease? There are two big areas. One is that there is a redistribution of blood flow towards the brain and away from the liver, the gut and the muscles if a foetus is undernourished for whatever cause. The other is that it is due to the foetal stress hormone response. So either the foetus is releasing stress hormones itself or the mother is releasing stress hormones and there is a breakdown in the placental barrier, which normally protects the foetus from the mother's stress hormones. We have shown in the sheep model that that is actually the case—that is, stress hormone exposure to the mother results in delayed foetal growth and a marked change in development of the brain. They are the foetal origins of adult disease.

There is a whole new world now of trying to find the cause of damage in children in the pre-birth period. The cause of cerebral palsy is multifactorial, but the majority of cases probably are not, and the cause of chronic lung injury. No longer do we look in the neonate intensive care nursery for the origins of these diseases, we look at an earlier period in time. The hottest theory in the world today—the one that we support and the one that we have evidence for—is that it is due to inflammation. There are periods of inflammation within the foetus, now called foetal inflammatory response syndrome, where a mother has a transient infection, maybe a urinary tract infection or some other inflammatory process, or perhaps some auto-immune response causing inflammation within the foetus, which then passes and leaves the foetus with damaged white matter and subsequent cerebral palsy or damaged lung tissue.

We know that there are very strong associations between inflammatory markers in a newborn baby and subsequent cerebral palsy and subsequent lung injury. We now just need to nail down the causative role and the factors that produce it because we have antagonists to these various inflammatory factors now available. So the research in the world is extremely exciting. When you consider the lifelong implications in this area, it becomes extremely cost effective. We are not talking about people with a 10- or 20-year life expectancy; we are talking about people with an 80-year life expectancy. If we look at a woman with a set of triplets, each of whom may be born damaged, we are looking at 240 life years in one patient. We have in one bed in this hospital as many quality life years as you will find in entire wards of some general hospitals. This is an extremely important area for us to do research in.

Obstetrics and gynaecology have been the poor cousins of the medical specialties for several centuries and, in particular, this century. A hospital such as this was a baby factory. This is where women come to have their babies. Birthdays begin on the day of birth. You have not existed until you are born. Medicine is now starting to understand that the priority area of medical research needs to come earlier and earlier in time, when the chances of benefit are greatest. But the society and the community have to be dragged along. For many people in the community there is still this preoccupation with the whole thing being the moment of birth. Ultrasound is changing that. Women, including indigenous women, are now appreciating that there is something going on inside there. Women say to you at 10 weeks, 'Oh wow! I really am pregnant.' We knew you were pregnant, but to see it on a screen is different. So I think the world of science started shifting 20 years ago. The world of medicine is shifting now, and I think the governments and health departments need to start following in response to the science and to our understanding of the true biology of what we are dealing with.

Labour and birth are not much of a biological event for the child. Birth is not an event for the foetal brain. The foetal brain does not really acknowledge the moment of birth. The foetal brain development has proceeded a long time before birth and it will proceed a long time after birth—birth is just another day in its life. You could argue that the role of an obstetrician and a midwife is to make sure that birth does not become a significant event in the development of the foetal brain. But in this day and age it doesn't. But we need to appreciate that labour is not the whole game.

Senator KNOWLES—Taking that one step further, could you explain to the committee what types of interventions are necessary when some of these things are detected, particularly in the case of cerebral palsy?

Prof. Newnham—The cerebral palsy story has a long way to go; we are at the early days of it. So preventing cerebral palsy by interfering with inflammatory processes, et cetera, has a long way to go. It is going to take a lot of funding, which is very hard to get at this time. There are other things such as foetal structural abnormalities. If you were to take, say, bladder outflow obstruction in the foetus—which is a not uncommon thing that occurs in little boys and which is due to just a single membrane, probably the hymen of the male, in the region of the prostate gland obstructing the foetal bladder—we watch it develop; it obstructs the bladder and it becomes extremely large, causing back pressure on the kidneys. These children end up having renal dialysis at the children's hospital. Forty per cent will make it to 10 years of age and then have a renal transplantation. They have a horrible life and can look forward to an early death. That is all caused by a single membrane as thick as a piece of glad wrap at the base of the penis.

With the developments in endoscopic surgery, there is no reason why we should not be able to work out how to pass a catheter up the penis. If we could do that at 18 weeks gestation we would cure these conditions. There would be no need for these children to have dialysis. There would be no need for them to have transplantations in childhood. So very simple interventions can produce lifelong and profound effects. Within the uterus is the area from where our greatest results can come. Pioneering this sort of work is relatively easy because it is untrodden territory—people have not been there before. So, when we do research studies using novel techniques on the foetus, we find amazing things because we do not have much data to tell us what we expect to find.

Dr Roberman—Can I just add something to that. The figures say that 80 per cent of the health care dollar is spent on people who will be dead within 12 months. Less than three per cent is spent on health education and, most importantly, preventive medicine. So I suppose we really should be looking at preventive medicine. Professor Newnham is talking about some of the things that actually prevent disease later on.

Senator KNOWLES—Based on the research that is being undertaken now, do you believe there is a need for re-education—a new culture, a new attitude—on the whole subject of intervention, that it should not be perceived or talked about as being something wrong?

Prof. Newnham—I think that is a slightly different issue. What I am trying to get across is that we need some lateral thinking. Instead of having an entire inquiry based on birthing procedures, we need to understand that it is not the main game. The main game from government should be to de-focus off the moment of birth and to start focusing on the amazing opportunities we have to improve the life of our community by steps at earlier times, including the Aboriginal community, who probably demonstrate the features of the foetal origins of adult disease better than anybody else in ours, which is foetal stress hormone exposure, low birth weight and, subsequently, hypertension, coronary heart disease, stroke, adult onset diabetes and early death.

So, if we are to concentrate on improving the life of the community, we need to focus a little less on the moment of birth and more on the areas in which science is telling us we should be going. So, is all intervention unnecessary? No. But, with all due respect, we have spent our entire careers talking about this—our caesarean section rate. What are we doing? With all due respect, we are shunting patients from one part of our hospital to one part of our health care system to another part and juggling the figures accordingly. We have produced data to show that the family birth centre, as wonderful as it is and as highly appreciated by women as it is, probably does not make a lot of difference to the babies or to intervention, not at the end of the day. We have data on this if you would like to see it. So we are just shunting things around. We are rearranging the deckchairs. We can do that as much as anybody would ask us to do.

Senator KNOWLES—While the main game is here, the focus is still being put in the traditional areas of the past.

Prof. Newnham—Yes. The main game is occurring in foetal development in the uteri out there in the community, where damage is being done, unbeknown to us, while we are messing around worrying about our episiotomy rates.

Senator KNOWLES—Exactly. Thank you.

CHAIR—You are doing very well, Professor.

Dr Roberman—Quite a good speaker, isn't he?

CHAIR—Yes. He is absolutely breaking my heart. Where do you want your funding from?

Prof. Newnham—Multi-origin funding, of course. But I would like to ask you to consider recommending that NHMRC make foetal research a priority area for funding, as are many other areas.

CHAIR—That is a very good argument for research. I have a great interest in it, and I thank you for the comments you have made to the committee. I do not think we need necessarily argue—and I would welcome your comments on this—that, because there is not enough funding going to a new research area—and so what is new; that does not mean I am not entirely with you—all cutting edge research has to try to persuade funders that it is a good thing to give it to it. I am not saying that it should be like that. I wish there were more money for research. I think I might make the case for more research for public health, which is an even poorer cousin than obstetrics, but I take your point that this has been an area that has had remarkably little funding into research.

Senator KNOWLES—Can I ask a question based on that assertion, Madam Chair?

CHAIR—Yes, by all means.

Senator KNOWLES—Do you believe that public funding for general health can be alleviated in the long term by this type of research that you are doing, which, as you say, is

whole of life research? If you can intervene in the foetus, then ultimately—not in our lifetimes of running obstetrics or politics or whatever—it will save money down the track.

Prof. Newnham—That is the idea. The big three preventative areas of medicine are public health, and, in particular, sanitation, immunisation and then early intervention, which is what we are talking about. They are the big three areas of prevention. Two of them have received political priority.

CHAIR—From time to time. I am very pleased to notice that sewerage is proceeding apace in Western Australia. We are very grateful for this public health advancement. Well done, Professor. I will take a bow too. If I listened to you, I could think it would be a miracle to have a normal baby. I do think we need to put into perspective that, despite all the prospects for things going wrong, is it not interesting how often bubs drop into this world fit and capable to live for 80 years? If I had high blood pressure, heart disease, imminent hymens across my bladder, to say nothing of diabetes and everything else, I am going to be doing awfully well to get through to 80.

Prof. Newnham—Senator, you are absolutely correct: most people are born normal; most people are born equal. What we are discovering, and what I have been trying to impart, is that a child that looks normal and has normal Apgar scores may well have underneath it the origins of many other things in life, including behavioural disorders in adolescence and adult disease that is camouflaged from the mother cuddling her newborn child.

CHAIR—What I absolutely do not want to get into is, ‘Well, my priorities are this, and I do not want to be sympathetic to yours,’ because I do. I would also ask that you give serious consideration to arguing the case for research, not by necessarily jeopardising commitments to any other kind of good health practice. For example, if we did fewer caesareans, we may save lots of dollars that are unnecessarily being spent at the moment—wherever they are being spent and by whom, but ultimately in the end it is the taxpayers—and those dollars could equally be rerouted to somewhere else. There is not a big package there, and it is not the sort of money that you are talking about.

Before I ask you some nasty questions about whether you are concerned at the high caesarean rate and the fact that it is rising and what you have to say about increasing the number of midwives and managed care during pregnancy, what do you say about the very high cost of keeping tiny birth weight babies alive? We can now, through neonatal intensive care—and we have cast our eyes across quite a few of them in the last few days—see huge numbers of dollars being spent to keep babies as little as 500 grams or less—

Senator GIBBS—The smallest was 375 grams.

CHAIR—That is right. They are born at 24 or even 23 weeks. That to me is almost directly counter to what you have been saying.

Senator GIBBS—And the child has a high risk of disability.

CHAIR—In three seconds, Professor.

Prof. Newnham—My job description as a foetal medicine specialist is to close neonatal intensive care units.

CHAIR—I see what you are saying, but you had better say it on the record, please.

Prof. Newnham—I had only three seconds. If I could have another three seconds: one of our highest research priorities is to prevent pre-term birth. The emergence of a neonatal intensive care unit, which is what you have just seen, we hope and trust will be a transient part in the evolution of science and biology. We hope that it will not last and that we will learn how to prevent pre-term birth. Those babies are currently being put there because, if they had been left where they were, they probably would have died. The next step is to make sure that they do not need to be delivered at all and that they can stay safely where they belong, which is inside the uterus. That is our priority. That is where we are heading to.

Senator GIBBS—I am really pleased to hear that. We have visited three of them, I think, and one of the doctors actually said to us, ‘We often ask ourselves whether we are doing the right thing, because a high proportion of those babies will have some sort of disability for the rest of their life.’ They are more dollars that could go to your research.

Prof. Newnham—With all due respect, most of them end up leading normal lives. But you have only two choices facing you. You do not have the choice of stopping neonatal care. That is an illusion. You have two choices. One is that you do try to do it: you kill these young Australians, which is not going to happen. The second is that you support the efforts to find ways to prevent pre-term birth. That is it. You cannot close neonatal intensive care units.

Senator GIBBS—I am not saying so. I hope that you do get your money for the research, that you do stop this and that we do have babies who come at full term, because it is heartbreaking to see a little thing that you could hold in your hand, virtually. I do not like to say this, but some puppy dogs are bigger. It is terrible.

CHAIR—We are going over time, but this is too important. We will see if we can push a little further on. Professor, were you going to say something in response to that, or are you reserving your comment?

Prof. Newnham—Yes.

CHAIR—There are some very important questions here. Our first term of reference talks about antenatal services. First of all, how do you define them? Do antenatal services include the care of the mother, such as standard screenings for blood pressure, diabetes, et cetera, or is it devoted entirely to foetal protection? Does the definition include both?

Dr Roberman—Antenatal services have to include everything.

CHAIR—Right.

Ms Collins—Which we offer.

CHAIR—I think it was attributed to you, Professor Newnham, that we should have one or two ultrasounds in the course of a pregnancy. Would you like to get that exactly on the record?

Prof. Newnham—I will try to be brief. We ran a study of nearly 3,000 pregnant women, half of whom were randomised to have a single ultrasound at 18 weeks, the other half of whom had five ultrasounds. It was called the Raine study, and it was published in 1993. It was the world's only randomised trial of multiple ultrasounds in pregnancy that has ever been performed. It showed that there were no deleterious effects on the children whatsoever, apart from a one per cent shift in the birth weight curve to the left in the babies that had had frequent ultrasounds. In other words, about a 30 gram overall reduction. We did not know if this was due to the ultrasound or if it was due to coming to the department an extra four times or the stress of that or the travel or whatever. By one year of age, the effect had gone. So at one year of age there was no difference in size between the children.

To summarise a very long story that raged across the world as a result of this Western Australian study, the study has shown that repeated ultrasounds have no long-term biological deleterious effects on the child; that there may be an effect on growth, as had been shown in the monkey model, which was a similar study but not done here. But it showed that there were no demonstrable adverse effects. We concluded that ultrasounds should be used with clinical judgment and only when clinically indicated, and Australian protocols reflect that.

CHAIR—Do we have some national protocols? Can you assure me that they are in place everywhere an ultrasound is?

Prof. Newnham—We have had protocols. The Australasian Society for Ultrasound Screening had recommended that all Australian women be offered an 18-week scan. That is now somewhat in disarray because of neucal translucency screening at 10 to 14 weeks, with a complete myriad of different protocols in place around this country at this time.

CHAIR—So, if there was, there are not now uniform protocols.

Prof. Newnham—Correct.

CHAIR—It also seems to me that, in terms of Commonwealth funding, there is a very high pressure on the corollary or the opposite of what you were saying. If there are no proven deleterious effects, can you also assure the committee there is no proven benefit of having multiple ultrasounds?

Prof. Newnham—We were demonstrating in our trial whether it altered pre-term birth rates. We were trying to reduce pre-term labour by providing frequent reassurance to women. We demonstrated that it did not affect pre-term birth rates, and also the frequent protocol of four extra scans did not improve outcomes. So we concluded from that that the policy at the time of a single scan at 18 weeks should remain the policy, and it did as a result of our trial.

CHAIR—That is useful for the committee to know. It is certainly not the practice, and we will be assisted by having that clear statement. I appreciate your saying that the world has moved on and these terms of reference do remind you of the seventies—so much of the

world reminds us of the seventies, doesn't it—but, whether we like it or not, it is a fact that caesarean rates are very high in this country, the highest rate near enough in the world. My own state of South Australia has the highest rate of all. Western Australia, from 1996 figures, has a caesarean rate for all ages of 17.9 amongst public patients and 26.6 amongst private patients, an average overall of 20.4 per cent. One in five babes born in this state are likely to be born by caesarean section. There are any number of reports, including the Western Australian report, which state that this number of caesarean sections is too high; that there is no benefit in terms of this number of caesarean sections.

I would like you to comment—if you do not wish to, then maybe the others can, but I really would welcome comment from all three of you—on this high number of caesareans and/or intervention rates. However, I note that you could almost exactly parallel the fall in forceps deliveries with the increase in caesarean sections. I do not know that they are directly related, but one is interested in those matching figures. Even so, they are one of our very important terms of reference. We are looking at the delivery of a healthy babe with a contented, satisfied mum, who probably has a fair bit to do with the ongoing health of this little baby before birth and after birth. I wonder whether you would care to comment on those figures? Also, do you have any reason to account for the fact that private patients have a much higher caesarean rate?

Dr Roberman—It is difficult to make an all-encompassing statement as to why. We have figures here that show one of the reasons why in this hospital, for example, only 7½ per cent of the babies delivered are to private patients. But looking at some of the figures showing the birth weights, for example, of those of less than 1,000 grams in this hospital, 21 per cent are private patients. So we are grossly overrepresented in this hospital with private patients who are brought here because the babies or the mothers have a major illness necessitating an early birth.

From our point of view within this hospital, it is difficult to say throughout the community itself. But we have two systems in this state—and I am not sure what happens in the other states of Australia—for funding of medical practitioners and the care of babies. In this hospital, all the doctors are paid on what we call a 'sessional basis': they are paid so much to come here and deliver and look after, antenatally and postnatally, babies. In some parts of the state, there are what we call fee-for-service systems working. The fee-for-service system means that a doctor is paid for what they do and not for the outcome. Fee-for-service payments do not do anything to reduce intervention rates because, if a doctor is paid to do something, it is more likely that they will do it, I think, although it is hard to prove. The same happens on the gynaecological side—which is the sister to the obstetrician side—where doctors get paid to do procedures and not to counsel people. So the fee for service system working alongside a sessional system in this state is difficult to sustain, I believe.

CHAIR—I appreciate your comments about the funding; they do interest us. We have had evidence that in America nothing reduced the caesarean section rate, until the rate that was paid for having a baby by the natural method was higher than the rate for a caesarean section. The caesarean rates then fell. We were given that evidence. We cannot necessarily ascribe to this, but it does make one worry about how much the funding of services contributes to the definition of what is good practice.

We have heard that in Victoria they have a health commissioner who, as she said, might be better called a health ombudsperson; she deals with complaints. We have been told that very good outcomes are achieved by the conciliatory resolution of complaints through that health service and that for those complaints to lead to law suits or medico-legal complaints is very infrequent. Do you have something of this sort in Western Australia and, if so, does it have the same benefit?

Dr Roberman—We have something like that in Western Australia. I am not sure of the benefits; I have not seen the figures.

CHAIR—Perhaps we will chase that up ourselves.

Ms Collins—We certainly have the Office of Health Review. That is an independent body where women and their families can go and ask for advice. It is the conciliatory mediator between the health service and the patient.

CHAIR—We have been told of optimal care, particularly for the mother and her family throughout pregnancy. From a lot of descriptions, that has turned out to be continuity of carer and is often the coming together of midwife and doctor—whether specialist, GP or whatever. Somewhere along the process, you get optimal care which leads to—and particularly with continuity of carer—higher satisfaction and, I suppose you could say, a happier mother.

I am just interested in terms of some of the things that you have said, Professor Newnham, about the stress hormone factor; that is, incidents of stress or illness in the mother having a deleterious effect. Do you also have work that shows that, if you do have a contented mother during pregnancy, you may get an optimal or better outcome? If that is the case, then can you see that leading back to the questions we more directly have been asked to look at: management of antenatal care, pregnancy and postnatal care from a holistic approach—a happy mum, a happy kid?

Prof. Newnham—That is what we were trying to do with that study. We began that study in 1989. The 1980s was the era when people were trying social and stress interventions to reduce pre-term birth rates by a variety of techniques. We employed frequent ultrasound as a way of reassuring women and showed that it did not have an effect. It would be a quantum leap, and an unjustified quantum leap, to say that the work we have been doing on stress could be translated into the continuity of carer. I think that would be an invalid leap to make.

CHAIR—On the evidence to date.

Prof. Newnham—On the evidence that we have at the moment, yes, because we do not know whether circulating stress hormone levels are different in women who have continuity of carers. It is too big a jump to make. I would not wish to speculate on that.

CHAIR—Are there any happiness hormones?

Prof. Newnham—I think I have some. We do not know what they are called.

CHAIR—There are certainly things called endorphins. I know that they are not around all the time; at least, it seems to me that you have to do some fairly exciting things to get them, like shoving a baby into the world. But there is room for the research to test the corollary of your evidence, is there not?

Prof. Newnham—Yes, that is true. We have done work on endorphins. Endorphins increase progressively over pregnancy, peak at the time of birth and then, with delivery of the placenta, they crash; they crash within hours, and that is probably the origin of postnatal blues. But to translate that into continuity of carer is difficult. There is an incredible paradox that has to be dealt with here in that the continuity of carer model, which is private practice, is where the high caesarean section rate is.

CHAIR—In some places it is in private practice, but in some other states that we have visited you can get continuity of carer through the public sector. This is very interesting to us, that we have now met more models than this world dreams of in terms of providing women with assistance through pregnancy. Certainly, there can be continuity of carer, as we have seen in South Australia at one hospital, with a very low caesarean section rate, funded through the public sector and working very closely with midwives, obstetricians and general practitioners, with them all having the capacity to see out there and/or to come in there, depending on what happens. That is very interesting and it is publicly funded and, therefore, accessible to all.

Ms Collins—I think we need to put some focus back on the role of the midwife. The midwife not only has a role in having the skill to detect the abnormal but also has an important task in education and health counselling. We in this hospital have certainly developed a number of models of care, and one of those more recently has been the team midwifery Know Your Midwife scheme. The Know Your Midwife scheme has as one of its outcomes to improve obviously the intervention rate and also the patient satisfaction rate. I am a great believer in that, if you improve your continuity of carer, you will certainly reduce your number of complaints and intervention. I think there are enough papers around to prove that.

Also, our family birth centre, which has now been going for some six-and-a-bit years, nearly seven, births about 400 women per annum, and their caesarean section rate is 10 per cent. Sure, that is a low risk population. However, the 10 per cent includes all those women of which 50 per cent are transferred out: 29 per cent prior to the onset of labour, 17½ per cent following the onset of labour—of which 75 per cent come into spontaneous labour. I think they are fairly powerful statistics in supporting continuity of carer.

Our continuity of carer model in the outpatient clinic includes all risk of patients—that is low, medium and high risk—so nobody is disadvantaged. It is really up to the woman. I think a lot of women, believe it or not, do like to go and sit in clinics and do like to chat and do like to network. That is the only avenue for communication for some women, and they learn a hell of a lot. So I think that it is our job to offer whatever model of care the woman wants, and to be able to offer that where we birth some 5,200 women per annum. Certainly we are doing that.

CHAIR—We are hopelessly over time and all of us have lots more we could ask you. If anything does strike the committee, could we contact you for dot points, not a thesis. Can I just say in concluding that it has been fantastic, thank you very much. The one thing that we are becoming absolutely clear about is the incredible value of our very large maternity hospitals and, I suppose I would say, first of all, our very large public maternity hospitals where private and public patients are both able to be delivered of babes but also where there is research and where there is the coming together of a number of streams.

What is emerging as clear as anything with this committee is that it depends on the focus or the attitude or the culture that the head of team really wants to create. If you want to change the practice, then you get a good woman or a good man in charge who will then lead the other professionals with the whole climate of change. I do not know about any primary or national criteria of care best practice guidelines that say, 'Pick the right person,' but that is emerging very clearly. I have to say that the energy, the enthusiasm and the commitment of you three says a huge amount about this hospital. So, again, thank you very much. You have been of great help to the committee. We will certainly note that the NHMRC has to be directed towards funding.

One last question: Professor Newnham, does your research earlier about the state of the foetus jeopardise the claims that we have to this point that birth is the marker at which a person is designated as being alive and human—if you could answer in one second?

Prof. Newnham—I have just lost my second.

CHAIR—Can I suggest that that is a question I could ask you to take on notice?

Prof. Newnham—Your question relates to whether you are a person prior to birth?

CHAIR—Effectively.

Prof. Newnham—I believe that you are. In our criminal law, you become a person when your umbilical cord is cut.

CHAIR—Preferably outside of the uterus.

Prof. Newnham—Outside of the uterus when your umbilical cord is cut. That is clearly arbitrary.

Dr Roberman—This does not happen in the United States.

CHAIR—It does not happen in the United States?

Dr Roberman—No. In the United States, a foetus is a person and can sue its mother. In Australia, this does not happen.

CHAIR—In the UK it does not happen either?

Dr Roberman—No.

CHAIR—There have not been too many cases, but there have certainly been a couple of hair-raising cases of that sort in the US. On that terribly exciting point, whole new terms of inquiry, thank you very much indeed.

Proceedings suspended from 10.49 a.m. to 11.02 a.m.

FACER, Mrs Enid Rose, Community Midwife, Community Based Midwifery Program

HICKLING, Dr Ralph Stanley, Chairperson, Management Steering Committee, Community Based Midwifery Program

REIBEL, Ms Tracy Lynne, Project Administrator, Community Based Midwifery Program

TAMAN, Ms Andrea, Vice Chairperson, Community Based Midwifery Program

CHAIR—I welcome representatives from the Community Based Midwifery Program. 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 would give consideration to your request. We have before us your submission No. 50. Is there anything that you would like to add to that submission? If not, would you like to make an opening statement? We are having trouble keeping to time; so, brevity being the soul of wit, if you could be witty we would appreciate it.

Dr Hickling—The Community Based Midwifery Program primarily came into existence because of the recognition that there would always be someone who would choose to birth at home with a midwife who was familiar to them and that they were no less entitled to a publicly funded service. The philosophy of the program is based on the fact that, in the majority of cases, pregnancy and childbirth are normal but significant events within the context of the family unit and the larger community.

The program aims to empower and assist birthing women by supporting their right to choose the most appropriate care for their individual circumstances. This choice may take account of religious or cultural attitudes and beliefs, the personal philosophy of the individual woman and her partner or her particular circumstances at the time. The program also aims to ensure that women are made aware of all their options with regard to pregnancy and childbirth and assist women in making their personal choice based on sound and unbiased information. Whilst we actively promote home birth as an alternative option among the choices available, we do not encourage home birthing to the exclusion of other models of care.

The midwives contracted to the program understand completely the importance of recognising that different women have different needs, and each woman should be assessed individually in taking account of her medical history, health and wellbeing, family circumstances and needs. This recognition is the basis of the community midwifery practise. Community midwives embrace a holistic approach of caring for women in the broader context of family and community. Community midwifery aims to meet the individual needs of women and their families while providing them with continuity of care from the same registered midwife throughout their pregnancy, birth and the postnatal period.

The program management's primary function is to present community midwifery practise as a safe and viable option among the range of choices available to women. This requires a great deal of patience and fortitude as medical practitioners continually resist any change to the status quo and actively place barriers to community midwifery practise. This resistance is

based on a failure to take account of contrary evidence because it does not support current practices.

There are, however, substantial bodies of research that indicate that primary midwifery care and home birth is not only a safe and viable option but is a very satisfying experience for those women who choose this option. It is therefore important that these women are not impeded in their choice of birthing option. Our program is a small example of what can be achieved. We hope our results justify an expansion of our service and its duplication in other locations.

There needs to be a substantial change to the way in which maternity services are delivered across Australia. As recommended by so many inquiries that have not taken place into maternity service provision, there is a recognised need for an increased role for both hospital and community based midwifery services as separate entities from services offered by medical practitioners. There is also a long overdue need for obstetric training to be reviewed to ensure that such training encompasses alternatives to the clinical management of pregnancy and birth. Both obstetricians and general practitioner obstetricians need to be guided towards a more inclusive and consultative process with the women who seek their assistance. Medical practitioners must stop seeing themselves as responsible only for producing a live mother and baby and instead understand that it is women who give birth and therefore women who need to be supported in that process. We thank you for the opportunity to address the Senate committee and are willing to answer any questions regarding our submission.

ACTING CHAIR (Senator Knowles)—Thank you very much. Does anyone else wish to make a contribution at this stage?

Ms Reibel—Not at this stage.

Senator GIBBS—How many home births occur on average in WA each year?

Dr Hickling—One hundred and forty?

Ms Reibel—A little less than that—approximately 120, and that number has been quite consistent over the last 10-year period.

Senator GIBBS—You obviously do not just do home births; you have the continuity of care and you go to the hospital with the mother, if necessary?

Mrs Facer—Yes.

Senator GIBBS—With the home births, is there a doctor in attendance at all—in the background, just in case?

Mrs Facer—No. We use a medical practitioner as our backup support, but they do not come to the births.

Senator GIBBS—So it is basically low risk women who are having their babies at home?

Mrs Facer—Yes.

Senator GIBBS—We have met with a lot of midwives. In some areas, they have been saying that they are not actually allowed in the hospital. I believe that in this hospital they are allowed to come in and be with the patient. Am I correct?

Ms Reibel—Qualified.

Senator GIBBS—Accredited; that is fine.

Ms Reibel—No.

Dr Hickling—They are not allowed to come in their professional capacity; they can come in as support persons. Would that be right, Enid?

Mrs Facer—Yes. There are hospitals in which we are accredited—that was the word that was used originally—in which we can work in our own capacity as a midwife, but the numbers are very small and the other hospitals are very resistant to allowing that to be taken on. The midwives are not resistant—it is the midwives whose role will be taken over by the community midwives—but the doctors are. It is the doctors who are saying, ‘We just don’t want any more staff around.’

Senator GIBBS—We have heard quite often that there is a lot of animosity coming from the obstetricians towards the midwives. It might be interesting for you to know that we visited the Queen Elizabeth Hospital yesterday in Adelaide, and they had an absolutely superb birthing centre where the obstetrician and the midwives worked in conjunction. This is what they have fostered. The head of that particular department, who is a man—a lovely doctor—had the idea that the midwives needed recognition, but that they should not be going alone, and neither should the doctors be going alone. The ideal thing was for everybody to work together.

Ms Reibel—I will just add to that. Prior to November 1997, independently practising midwives had enjoyed a relationship with some metropolitan maternity units, where they did have access on transfer of their clients. Those privileges were withdrawn across the board in November 1997 due to a request from our program to have the accreditation issue formalised. At that point we were informed that, due to the non-delegable duty of care that hospitals had in relationship to their patients, they could no longer allow independently practising midwives to practise within a hospital environment. That was resolved through an initiative of the Metropolitan Health Services Board, who convened a working party to address the issue and came up with a resolution of casual employment contracts that maternity hospitals could invoke for community based midwives. This would allow them to become casual employees of the hospital on transfer of their client. As Enid has indicated, that has been taken up by two hospitals and the birthing centre here at King Edward, but we have not had the opportunity to negotiate such contracts with any other public maternity units.

Senator GIBBS—That is interesting. So, if that happens and if the mother is transferred, the mother will stop paying you, and the hospitals will start paying you.

Ms Reibel—The mother does not pay for this program. This is a federally funded program, and mothers receive all their midwifery care at no cost.

Senator GIBBS—Nothing at all?

Ms Reibel—Nothing at all.

Senator GIBBS—That is good. In South Australia, they are going to introduce a four-year course at university, TAFE or whatever institution, where people can actually study to become a midwife and get their degree. At the moment, the only requirement is for a nurse—I have nothing against nurses, do not get me wrong—to do a year's midwifery. They thought that this will upgrade the status and the qualifications of midwives. How do you feel about that?

Mrs Facer—As an English-trained midwife, this is how 40 per cent of midwives are trained in England. They come to Australia and cannot get positions because of the problem of not having their registered nurse qualifications. There are a lot of midwives out there—when we are so short of them—who could actually be practising. The problem came up that, because it became a second degree at university—because they are taking it out of hospitals—nurses were not going on to acquire further qualifications because they could not afford the fee, which is about \$8,000 for the year. This was then discussed by the ACMI to see how they could overcome the problem, and direct entry was the only way to go.

Senator GIBBS—If this became a national practice in each state, it would probably alleviate the antagonism of obstetricians towards midwives, who might think, 'They are only nurses.' You will actually have the status yourselves.

Mrs Facer—Personally, I find that the doctors who do work with us actually recommend us, and they also call on our services for patients who they consider require one-to-one care. Often they will have emotional problems rather than medical problems, and doctors know that having a one-to-one carer is probably the best way to go for those women. It appears to me that it is the people who have never worked with us who are antagonistic towards us.

Senator GIBBS—This is right. This has been fascinating. I have learnt so much during this inquiry about the actual birthing methods or models that women are asking for. What we discovered in South Australia was terrific: the woman went to her obstetrician, confirmed she was pregnant and did all that sort of thing—she was quite healthy—and then had a midwife look after her for her term. Of course, when she was giving birth, she wanted the obstetrician there because, as she said, 'I am paying you and I want you there as insurance.' The obstetrician was fine. He said, 'I just sit in the chair and watch.' It seems that working together does so much for the happiness of the mother and the baby, and in having the absolutely natural birth. If anything does go wrong, the obstetrician can whip her out of there and into surgery within minutes because they are all on the same floor, .

Ms Reibel—We have certainly found, through the survey structure that we use to monitor our program, that client satisfaction with the service that the midwives offer is exceptionally high. That seems to remain whether the woman stays at home and births or whether she is transferred. The consistent type of feedback we get in comments is: they were completely trusting of their midwives; they felt empowered in their ability to give birth; and they felt the whole concept of continuity of care had in fact given them not only a relaxed pregnancy but often a quite incredible birthing experience. We believe—and hope to confirm this through some research we are currently conducting—that this translates into a better adaptation to parenting. It certainly assists in the establishment of long-term breastfeeding, and there is very good anecdotal and evidence based research that continuity of carer also contributes to a decrease in postnatal depression.

Senator GIBBS—How long will your funding continue for?

Ms Reibel—We are currently federally funded until June 2001 through the Alternative Birthing Services Program. We are negotiating with the Health Department of Western Australia at the moment to secure state funding for both an increase in births and ongoing funding once the Alternative Birthing Services money ceases. We are still in that negotiating period and we have not had any confirmation of funding.

Senator GIBBS—How sympathetic is the Western Australian government? Are they likely to give it to you?

Ms Taman—The Metropolitan Health Services Board have, if you like, endorsed and supported the business case that we have put forward. We are informed that we are sitting in top priority for that funding program, but it has not been finalised yet. We have been given full support verbally, and confirmed by some supportive correspondence, that the state health department recognises the model of care as a good alternative and certainly one that provides an opportunity for more of a community focus on maternity care. Essentially, that is what our service is all about.

I want to pick up some of the previous evidence in relation to the networks that are developed in the clinical setting. Importantly for us, we have a partnership with the Pregnancy and Childbirth Resource Centre, which is also funded through the Alternative Birthing Services Program and operates out of East Fremantle. That centre essentially provides women with resources such as books, videos and all sorts of information in terms of choices in childbirth and the process of childbirth. It also provides a network not only for women who use our program but also for women in the broader community to create their own networks and ongoing community groups. A substantial number of these networks exist after the birth of the child and are ongoing through the school years. So there is a great need, I believe, for resource centres like that, or for that information to be available in the broader sense throughout the community. We have certainly seen the benefits of them, and without them I think the information that is given out to the community would be less.

Senator GIBBS—I was quite encouraged to hear that Dr Turnbull had put out that information booklet. The evidence we have been given so far seems to indicate that women are not being told of alternatives and that they are not being told of all the dangers—for example, if they have to have a caesarean that is fine, but they are not being told exactly

what will happen. Because of the way you are working and networking, it seems to me that Western Australian women are far more informed. Am I correct?

Ms Taman—We are working on it.

Senator GIBBS—It is very encouraging. Could I just get back to the midwife course. I have a particular interest in Aboriginal women. I come from Queensland and, like Western Australia, it is rather large. We were talking to an Aboriginal group yesterday, and they were saying that Aboriginal women are uncomfortable about going to hospital because they do not feel they are sick. Consequently, they are not looking after themselves antenatally and this is causing all sorts of problems. They did say that if midwives could be trained to go back into the community to help the people this would alleviate a lot of problems—for example, they could encourage hygiene, proper food and all the rest of it. Do you have any contact with Aboriginal women?

Ms Reibel—We have endeavoured in the past to encourage Aboriginal women to consider the program. There are two problems there. The first is that, unfortunately, a lot of indigenous women are considered to be high risk during pregnancy and therefore unsuitable for our program. Secondly, it is actually making the contact.

We have, however, begun negotiations with Kay Jones, who is a researcher who has just taken up a position with the Children's Research Institute here. She is implementing a research project that will run over two years. It is a pilot program where, with the assistance of Aboriginal health workers, she will follow 40 Aboriginal women from pregnancy through to the child's second birthday to monitor not only the pregnancy but the first two years of the child's life.

They have approached us and we are beginning negotiations to encourage women from that pilot study—of which I believe there will be 40 women initially. We would assess those women to find out which of those women would be suitable to come into our program. We hope that that will be the beginning of an association with indigenous communities in the urban area and that the program will encourage Aboriginal women to use our service. We are very well aware of the fact that Aboriginal women do avoid using hospital based services, so we are hoping that that will in fact lead on to a much greater involvement by Aboriginal women in our program.

CHAIR—Is your present funding direct federal funding?

Ms Reibel—That is correct.

CHAIR—Do you understand that that funding has now been broadbanded with other money from Canberra?

Ms Reibel—We have had no confirmation, to my knowledge, as to what the situation is. We were originally informed in the latter part of 1998 that the funding that was to go to June 1999 had in fact been extended to 2001. Beyond that, we have been given no indication as to what will happen with the Commonwealth funding.

CHAIR—To follow up on a question from Senator Gibbs, do you actually cover Aboriginal midwives in the remote and rural areas?

Ms Taman—Unfortunately, our service, until June this year, has been limited to the south metropolitan area. In June this year, we took a step to broaden that service to the broader Perth metropolitan area. We receive only \$220,000 a year to fund the service that we operate for 70 births. Given that it is a community based program—it needs to be a community based program in order to rely on the volunteers to meet the needs of the program—any sort of expansion that the program took on in the future would have to look at ways in which similar support networks and resources can be developed anywhere where the service is extended to, particularly in regional areas, where there might be some partnerships between the local regional hospitals. That is a whole other strategy.

CHAIR—You do not network with other community midwife groups across the state?

Ms Taman—We do. Community Midwifery WA is our membership organisation, made up of both community midwives and people who support community midwifery.

CHAIR—Are they funded under Alternative Birthing?

Ms Taman—No, the organisation is not funded; the program is funded, if I can make that clarification. Community Midwifery WA is the incorporated organisation which receives the funding and therefore manages the funding on behalf of the program. The program is a project of the organisation.

Mrs Facer—When WA first applied for their federal money from the ABS, we tried to set up an Aboriginal program in Halls Creek. Unfortunately, the Aboriginal women there wanted one of their own and there was no trained midwife who spoke their language, so it all fell through. I think this is probably one of the biggest problems that the women have when they are moved out of their area and brought down to Perth: they are a one-off; they are on their own; there are very rarely two of them from the same community in the hospital at any one time. The last Aboriginal liaison officer whom I met—I do not know whether there has been a change—said that even as an Aboriginal she was rejected by some Aboriginals because she did not belong to their community.

CHAIR—Do you know of any pressure in Western Australia for birthing in the homelands, as it used to be called?

Mrs Facer—I think the person to ask is someone you will be hearing from after lunch, Linda Rawlings, because she has worked with the Aboriginal women.

CHAIR—Thank you very much. If there is anything further that you feel that you did not get the chance to tell us, please feel free to remind us again. If there is anything further that we need, we will contact you.

[11.28 a.m.]

INNES, Dr Kathleen May, Councillor with Portfolio, Joint Consultative Committee, Obstetrics/Gynaecology, Royal Australian College of General Practitioners

CHAIR—I welcome Dr Innes from the Royal Australian College of General Practitioners. 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 numbered 70. Do you wish to make any alterations to that submission?

Dr Innes—I have some additional information which relates to a best practice model and some data related to that which I am happy to provide.

CHAIR—The committee welcomes that. I believe you are going to show us some overheads. Please proceed to do so, along with any introductory remarks that you wish to make.

Dr Innes—I present here on behalf of the Royal Australian College of General Practitioners and have very recently resigned as vice-president of that organisation. During my time as vice-president, I also held several other portfolios which may be of interest to the committee—the portfolio for the Joint Consultative Committee between the Royal Australian College of Obstetricians and Gynaecologists, the Royal Australian College of GPs and the Australian College of Rural and Remote Medicine; and the portfolio for Aboriginal health—and I have a particular interest in general practitioner obstetric work force issues.

CHAIR—May I ask what you do in your free time?

Dr Innes—I actually work as the state health liaison GP for Western Australia—and I have three children and a husband! The reason I give you this background is that I actually wish to present to the committee what I consider to be best practice—best practice from the perspective of a community based general practitioner/obstetrician who has worked for 16 years in rural and remote Australia. I come originally from Victoria and worked in rural Victoria for 10 years. I have advanced obstetric skills in obstetrics and gynaecology and actually do procedural obstetric practice in Geraldton in Western Australia.

The data I want to present to you is a community based team approach to delivery of obstetrics and gynaecology services in a regional area. In a nutshell, we have a team of one specialist obstetrician/gynaecologist, about eight GPs—public and private sector—and a team of midwives in both hospitals who work in the community and who work in the regional hospital. During the time I have been in Geraldton and during the time we have had this specialist approach, we have reduced the caesarean section rate down to seven per cent. I suspect that probably makes us nearly the lowest in the country.

CHAIR—That is fantastic.

Dr Innes—That is the data I want to show you. We also have managed to provide an excellent regional service. Obviously, without a paediatrician, we have to fly people out, but

we are in a situation where I feel we provide a very good service and I would like to show this to the committee as a model.

Overhead transparencies were then shown—

Dr Innes—As you can see, this shows the total births for 1994 through to 1998-99. To explain the geography, Geraldton has a population of 25,000 to 30,000 and the whole region, if I look at my division of general practice, extends from Jurien to Exmouth—1,200 kilometres from north to south and 800 kilometres from east to west. The regional centre picks up a lot of this.

As I say, we have one specialist female obstetrician/gynaecologist—she works in a team with the GPs—and there were 659 births in 1994-95. That was the year in which she started. Now we will look at the figures for 1998-99: a similar number of births, perhaps a few more, because we have the facilities to drain the region. But if you look at the caesarean section rate, it has gone from 16.5 per cent to 7.3 per cent. We do expect it to rise slightly from 7.3 per cent, but I thought that was useful information.

The other highlight of this data which I wanted to show you is point 6. 'TOS' stands for 'trial of scar'. What we are saying is that, for women who have had a caesarean section in the past, we actively promote trial of scar management. In most cases, provided that someone does not have a recurring indication for their caesarean section the first time around, we do try to deliver people vaginally.

CHAIR—For the record, can you explain briefly what trial of scar means?

Dr Innes—Trial of scar is an attempt to have a vaginal delivery with a previous caesarean section. So what we have managed to achieve in this regional unit is 70 per cent success with our trial of scars. The other point is that we do make an attempt to deliver most of our breeches vaginally. Our obstetrician was trained in Africa and she is very meticulous about trying to deliver breeches vaginally. That is all the information which I want to present by way of overheads.

I want to talk about best practice and a team approach. It is absolutely vital that people see obstetrics and childbirth as part of a normal life event. Women having babies are not sick. Women having babies need continuity of care. Women having babies in rural areas need access to best practice, the same as women having babies in metropolitan areas. If you look at the figures, some work done by Les Wellard and Richard Hays in New South Wales in 1993, which is referred to in my submission, showed that, in rural areas of Australia, general practitioners are responsible for providing most of the antenatal and obstetric care.

Rural obstetrics is safe. The figures will indicate that women who have babies in rural areas have reduced access to care but the outcomes are in fact comparable. The point that I am really concerned about here is that worldwide research shows that rural obstetrics is safe and that rural general practice obstetrics is safe. The outcomes of rural units in places like Canada indicate that rural general practitioners are particularly good at identifying problems, picking up the problems early and transferring women out. That is why it is so vital to maintain these services, because the research also indicates that when you close small, GP-

run obstetric units in rural areas, the perinatal mortality statistics skyrocket. That is because rural women want to deliver close to home; in particular, Aboriginal women want to deliver on their lands near their people. They will resist attempts to send them, with all due respect, to places like the wonderful, artificial environment in which people get parked at this institution.

Rural women will present late in premature labour with undiagnosed complications. It is partly because they have not had access to adequate antenatal care; or they have had access to inappropriately delivered antenatal care, or 'one size fits all' type of antenatal care or 'This is the service; take it or leave it' type of antenatal care. There are important messages here: you have to provide culturally appropriate services, you have to provide care closer to home and you have to provide something that recognises that a woman who is living on a station in a remote part of Western Australia with three other kids cannot come and spend a month sitting on the doorstep of King Edward hospital. We have to be able to provide some model of care that will address her needs. We also have to be able to provide some model of care that will address the issues of Aboriginality and culturally appropriate services, and that model must utilise Aboriginal health workers as an absolutely important part of the team. We need to be taking care to women; we need to be taking care away from institutions and into the community.

I speak with passion about this because I am a rural GP obstetrician. For me, obstetrics is a vital part of general practice. Unfortunately, the statistics do not reflect this. General practitioners are dropping obstetrics in droves, and they are dropping it for all sorts of reasons. In WA, we have to have general practitioner obstetricians; in rural Australia, we have to have GP obstetricians because the specialists, by and large, will not move to rural Australia. It is important that we have well trained GPs who are able to practise safely within a small hospital environment. That means that small hospitals have to be adequately resourced—with money but, more importantly, with the human resources that are necessary. If you are looking for good perinatal outcomes, you have to be able to guarantee that, if somebody rolls into a small unit, the actual equipment necessary for the delivery is there and that you have somebody who knows how to use it and who can recognise when there is a problem and do something about it pretty promptly.

Once you close those units, you get this incredible downward spiral. Closing acute services in a small rural hospital is a disaster because, once you lose your acute services, you effectively turn many of these small rural hospitals into nursing homes. Because we live in a cost containment environment, the sort of personnel who staff nursing homes tend not to be able to provide acute medical services, acute nursing services or acute midwifery services within a facility. Then you have women rocking in in premature labour who often deliver very precipitately. That is where perinatal mortality really increases.

CHAIR—Does that more or less finish your opening statement, Dr Innes? Were there three or four other points? You can say the other things you need to say in answer to questions, if you like.

Dr Innes—I represent an organisation of general practitioners, and I think it is important briefly to mention general practitioner obstetrics in metropolitan areas. Although I do not practise in a metropolitan area, I think there are situations—particularly in outer metropolitan

areas—where GPs are still a very important part of the team. There is an increasing tendency for that community based team approach to be less common. It is important that we address not only the rural issues but also the outer metropolitan fringe. The mortgage belt is where a lot of our babies are being born, and it is important to keep GPs as part of that team. There are a couple of hospitals where I am in direct contact with some of their GPs, and there are problems in some of the outer metropolitan hospitals.

There are problems because the number of general practitioners who are doing enough deliveries to actually be able to afford their insurance is starting to decline. What you have is decreasing numbers of GP obstetricians who are providing care to greater numbers of people. Then you obviously have rostering problems because the fewer there are of you to do it, the thinner you have to spread yourselves. There are also problems because, if you are a GP, you perhaps have less clout when it comes to asking an anaesthetist for an epidural, and perhaps you have less access to the sorts of services that you need to do your job adequately.

CHAIR—Are there sufficient anaesthetists?

Dr Innes—My impression is that in some of the more peripheral hospitals there are difficulties getting anaesthetic services after hours.

CHAIR—Perhaps at this point we can take some questions.

Senator KNOWLES—I want to come in on the question of trying to encourage more doctors to undertake obstetric work. I notice on page 3 of your submission you highlight some very real problems, including the cost of indemnity insurance. We heard this morning from Dr Turnbull that the state government contributes a proportion of that insurance for general practitioners. What is that proportion? I did not ask Dr Turnbull this morning.

Dr Innes—This is an interesting issue. There are probably about 400 rural GPs in Western Australia and about 2,000 in total. Rural doctors are given a state government subsidy which matches the gap between non-procedural practice and the obstetric insurance.

Senator KNOWLES—The difference between the \$7,500 and the \$35,000?

Dr Innes—No, \$35,000 is what it costs you if you are a specialist. If you are a GP, you can insure yourself in a variety of different categories.

Senator KNOWLES—Just so that we can simplify this, what is the cost of obstetric cover for a general practitioner?

Dr Innes—My last medical defence bill was for \$7,500.

CHAIR—But what is the gap?

Dr Innes—The gap between non-procedural and procedural is about \$5,500.

Senator KNOWLES—What I am really trying to get at is: what does the actual general practitioner pay out of that \$7,500 vis-a-vis what the state government contributes?

Dr Innes—In some cases, \$7,500. There has been a recognition that rural GPs will probably get \$5,000 off that. They will actually make up the difference between procedural and non-procedural. But if you are an urban GP, you do not get it because you are not providing an essential service. This money has been set aside by the state government to support rural GP obstetricians.

Senator KNOWLES—The other thing that I think you point out very clearly on that same page is the perceived need now for diagnostic imaging, not just in obstetrics. There are more and more referrals for diagnostic imaging and pathology and everything else by every doctor. Would it be fair to say that that has been escalating due to the fear of being sued at any time?

Dr Innes—We practise in a very litigious environment.

Senator KNOWLES—Precisely.

Dr Innes—I think fear drives a lot of this. It does hang over your head if you know that for the next 25 years the decisions you make tonight or at 2 o'clock in the morning may impact down the track. You do not think about that at the time.

Senator KNOWLES—Exactly. When you say that HIC information says that we spend more in diagnostic imaging than on clinical antenatal care, are you referring specifically to obstetric imaging or are you referring to general across-the-board imaging?

Dr Innes—I am talking about diagnostic imaging for obstetrics. We spend more on taking pictures of babies than we do on delivering them.

Senator KNOWLES—Precisely. That is the point I am getting at: there is nothing extraordinary about that except that, due to the option of litigation for the next 25 years, it is a safety measure that the doctors now feel if they do not undertake will put them at greater risk than they would otherwise need to be.

Dr Innes—Does fear drive practise? It is hard to say.

Senator KNOWLES—I would not blame them. I am not saying that in a critical sense.

Dr Innes—Particularly as we have Professor Newnham saying that you can have as many ultrasounds as you like. The reality of that, though, where I live and work, is that you cannot have as many ultrasounds as you like, if you live in the middle of nowhere and you do not have access to all of this high technology that we are talking about. I do not want to take exception to anything that he said; in fact, I think focusing on antenatal care is absolutely critical. I would rather focus on providing a whole-patient-in-context-in-this-society type approach and give them access to good community based antenatal care than a whole lot of high-tech services.

Senator KNOWLES—I suppose the point I am getting at there is that, where a service is available, I do not blame a doctor for using it if there is a question mark surrounding the mother's or the baby's care. Let us face it, a place like Halls Creek has been mentioned a

number of times today. You do not have ready access to a whole lot of things when you are way up in the middle of the Kimberley, on the edge of the Simpson Desert or wherever. If it is not available, it forms part of a defence, for want of a better expression. Therefore, I think the way we can try to encourage people there to practise obstetrics is a very big question. There is the lifestyle issue: there are an awful lot of people who do not want to be dragged out 24 hours a day. That is a fair statement, isn't it?

Dr Innes—Can I also say that one of the problems in remote places is the lack of access to primary care services generally—not just for obstetrics. That issue really needs to be addressed at a system level.

Senator KNOWLES—Can I ask you about the issue of Aboriginal health. Much has been said today about Aboriginal health. I do think from time to time that we try to put a lot of the Aboriginal communities into boxes that they do not want to be in; therefore, there are a lot of do-gooders who say that you have got to send them off to there because that is the best place for their treatment, whereas they would much prefer to stay in their communities and have natural childbirth and, quite frankly, suffer the consequences of that. Many of those communities on the edge of the desert have repeatedly said to me, 'I wish the white fellas would buzz off and let us manage our health matters'—or whatever—'in a way in which we are tribally accustomed.' Do you believe this do-gooder attitude is really starting to impact on what they want and what is practicable as opposed to what we might think is necessary for them?

Dr Innes—I do not believe Aboriginal women want to die in childbirth.

Senator KNOWLES—No, they do not want to die in childbirth, but they do know that they can suffer the consequences if they choose to have their child in their communities and not leave them.

Dr Innes—I think what we have to be doing is taking antenatal services to the Aboriginal women in their communities, and we need to be taking them in a culturally appropriate way. It is access to antenatal care that is the most important issue here. If you have got a GP, Aboriginal health worker and nurse team which goes to the community and sees the pregnant women as part of the spectrum of continuity of care, they will have the opportunity to pick up the fact that their blood sugar is 26 instead of five; they will have the opportunity to see if the women have pre-eclampsia or toxæmia in pregnancy about to happen; they then have the ability to select the more high-risk group and perhaps enter into some sort of partnership as to how they can best deal with that when the time comes.

There is going to be a group of those women, particularly Aboriginal women, who are going to be diabetic. The percentage of diabetes amongst the Aboriginal community is frighteningly high. It is exaggerated by pregnancy, which is often a precipitating factor. I think it is more about developing a model in partnership with Aboriginal people to establish the most appropriate care for them and to offer them informed choice.

CHAIR—This is a really interesting submission. I appreciate, too, the overheads that show that in Geraldton the caesarean section rate has fallen significantly.

Dr Innes—We have a very high percentage of Aboriginal people. Thirty per cent of the community 100 kilometres to the east of me are Aboriginal.

CHAIR—That is very interesting, because according to your figures you have halved the rate of caesarean section in about three years.

Dr Innes—Yes.

Senator GIBBS—Impressive.

CHAIR—That is fairly dramatic. I suppose if you drop it from two to one, you have dropped it by 50 per cent, but you are talking about a fairly significant number of births, so we are pleased to have those figures on the record.

There are a number of questions that I want to ask. First of all, Senator Knowles has alluded to the fact that you claim in your submission that information from the HIC indicates we are spending more per year on diagnostic imaging antenatally than we are on clinical antenatal care. That is a statement. It is blissfully without being for or against. We have also heard from Dr Turnbull and others that the case can now be made that there is far too much ultrasound being done—to name just one procedure—or at least there is no measurable benefit for many of the ultrasound pictures that are taken; that if there was best practice in this area some few years ago, best practice has now gone out the window and everybody is doing all sorts of different things. You talk about best practice in other areas. Do you think best practice would be a help in this area too?

Dr Innes—It is difficult to develop guidelines in this area. Personally, I order a lot of ultrasounds, but I tend to target them. I order routine ultrasounds on everybody. Development of best practice guidelines probably is something that could be done in partnership between the College of Radiologists, the College of Obstetricians and Gynaecologists and the College of General Practitioners.

CHAIR—To say nothing of the federal government that picks up the tab. I am sure they are going to have a great interest in that little line in your submission. It is one of the best lines I have seen.

Dr Innes—It actually bothers me slightly that it has not been sourced, and I need to chase that up.

CHAIR—Yes, that might be helpful. I would just like to put on the record what you say here when you state:

It is important to note that a high Caesarean section rate is not indicative of optimal obstetric practice.

Vaginal delivery is the preferred method of delivery in terms of maternal and infant morbidity.

Are these claims of yours or do you think that these are defensible statements?

Dr Innes—There is no question that these are defensible. An elective caesarean section performed at 9 o'clock on a Tuesday morning does not give the foetus the triggers that it is time to wake up.

CHAIR—There seems to be research coming to the committee that the process of vaginal delivery does contribute to the establishment of respiration in a little babe.

Dr Innes—Yes.

CHAIR—We were also very interested to note that in the South Australian *Advertiser* the other day there was a photograph of a mother with a lovely little babe and the mother said, 'I had a caesarean section because I wanted no pain.' One wonders what kind of counselling she was given. We do not know the full story; those lines are all we have. But we have certainly had a lot of evidence that people are being encouraged to have a caesarean section because it saves you damaging your pelvic floor, it saves you getting a prolapse or incontinence and it saves you pain. Would you care to comment on those claims, all other things being equal of course?

Dr Innes—In my experience of obstetric practice, women walk away from vaginal deliveries and six weeks later women are still having trouble with their caesarean section scars.

CHAIR—That says it interestingly. On page 2 of your submission you state:

Best practice is a collation of expert opinion, not necessarily evidence based.

I allow the 'not necessarily', and you might tell us what it is about evidence based practice that makes you add 'not necessarily'. Then on page 5 of your submission you state:

Best practice guidelines need to be evidence based and developed by practising clinicians informed by national and international research.

It is that I am a bit bloody minded in this, Dr Innes. Could you please explain these two claims?

Dr Innes—Evidence has many levels. Cochrane level 1 evidence is difficult to apply to the science and the art of medicine. Anecdotal evidence is still evidence. Ideally, it is great to develop best practice guidelines, provided they are in context. The context in which I live and work is very different from the context for a specialist obstetrician practising here at King Edward. It is difficult to develop generic guidelines. Wherever possible, we need to develop them with the most appropriate evidence.

CHAIR—Quite, but your claim that 'a high caesarean section rate is not indicative of optimal obstetric practice' applies whether you are far out in the bush or at King Edward.

Dr Innes—It applies anywhere.

CHAIR—We have been told two things. In some evidence, people have told us that best practice guidelines cannot be described, and you cannot even talk about national best practice

guidelines because you would have to talk about the care in a small hospital being very different from the services provided in a large hospital—and those versus midwifery, et cetera. Others have said, ‘Absolute nonsense; best practice guidelines stand.’ Those guidelines would then be what you would aim for or would be properly qualified by what is appropriately delivered in various places. I suppose we could argue about what is meant by defining best practice guidelines. I do not think everybody wants totally blind, if randomised, control trials on everything—but you do allow that evidence based and best practice are goals to aim for?

Dr Innes—I do.

CHAIR—Nationally?

Dr Innes—Absolutely. I would argue that the principles of best practice apply no matter where you are geographically located, because the principles are around informed choice.

CHAIR—Could the government have a hand not so much in defining best practice guidelines as in challenging the profession—or whoever the collaborators are—to define them?

Dr Innes—That would be essential.

Senator GIBBS—We have been hearing quite frequently that women are actually demanding to have a caesarean. They are saying it is the best thing. Are women in Geraldton or out in the bush any different? Are they more informed? You have more of a hands-on approach than most people we have come across so far.

Dr Innes—I try to inform all of my patients about the options that are available to them, but I also form a partnership with them. I say, ‘Look, you’ve got to prepare your body to run a marathon. This is no different. You have to have a healthy diet and you have to get exercise.’ We talk about this. I give them my natural childbirth books and say, ‘This is what we aim for.’ But let us face it, we have to be realistic here. Sometimes people have complications, and you may end up with a caesarean section. It can happen to anybody if we have an emergency situation. I encourage women and their partners, who seem to be being left out of this a bit, to read the information that I give them, make choices based on it and write down a birth plan, which we will discuss. The birth plan deals with a whole lot of things: pain management in labour, whether or not patients want an injection for the third stage of labour and whether or not they want their baby to have vitamin K injections. It deals with all of these things, even to the point where it asks how you would deal with the situation if your baby were to die. People need to understand that this is a risky process. Have I answered your question?

Senator GIBBS—Yes, you have.

CHAIR—I should just say to both you and Senator Gibbs that this is terribly interesting and there is no pressure, except that we have just heard that one of our witnesses has to leave at a certain time. Do you think you could make your answers a little shorter?

Senator GIBBS—I have just one question. You say that a lot of GPs are dropping obstetrics. Does this have anything to do with the fear of litigation? It seems that, wherever we go, this seems to be quite a fear.

Dr Innes—I actually did some research in Victoria which looked at the reasons why general practitioners were ceasing obstetrics, and I compared a metropolitan group with a rural group. There were two major reasons why general practitioners drop obstetrics, and they are not what you might think. The first one concerned personal family and lifestyle issues. Obstetric practice is very intrusive; it is intrusive on your personal life, your family life and the rest of your medical practice. So when it is not the core business of your medical practice, you tend to look at things you can get rid of, and obstetrics is one of them. People do obstetrics for the love of it.

The second reason people are looking at ceasing obstetric practice in Victoria—particularly between 1996 and 1998—is the rising insurance premiums. A third reason is the perceived threat of litigation. There was, in fact, another major issue that we looked at: being able to get back-up in an emergency. This fear of being alone with an emergency is something that is very high in the minds of general practitioners. It is not the litigation; it is the fear of not being able to cope with an emergency in an isolated place. So there are a whole lot of issues, but by far and away the most important are the issues of personal family and lifestyle, rising insurance premiums, interference with other work and this idea of not being able to cope with the emergencies when they occur.

CHAIR—On page 2, you say:

(c) the variation in such procedures between public and private patients; Variation in childbirth practices is often clinician dependent. AIHW data from all obstetric and gynaecological procedures for 1995-6 indicate a larger number of interventions (e.g. Caesarean section, episiotomy) being performed on public patients.

However, when examining the data in certain age groups, it is apparent there are higher rates of intervention per head of population in private patients in the older age groups.

I want to know about that ‘larger number of interventions on public patients’. If you cannot give us that data now, could I ask you to take it on notice.

Dr Innes—It is sourced. It is from the Australian Medical Workforce Advisory Committee report. I am very happy to provide you with a copy.

CHAIR—It just seems to be contrary to the evidence. For instance, in looking at the public versus private patient in Western Australia, in every age category public patients have fewer caesarean sections. It may be that interventions include CS and episiotomy, for example, in which case we might get a different rate. The committee will follow that up.

Thank you very much, Dr Innes, for a number of things, including some great lines on a piece of paper, some excellent data and some wonderful work. If anything strikes you that you desperately wished you had told us, feel free to drop us a line.

Dr Innes—I will.

[12.08 p.m.]

MICHAEL, Professor Con, National Director of Health Policy Development, St. John of God Health Care

CHAIR—Welcome, Professor Michael. Do you have any other comment to make about the capacity in which you appear before the committee today?

Prof. Michael—I am appearing in my capacity as National Director of Health Policy Development for St. John of God Health Care System. Until three months ago, I was chairman and professor of obstetrics and gynaecology at the University of Western Australia where I have worked for 32 years. So I am aware of the public sector and the private sector.

CHAIR—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 choose to do so and the committee would give consideration to your request. Would you like to make an opening statement and then field some questions? If you do not wish to make an opening statement, please say so. Before beginning your statement, Professor Michael, I just wanted to ask you if St. John of God is hooked into the network of the Catholic health care system?

Prof. Michael—Yes, it is in the Catholic health care system.

CHAIR—Does St. John of God belong to Women's Hospitals Australia, with Professor Oats? Are you in the same network as that?

Prof. Michael—Yes, they are the Mercy Hospital.

CHAIR—Does that include the Mater hospital in Brisbane?

Prof. Michael—Yes.

CHAIR—I actually thought we were given a reference saying that we must talk to Professor Michael when we were in Western Australia. I cannot recall whether we were told to do that by Catholic Health Australia or the Women's Hospitals Australia or both. Anyhow, it does not matter which hat it is.

Prof. Michael—It does not matter; I am here.

CHAIR—You are dead right, Professor. We will follow that up. What can you tell us, or would you rather take questions?

Prof. Michael—I think I would rather take questions. But, as an introductory remark, this must be about the fifth inquiry I have taken part in about intervention or caesarean section or obstetric care. I have written two reports, one of them quite a large report in the early 1990s for the health department on the whole of obstetric and gynaecological and neonatal services. Nothing seems to happen. Most of these reports tend to gather dust and the exercises seem quite futile.

The Turnbull report was tabled in parliament, it was responded to, and as far as I am aware none of the recommendations were ever implemented. None of the recommendations I made in 1991 were implemented unless they were cost neutral, and clearly none of them were cost neutral—there were a couple that were cost neutral. So I wonder where all these things lead us to. It is not being disrespectful and it is not being rude; it just being a pragmatist.

CHAIR—Given that background, Professor, we are doubly grateful that you should come today instead of sending a letter saying, ‘I have been here twice before and I am not coming again.’ We very much appreciate your coming. Were any of the recommendations in your report recapitulated in the Turnbull report, or did you strike different recommendations?

Prof. Michael—Some were—some of the episiotomy data in the Turnbull report, for instance, saying that the episiotomy rate is 42 per cent in the average community and lower than that in the private sector. The private sector system, certainly the St John of God, has a 27 per cent episiotomy rate. So I wonder whether some of the data was entirely accurate. I would think somewhere between 27 and 50 per cent would be the average episiotomy intervention rate—if you believe that episiotomy is intervention. I think a lot of people do believe episiotomy is intervention, whether it is good intervention or bad intervention.

The other issue is that all intervention must be bad, and there is this philosophy that goes around that all intervention, whatever happens, has to be a bad outcome for the mother and for the baby. This is not so. There are very good indications for intervention, and as long as you adhere to those indications I think that is standard obstetric practice.

CHAIR—Where would we find a copy of those guidelines for intervention?

Prof. Michael—There are guidelines on the labour ward here which I helped establish some years ago on the management of pregnancy—when to refer, when not to refer—and those guidelines were based on issues that arose from the Joint Consultative Committee of the Royal Australian College of Obstetricians and Gynaecologists and the College of General Practitioners. They are also being used in most of the peripheral hospitals in Western Australia.

CHAIR—I think your point about intervention is well made, Professor, and I do not think anybody on this side of the table argues against intervention. What we have to recognise first of all is that Australia has an extraordinarily low maternal and perinatal mortality. Those figures are extremely low, despite the fact that the Aboriginal figures are included and are, particularly in perinatal areas, three times greater than the non-Aboriginal figures. So if the Aboriginal figures are included, our figures are extremely low for the non-Aboriginal population.

If you like, we have done so well that we are now dealing with a smaller percentage of cases that are harder, and clearly there are going to have to be different sorts of questions asked. But, so far, everybody who has come before this committee or who has put in a submission has said that they think the intervention rate—that is, particularly the caesarean section rate—is far too high, that it is a major concern that it is so much higher for privately

insured patients and that things like the age of the mother or the demand by the mother for caesarean section and so on simply do not account for the difference.

Prof. Michael—Yes, I accept that a caesarean section rate of 20 per cent is high. If you look across the private and public sector, of the total number of caesarean sections performed the numbers for emergency caesarean section are exactly the same: ten per cent of caesarean sections in the public sector are done for emergency indications and 10 per cent of caesarean sections in the private sector are done for emergency indications.

It is with elective repeat caesarean sections that you have a 20 per cent rate in the private sector, and that raises it to somewhere between 20 and 30 per cent overall. That is the difficulty. In that group you have patient choice, previous caesarean section and risks, and type of previous caesarean section. A caesarean section is more common nowadays in the smaller neonate because the outcome for neonatal intensive care is so good. The better the condition you deliver the baby in to the paediatrician, the better the outcome. These are issues that have arisen in the last 10 or 15 years. What you said is absolutely right: that perinatal mortality is only at about eight per 1,000 in the big institutions. To get another perinatal survival is going to be extremely difficult—you are almost at the irreducible minimum—and very costly. Even with technology, you may not ever prevent that additional one.

As far as the Aboriginal population is concerned, they do have a high perinatal mortality rate because they have a high incidence of diabetes, hypertension, foetal growth retardation and foetal growth restriction. They are overrepresented in the maternal mortality figures: they are two per cent of the community and may account for as high as 30 per cent of the maternal death rate in this country. In the last triennium, almost 40 per cent of the maternal death rate in this country was attributable to the Aboriginal people.

CHAIR—We have just seen some data from the Royal Australian College of General Practitioners in Western Australia, which shows that, over the last three to four years, the number of caesarean sections being done in Geraldton has halved. I presume that the status of the women of Geraldton has not so significantly changed in the last three years that it is not comparable to the status of women three years earlier. From what you say, too, I presume that a reduction in caesarean sections is a good thing. In your experience, what has been the principal factor in reducing the caesarean section rate?

Prof. Michael—In Geraldton?

CHAIR—No, anywhere.

Prof. Michael—The most important factor is continuity of care—that a single person manages such a patient throughout the labour. The reason why the Geraldton figures are so good is that they now have an obstetrician resident in Geraldton, which they did not have three years previously. She is a very committed obstetrician and, as I am sure Dr Innes would agree, she has taken on the philosophy of trying to achieve vaginal delivery. Against that background, you need to remember that one per cent of scars will rupture in labour. Provided you are able to recognise the dehiscence before it occurs, you may be able to reduce the morbidity and the mortality both to the mother and to the infant.

CHAIR—This evidence said an interesting thing—and it is evidence that we have had from other places—that is, it is the mind-set of the people in charge that makes a significant difference. If the chief obstetrician, the chief general practitioner and the chief midwife were all of the view that what we should be doing is aiming to get vaginal deliveries every time, it would be the best indicator for change in the C rate. You do not disagree?

Prof. Michael—No, I do not disagree at all.

CHAIR—It is interesting that you cited the attitude of an obstetrician in Geraldton. We heard yesterday that one of the factors that make my own state of South Australia the state with the highest caesarean section rate is that it has the highest number of obstetricians—who are largely the only people who can perform a caesarean.

Prof. Michael—Yes, it has.

CHAIR—So, we have evidence that a lot of specialists equates to a lot of caesarean sections. The difference with the obstetrician in Geraldton is that she is committed to vaginal delivery. She has the skills to knife them all, but she chooses to encourage the practice of vaginal delivery.

Prof. Michael—Absolutely. Also, she is a shared carer with the local general practitioners, and they do extremely well and have a very good relationship. With this single mind-set, single relationship continuity of care and the same people managing the patient, I think you can achieve vaginal delivery.

CHAIR—You say, with a bit of depression, that we have done this a number of times before. Indeed, we have. I think it must have been about 12 years ago that I asked my first question in the Senate about this extraordinarily high caesarean section rate. So I suppose that we can say we are still hunting for the snark; if we can only catch it and get it faced in the right direction.

One thing being very slow to change over that period has been the attitude to what is called alternative birthing, birthing centres or natural childbirth. There has been a climate where it has been said that women should go into hospital and have their babies under medical supervision in a clinical medical setting, and that having babies at home or in a birthing centre is still regarded as aberrant.

We have had evidence presented to us about women requesting caesarean sections. We were told that at a meeting not too long ago, less than a week ago, 300 obstetricians were asked what they would do if a woman asked for a caesarean section. In response, all 300 of them raised their hands and said, ‘Yes, we would give it to her.’ But if that same woman asked for a home birth or to go to a birthing centre, she is regarded as slightly nuts and obstetricians are much less likely to support her request for no intervention. Please comment.

Prof. Michael—I am sorry that that is the perception or the attitude of obstetricians. I think, frankly, models of midwifery and obstetric care are very important. When I was the President of the Royal College of Obstetricians and Gynaecologists, we developed models of care of which there were four involving the midwives predominantly in birthing centres.

Home birth is another issue; but, conducted properly and adequately and with the full, informed consent of the individual, let it be. But birthing centres seem to be a very useful alternative and, when they are near obstetric and medical care, they are very useful and very sensible alternatives. I do not have a problem with birthing centres.

CHAIR—So why is it that we do not have the climate change yet?

Prof. Michael—Again, I think it is a personal issue. I think that obstetricians are trained in a medical environment and they are trained in an abnormal environment. All the training positions in this state are in this hospital, and this is the only tertiary obstetric and neonatal hospital in the state. Some of them go out to the periphery, which I endorse and have supported. I think it is very important that they go to the smaller rural hospitals where they can learn alternative or less tertiary services. I think that must have a bearing on them in that they decide that operating or doing a caesarean section is in the best interests just in case this happens. I think that is the way they are trained.

I think lifestyle, indemnity insurance and litigation are all other factors, and I think they are very real factors. I think obstetric litigation is ridiculous. I think the Teto report failed, and failed badly, because it did not identify alternatives to the current tort system but did identify that we have too many adverse outcomes, particularly across the board in all medical intervention. But unfortunately the issues of a no-fault compensation tort system were never addressed. In the meantime, indemnity insurance has doubled, literally. So there are many issues that have affected the obstetrician.

CHAIR—In Canberra, on behalf of the Australian Catholic Health Care Association, Francis Sullivan said in evidence that he thought national best practice guidelines, if clearly defined, could be used in court to say, ‘I actually followed best practice guidelines,’ as a defence against the increase of suing. I wonder whether you would care to comment on that.

Prof. Michael—That is a very sound statement. But I do not believe that any best practice guideline has ever been taken into court. There is no record, as far as I know, of best practice guidelines being held up in court and it being said, ‘But look, this is what best practice suggests; why did you depart from best practice?’ I think that is the first issue. The second issue is that best practice guidelines have frequently allowed out of court settlements; and, thirdly, they have allowed plaintiff lawyers not to take on cases and defence lawyers to take them on or not take them on. So that is really where they have finished up.

But best practice guidelines are as good as they are bad. They have to be flexible and they have to be sensible. I agree that you should have best practice guidelines. But if you wish to depart from them because the clinical situation suggests it, and you can support such a departure clinically, then I believe that that is a reasonable thing as well. I do not think they should be rigid and I do not believe that they should be used in litigation. Earlier you made a remark about there being too many obstetricians and too few patients; I think the same could be said for lawyers.

CHAIR—I am terribly tempted to join you with a loud ‘Hear, hear!’ I wonder whether the college speaks to appropriate lawyers about such matters as this. We were told that, for example, clear evidence is emerging that cerebral palsy is not so much a birth matter but an

antenatal matter; evidence is showing more and more that cerebral palsy damage is more likely to be antenatal than birth, but courts do not want to know about it. I think that sounds as though some of our legal friends might need some further—and I suppose I dare not say this—re-education. But that I think is very depressing. If the medical evidence is showing that—and it seems to be, on the evidence we are getting, that it is emerging that way—it is a shame that is not getting into courts.

Prof. Michael—I think it probably is. I think the only cases that get up in court are really those that have very distinct intrapartum or antepartum indications. Most of the cerebral palsies—at least 95, 98 per cent—are related to an antepartum event which in most cases is not identifiable, and that is the difficulty.

Senator GIBBS—Basically, Professor, in talking to Senator Crowley, you have answered just about every question I was going to ask you. I have just one quick one. It has been evolving in this inquiry that there is this culture of mothers who think, if they have a caesarean, they will have a perfect baby and that other things will not go wrong—and they are often not taught about that.

Also, I must say that it is really refreshing to speak to somebody like yourself who has similar views to Dr Pridmore in South Australia; that is, you believe in continuity of care and do not wield the knife unless absolutely necessary. But it seems that the evidence is showing that most obstetricians will wield the knife because of what you say: it is better to be sure; there could be litigation; and basically because of the way they are trained. Do you think we should be training obstetricians differently so that a caesarean is only done as an emergency measure?

Prof. Michael—I think obstetricians are specialists and they are there to deal with the complex and complicated case. My preference for normal obstetrics, as it were, would be for the general practitioner/midwife model because I believe that the general practitioner is the key person in obstetric care. But unfortunately the general practitioner is being edged out of obstetrics for a number of reasons, and I am sure that Dr Innes would have alluded to those reasons. But some of them are also patient choice. I think they think, if they go to an obstetrician, they might get better care; that is not always so. I think general practitioners really are the cornerstone of practice in this country, and that includes obstetric practice.

Senator GIBBS—Yes, exactly. But a lot of the obstetricians have been telling us that there is a high rate of caesarean section in this country because the women are demanding it.

Prof. Michael—I think there is a lot of truth in that. I think there is an increasing demand; there is an increasing demand particularly with the older woman, the woman who has had a previous caesarean section. I do not know that I would ever agree to—and I think I have agreed to one probably only once in my professional life—a caesarean section in an uncomplicated first pregnancy. But in the second pregnancy, yes, I have been under pressure, just as every other doctor has been under pressure, for a caesarean section from the patient and particularly from the women who are dealt with in the private sector. They are significantly older than the women who are dealt with in the public sector and more than the state average in the public sector. So these women often have deferred their pregnancy; they

have had a risk factor in their first caesarean section, and that risk factor may still be present in a subsequent pregnancy. In those situations caesarean section is the treatment of choice.

But if it is sort of fifty-fifty each way—should we give it a go or not give it a go—then you will find that the woman will have a lot of input into that decision. She may not wish to undergo a prolonged labour or a painful labour, and she may not wish to have the problems of a pelvis or a difficult vaginal delivery. These are just preferences. There is a lot of pressure from the women in the community for caesarean section.

Senator GIBBS—That seems to be the case. I suppose it is understandable that, if women are doing this sort of pressuring—and I am sure they are—the obstetrician does carry out the caesarean because I suppose there is always the thought ‘If anything does go wrong with this child, and it is really not my fault as a doctor anyway, it is going to happen, I am going to face a massive lawsuit.’

Prof. Michael—I think that is the philosophy, that it is much easier to undertake a caesarean section at a time that is convenient to you and convenient to the patient under ideal conditions. That would be hard to not accept. You may have a woman who is forceful enough or says, ‘Yes, look, there’s no reason for me to have a vaginal delivery and I am not going to have one.’ On the other hand, you could have the same woman being forceful enough about a vaginal delivery. Provided that she accepts the risks associated with a vaginal delivery, that is fine. But it is all a matter of consent.

Senator KNOWLES—Professor Michael, it does worry me that the private sector is continually painted as the bogey in terms of increased intervention.

Prof. Michael—Having jumped ship, as it were, for three months, I feel the same problem. I can assure you that the standard of medical care in the private sector is not worse than the standard of care in an institution such as this, where I have worked for 32 years.

Senator KNOWLES—Precisely, and I think it is a shame for people to have a perception that one sector is somehow better or worse than the other.

Prof. Michael—Really, given the financial constraints that are occurring in the Australian health system at the moment, it will be impossible for each sector to operate independently in the future. I think we are going to see great changes in our health care system where the private and public sectors will depend on each other for rationalisation of services. I am sure that is going to happen.

Senator KNOWLES—I think it is worth noting, from the committee’s point of view, the number of differences in a positive sense that are occurring in the private sector as well in terms of the number of people attending antenatal classes. As you say here, levels of attendance in Western Australia are up to 87 per cent in the private sector, whereas it is only 55 per cent in the public sector. With epidurals, there was a difference in a positive sense, and with episiotomies in a positive sense. So it is a shame that the private sector is being portrayed in this way.

Also I notice that page 4 of the Australian Catholic Health Care submission states precisely what you were just saying to Senator Gibbs, that there is 'a clear increase in caesarean section rate with increasing maternal age'. Let's face it, most of those people are privately health insured if they are going to run that risk; and, secondly, many of those people have a susceptibility to complications. So they are going to be in the higher category—

Prof. Michael—Higher risk, anyway.

Senator KNOWLES—higher risk category before they even start off. Do you think that there is anything positive that can be done in a government sense to start to restore the balance of opinion between the two sectors?

Prof. Michael—I think the private sector reflects—as I have said in that report—the continuity of care which occurs either at general practitioner or obstetrician level, just as it occurs in the birthing centre with a midwife in low risk level 1 cases where the outcome should be extremely good. Being conscious of pain relief in labour and as women are conscious of pain relief in labour, I think the community should not be critical of epidurals but should be supportive of good appropriate analgesia, whatever suits the individual. If an epidural is what they want, then I do not have a problem with an epidural. The only way they will not get it, as I said in the submission, is if they are in a rural service where, in fact, epidurals are not available. I know a town 60 miles from here where women are transferred to major centres not because they have an obstetric indication but because they want an epidural and that epidural is not available.

In this hospital across-the-board epidural rates would be somewhere around 70 per cent; and for caesarean sections the epidural rate would be close to 99 per cent. The reason for that is that you have a anaesthetic team that is committed to epidural anaesthesia, and they do it extremely well and the risks are minimal. Not all women will be able to walk into the labour ward when they are halfway through labour having not felt a contraction and then deliver in two hours and go home tomorrow. That does not happen. There is the position of the baby and the state of gestation, whether they are overdue or at term. All these things, particularly if they are overdue, will influence the labour in some way.

So to lump everybody together as being the same sort of person I think is wrong, and that is what we do. Consequently, because the private sector tends to have a lot of high risk women, I think these high risk women in the private sector are more likely to have intervention. But, equally, you should also remember that in this hospital, this big institution, where the standard of care is excellent and the standard of care for women who are tertiary level is absolutely as good as anywhere in the country, only 30 per cent of patients are high risk at the time of delivery. So should we be sending those other 60 per cent out to the periphery to be managed by general practitioners and midwives and have this as a centre of excellence?

But I agree that you cannot generalise and you cannot paint the private sector as being overinterventionist any more than you can paint the public sector as being underinterventionist. I have seen underintervention in the public sector which would clearly contradict Senator Crowley's guidelines—absolutely contradict them.

Senator KNOWLES—I must admit that I do share your sense of frustration or exasperation in terms of sawing sawdust again on another inquiry. I think really what we need is politicians sticking their beaks out of some things as opposed to sticking them into some things. What is your opinion in terms of political intervention, for want of a better word, in trying to manipulate some of the outcomes that we are seeing today?

Prof. Michael—I do not think anything will happen unless there is political intervention—or lack of intervention, and I think this is more likely. I know that Hilda Turnbull's report was tabled in parliament. I do not agree with Hilda Turnbull's report, but that is my opinion. A lot of things in it are extremely good and a lot of things in it are useful. But it was tabled in parliament, and that was it. The minister of the day, who happened to be Kevin Prince, made his submission and over it went. As I understand it, the catalyst or the initiative for that report was indeed the high caesarean section rate/intervention rate in the town of Collie where Hilda Turnbull is the sitting member. Also, there is my own report, as I said earlier—but only if it were cost neutral. Two Aboriginal reports that I have written have never surfaced.

Senator KNOWLES—My position has been quite unequivocal on this right from the word go: the intervention of members of parliament in things such as this as opposed to a decision between doctors and mothers is sort of undesirable, so to speak. I believe that responsibility ends up with the doctors and the mothers for clinical decisions that are in the best of interests of the mother and the baby. Do you think there is any reason that there should be any other intervention from our side?

Prof. Michael—The intervention that I was considering was not that of interference with the professional relationship or the professional advice; it was to supply adequate obstetric and midwifery facilities, particularly in the rural areas of Western Australia or Queensland, which is similar, or outback New South Wales.

Senator KNOWLES—Which is primarily a state responsibility, not a federal responsibility.

Prof. Michael—State not federal, absolutely. But I think the important issues are those of providing adequate care, adequate general practitioner reskilling. A general practitioner in the rural area cannot come to a major centre unless somebody goes in and looks after their practice, and they cannot afford to pay that person. There should be subsidies from the federal government to enable there to be development, personal development, personal reskilling. You would get a lot of people staying in rural areas if you were able to improve their continuing education and facilities.

Senator KNOWLES—The federal government, for example, has made an exception for some parts of rural Australia, including rural Western Australia, in relation to overseas trained doctors because of the lack of number of doctors prepared to go back out to the bush. I think it is those sorts of initiatives that you are expanding upon now that need to have the focus as opposed to trying to points score in some area.

Prof. Michael—As president of the medical board, I am not altogether agreeable about overseas trained doctors and their training. I think we have to consider redistribution of our

medical work force and we need to consider our own people. Those overseas trained doctors who are well skilled, who come from recognised countries where the college of general practitioners is not dissimilar from our college of general practitioners, I have no problems with, and I would welcome them.

Senator KNOWLES—Dr Wooldridge has set the high-jump bar fairly high for those people now—

Prof. Michael—He has now.

Senator KNOWLES—and that is an improvement on previous practice.

Prof. Michael—Yes.

Senator KNOWLES—But the problem I suppose is that, because so few of our own have been prepared to go back out there, some allowance had to be made to make sure that the people resident in the country towns were covered. So the priority then became the people, and making sure that the doctor had adequate qualifications that were recognised in Australia as being equal to those of Australian trained doctors.

Prof. Michael—I would support that. It will attract those who are appropriate. I am not sure what it will do for the temporary resident doctors; it will create problems, I am sure. There are so many of them waiting to be assessed; I think across the country there are 1,200. But that is the major issue. I do not know how you resolve that one. Nor do I know how you resolve the provider number legislation, and that will have a severe impact on vocational training.

CHAIR—We have been considering variations in antenatal screening, and best practice guidelines might need to be subsetting—and I would be interested in your comment about this. As we get a new piece of high-tech equipment, for example, it seems that we do need perhaps a trial period to establish whether or not it is worthy and then the optimal way for it to be effective. It then seems that we need, somewhere along the line, best practice guidelines for the optimal use of that piece of equipment. It says here that information from the HIC indicates that we spend more per year on diagnostic imaging in antenatal area procedures than on clinical antenatal care.

Dr Innes, having had that read out to her, suddenly went cold with sweat all over—and she is doing it again behind you right now—worrying that, ‘My gosh, maybe this is not true.’ But supposing that it is true—and I feel sure that it is—on the face of it, does that cause you to think, ‘Well, hold about, maybe we do need some clear guidelines on diagnostic imaging antenatally’?

Prof. Michael—Absolutely. It does concern me that too much ultrasound is undertaken in pregnancy. But, if I can perhaps make Dr Innes’s cold sweat even worse, diagnostic ultrasound HIC costs more than the whole of obstetric services—not just antenatal care, but antenatal care, confinement and postnatal care. That was about two years ago.

CHAIR—Ergo, what—therefore, what follows?

Prof. Michael—Then I think—and I agree, I have made that statement—far too much ultrasound is undertaken. That is the case, firstly, in early pregnancy. I still practise clinical medicine, so patients still come to see me. After about 12 weeks, they might come with three or four ultrasound examinations having been done in that first 12 weeks just to make sure that the foetus is okay.

I do not think you need to do an ultrasound in the first trimester of pregnancy unless there is a clinical indication. That may be bleeding or, alternatively, uncertainty about gestational dates—because one of the other screening tests that you are going to do in those patients who accept it is for Down Syndrome which is carefully tied to gestation. So, if the gestation is wrong, the outcome will be wrong.

I think the only mandatory ultrasound really is at 19 weeks for the anatomy of the baby. Some people would say that is unnecessary, but I do not agree with that. One scan at 19 weeks would be considered by me to be best practice; thereafter, it would be only when clinically indicated.

CHAIR—We have received evidence—and I think yours corroborates this—that there were guidelines for ultrasound, to take just that example, that they have been completely lost and now people are having all sorts of different variations in the number of ultrasounds per pregnancy, per place, per whatever. Do you suggest that it would be a good idea to have some clear national guidelines on the appropriate use of ultrasound during the antenatal period?

Prof. Michael—Yes, coming from a responsible body. That could be done by the Australian society or the college, which has a subspecialty of ultrasound, under the auspices of NHMRC.

CHAIR—Can you comment on the training of operators of ultrasound or the ultrasound equipment? Is it necessary for us to have guidelines about the training and the sort of ultrasound too?

Prof. Michael—Yes, I think so. There are guidelines for those who are in specialist ultrasound, whether they be obstetricians and gynaecologists or whether they be radiologists. They either take diploma of diagnostic ultrasound or other training within their qualifications. These are recognised by the College of Radiology and the College of Obstetricians and Gynaecology. That is the specialty group, and I think they are the ones who are important.

But I do not think you require training to operate a small real-time ultrasound machine in your surgery and attract a benefit for it. I am pretty sure that you do not, although there are a lot of medical politics about this. I might add that it is not only obstetric ultrasound; it is vascular ultrasound, doppler of the legs and all those things, which attract enormous sums of money.

CHAIR—I am very interested in the establishment of professional standards, best practice guidelines and what have you. I found it extremely interesting that people are saying that best practice should be established by ‘the professional’, and the midwife is usually a bit

of an afterthought. It is emerging—and most of us are actually suggesting it—that ‘professional’ should include midwives, GPs and obstetricians. But there is this pesky creature called ‘her’—the mother—and I am finding it very interesting that so many people are also now saying, ‘You would have to do this in consultation with the mother,’ which is certainly a significant improvement on 25 or 50 years ago when perhaps there was an attitude of ‘lie down and take it’.

I think Dr Innes has just indicated that I should also talk about the family and/or the father. It is understood that when we talk about the mother it is her in particular; but it may be a her and a him. What do you think it says about professional standards if, as we are being told, a specialist obstetrician will say, ‘Yes, but if the mother demands it, we will do it’? There seems to me to be a tension there.

Prof. Michael—There is. I think you can make up all sorts of excuses to justify such a statement, and I certainly do not propose to do that. I would try, and I still try, to deter the mother, and give her the reasons why I think she should have an attempt at a vaginal delivery and that I would be prepared to interrupt that vaginal attempt at any time by caesarean section. This was what I was saying earlier about continuity of care. I know the woman; I see her in early labour; I see her throughout labour, and I manage her confinement. It does not happen in the public sector because there may be several different people. I have often said that, even in the private sector, the only person who is common to the whole labour is the patient. The doctor and the midwives change because industrial regulations demand that the resident and registrar staff have a clearly defined working day or week, because it is considered to be unsafe if it were excessive.

So I think continuity of care is important. If the mother is confident enough to be able to accept that continuity of care and your reassurance, I believe you will convert a number of them. But if you make those sorts of promises and you do not turn up to the delivery or you are away or something, then the whole issue falls apart. I do not know how you cope with that.

CHAIR—It seems to me that the other side of what you are saying is that consultation with the mother or the mother and father has to be included in your professional best practice guidelines.

Prof. Michael—Absolutely. I think communication is the single most important factor in managing a pregnant woman—not the fact that I can do a caesarean section or a vaginal delivery. It is the communication that is the most important thing. Most litigation and most complaints about doctors to the Office of Health Review are not about standard of care; they are about communication. I think even litigation would be minimised by adequate communication skills.

CHAIR—Curiously, that is exactly the evidence that we were getting from the Health Commissioner in Victoria, who is proposing that her name be changed to ‘Health Ombudsman’. She says that any number of complaints are resolved by conciliation when people finally get to have their say with an expectation that they will be heard, and that if this had happened earlier on, a lot of the difficulties would go away.

Prof. Michael—It goes away. I meet with the Office of Health Review in this state once a month and look at the complaints. So I have no doubt that communication is the most important basic fundamental of all patient care.

CHAIR—So that should perhaps come into obstetrician undergraduate training—

Prof. Michael—More importantly than that, I think obstetrics is such a sensitive discipline—gynaecology is even more sensitive—that the doctors should have that discipline and sensitivity, particularly people like me who are males. There are a lot of women who do not want to go and see males, and I respect that. That is probably a good thing. Nonetheless, I think if you are managing a patient in those sorts of disciplines, sensitivity and communication are really most important.

CHAIR—On that note, thank you very much, Professor Michael.

Proceedings suspended from 12.55 p.m. to 1.57 p.m.

RAWLINGS, Ms Linda, Committee Member, Birthplace Support Group Inc.

CHAIR—Welcome. The committee prefers all evidence to be given in public, but should you wish to give your evidence, part of your evidence or answers to specific questions in camera, you can ask to do so and the committee will give consideration to your request. The committee has before it your submission No. 171. Do you wish to make any alterations to that?

Ms Rawlings—No, I do not.

CHAIR—Would you like to make an opening statement and then field questions?

Ms Rawlings—Yes. I see birth as absolutely fundamental. My perspective is somewhat different to the majority of views on the experience of birth. Perhaps this is as a result of my first pregnancy back in 1981. I was born at home in England. As I became more pregnant I realised that I would need a midwife, and was actually quite shocked to find that there was only one in the phone book at that time. I soon came to realise that, in Australia, babies are born in hospital. I think it is quite odd that I could live in this country for 17 years and not realise that babies are indeed born in hospital.

Another factor touched me deeply during this pregnancy, and this was the fact that my Aboriginal sister-in-law, a semi-traditional Ngaanyatjarra woman from Central Australia, was also pregnant. She was preparing for her second child's birth. She had to leave her community to give birth 2,000 kilometres away from her people. She gave birth with people who did not speak her language and everything was unfamiliar. For all intents and purposes, it was like birthing on another planet. I went ahead and birthed very easily at home. I felt that there was a deep contradiction between the two experiences of childbirth, and I have become very politicised about the issue.

When my first child was about two years old, I went back to university and studied for four to five years, looking at childbirth from the non-medical point of view—looking at all other aspects: the emotional, social, cultural and anthropological perspectives—and it is from that deep commitment that my work has grown and developed and it is why I am sitting here today.

Senator GIBBS—You say that you studied for four to five years; are you actually a midwife?

Ms Rawlings—No, I am not a midwife.

Senator GIBBS—What did you study?

Ms Rawlings—I studied at Murdoch University. I did a double major in women's studies and human communications. I have made films about childbirth. I have spoken at many conferences on childbirth. I have undertaken workshops related to childbirth. I write about childbirth. My life is childbirth. But I am not a midwife. I have also attended many births in the role of a doula.

Senator GIBBS—So, obviously, you are supportive of midwives and homebirths, but—as you have studied it—you are not narrow in your perceptions and believe that people should give birth only at home. Obviously, you are advocating choices for women—if they want to have a child at home or if they want to go to a hospital they are entitled to. We have listened to a lot of submissions from midwives, and they have a problem in some states. If they are caring for the mother at home they cannot go into hospital with the mother or, if they can, they are there only as the support person. Are you advocating that midwives should be allowed in hospitals and accredited so that they can actually assist with the birth?

Ms Rawlings—Yes, I think that is absolutely fundamental. When a woman decides to give birth at home she does so for a whole host of reasons. Usually, it is very important for that woman to connect quite deeply with the primary care giver. Obviously, to have the conviction to give birth at home, birth is very important to her. Once she is transferred to hospital, after she and her midwife have decided it is a responsible thing to do, I think it puts a great stress on the woman if her primary care giver is no longer able to act in that role when she has the skills and the training to do so.

Senator GIBBS—You mentioned that your sister-in-law is an Aboriginal person. Were there no facilities for her to give birth where she lived and so she had to be transported to a hospital?

Ms Rawlings—No, it has been the health policy in the Ngaanyatjarra land since the mid-1970s for the women to be removed from their communities to give birth in hospitals in Alice Springs, Kalgoorlie or Perth. I would like to table a research document I did for the review held in WA in 1989 on obstetric and gynaecological needs across the state. This particular piece of research was funded by the Women's Trust and represented the needs and concerns of the Ngaanyatjarra women. Many of them would prefer not to leave their country to give birth. Obviously, there are not sufficient facilities and certainly not the health policy support for them to do that, but it is at great cultural, social and often physical cost to the women themselves.

Senator GIBBS—I can understand that. How would you remedy this situation? What can the authorities do to remedy this situation?

Ms Rawlings—As I mentioned in the submission from the Birthplace Support Group, there are two things that can be done. The first is to look very closely at the doula training program that has been initiated and implemented out of Cairns Base Hospital, where Aboriginal women are being trained to act as support people for their sisters, daughters or whomever, so that, when these Aboriginal women go to regional centres to birth, they actually have someone with them who is there not only as an appropriate kin but also to give them the appropriate cultural and physical support and caring that is necessary for them to birth without complications beyond what is normally expected.

The second thing is that Aboriginal women should be re-empowered to make decisions about birthing for themselves. I did mention a very radical program that has been implemented in Povungnituk in northern Quebec where the female elders were given the support to take birthing back into their hands and to return it to their lands. They have had extraordinarily positive results. Not only is this felt on an individual basis but certainly

throughout their community there is a lot more strength and pride as a result of having birthing back on the land.

I think there is in our society, certainly within our health system, an overemphasis on statistics. I think that we have to bring a cultural element into the reading of statistics and see whether there are actually any social or cultural costs as a result of striving forever for better statistics. Are we getting better statistics at the expense of Aboriginal women who feel disempowered, abused, lost, lonely and unsupported throughout their birth experiences? How does this impact on them as individual women, how does this impact on the child born, and how does it impact on their culture and survival into the future?

Senator GIBBS—When you talk about the Aboriginal women being trained so that they can be a support to their sisters when they are giving birth, what about the antenatal area? We have heard a lot of evidence that there is a huge problem with Aboriginal women before birth. They do not like to go to the hospitals because they are not sick, and, because of that, they might go once and then they do not go again until they are ready to give birth. The problem may be that they are not eating properly, they might be smoking, they might be drinking—all sorts of things—and of course they have probably got illnesses themselves. So the poor little child has low body weight and has not got much hope. Most things are going against it.

Ms Rawlings—I do believe that when there is no option to give birth on the lands, there is certainly no incentive for the Aboriginal women to take better care of themselves. If there were an incentive—like saying, ‘If you eat well, exercise well and do all the right things, you can birth here because we have implemented this and other support for you to do so,’—then there would be something to strive for. At this point in time, there is nothing for many of the Aboriginal women living in remote communities.

Senator GIBBS—Thank you very much. That is very interesting.

Senator KNOWLES—I just want to clarify in my own mind some things about your submission. Is it fair to say that you are—‘hostile’ might not be the word, but I might use it anyway—a bit hostile towards the medical profession and its *modus operandi*?

Ms Rawlings—‘Hostile’, I think, is a little strong, given that my third child was born by caesarean section three years ago. It would be ridiculous for me to be hostile. I hold great concerns about the biomedical perspective of childbirth and how it has saturated our society to the degree where, when you speak to young women about childbirth, there is invariably the assumption that they have to birth in hospitals because they need medical assistance to do so.

Senator KNOWLES—I suppose where I am coming from is that you seem to focus, basically, on childbirth as opposed to the entire pregnancy. Your whole presentation seems to have surrounded the event as opposed to the entire time of monitoring, checking and ensuring everything is fine.

Ms Rawlings—I do not believe that is true. You will note that I have talked at length about antenatal processes and the sociological and anthropological effects of the biomedical

representation of childbirth in our society. I do think that there are problems with the antenatal processes, in that they do focus excessively on the medical, body, side and not enough on the emotional, social, spiritual and cultural side.

Senator KNOWLES—But isn't the medical side equally important? For example, are you aware of work that has been done by Professor Newnham in terms of antenatal research in detecting disease long, long before a child ever comes into the world at birth?

Ms Rawlings—No, I am not specifically aware of that work. I did make a statement at the beginning of the report making no apology for my bias, given the fact that the majority of submissions would be coming from the biomedical side. I see that I am sitting here today representing the other side, but please do not read this as being hostile. Please read it more as attempting to balance the perspectives out a little more.

Senator KNOWLES—I suppose, from where I look at it, from what you are advocating, there can at times be a dangerous emphasis on a greater focus on emotional support and conflict resolution—as you talk about on page 5 of your submission—as opposed to ensuring the health and wellbeing of the mother and the foetus in a medical sense, going through the pregnancy.

Ms Rawlings—I do believe that the health and wellbeing of the child has a lot more to do with the emotional state of the woman than medical professionals are willing to acknowledge.

Senator KNOWLES—But you believe that the emotional state of the woman is going to somehow prevent or detect a serious abnormality?

Ms Rawlings—No, I don't.

Senator KNOWLES—So how is that going to be done if it is not done by the mother being treated in a professional sense?

Ms Rawlings—I think that women should be allowed to choose whether they take that road or not. Some women, as they have in ages past, have gone through their pregnancies and only found out at the time of birth that there is a problem with the child. They have then brought together whatever support they have deemed necessary to help them through this. We do have technology available to us, and many, many women choose to find out whether their baby is perfect before it is born and choose not to deliver a child if it is not. You must understand that a significant proportion of these children are in fact healthy and are aborted without there being due cause.

Senator KNOWLES—I am not talking necessarily just about those being aborted. I am talking about those who can have any abnormality fixed in vitro as opposed to having the child born with an abnormality which it is going to have to carry for the rest of its life, if not die from.

Ms Rawlings—Okay. I consider that to be a judgment from certain perspectives that a whole, perfect person is better than a person who has a disability, an illness or whatever. I

think there is undue pressure on women throughout pregnancy to give birth to the perfect child and that this has become more important to them than anything else. I claim that there are other things that are important, including sustaining an experience of pregnancy and a connection with the child which is totally unconditional. I would hope that our society would provide all the supports that are necessary, post-birth of any child, to deal with any circumstances which might find an ill child within it.

Senator KNOWLES—Are you actually suggesting to me that there would be women who would be not wanting to have the perfect child, health-wise?

Ms Rawlings—I do not think any woman would choose to have a disabled child, no.

Senator KNOWLES—Precisely. If they had a choice and they are asked, ‘There you are, there is a disabled child and there is a child that is fit and healthy; which one would you prefer?’ I cannot see many people lining up on this side saying, ‘I would prefer to have a disabled child.’

Ms Rawlings—I would invite you to go and speak to the parents of down syndrome children.

Senator KNOWLES—We have colleagues who have down syndrome children and they love those children—absolutely adore those children. I am not for one moment trying to say that the parents do not love those children—that is a different story altogether. But if those very same parents were asked whether they would like to have a normal child or a down syndrome child, they would all say that they would have loved their child to have been normal because they would have a normal life.

Ms Rawlings—That may well be the case. My deepest concern is that, as a result of the Senate inquiry, we do not get more impositions on pregnant woman to have this test, that test and everything else. I sincerely hope that, as a result of the Senate inquiry, pregnant women are given all the support to experience their pregnancy free from pressures from the medical profession that will shape their experience in a way which takes them and their child away from each other. I do believe that, as a result of all the neonatal tests, many women go through their pregnancies not even connecting with their child until they know it is 100 per cent perfect.

CHAIR—Ms Rawlings, I just want to interpolate there because we are pressured for time and I want to have the opportunity to ask you a couple of questions. You said that you were not too keen on necessarily just pursuing statistics and getting the statistics right. However, I would urge caution on that line, because you have a beautiful statistic from Povungnituk where the caesarean rate dropped from 21 per cent to three per cent. So do not throw statistics out altogether, especially if they make a case like that one. I would like to know a little more about that, so perhaps we will seek that information for ourselves. It is particularly interesting. That is a very significant drop.

First of all, it is wonderful that you have come, and please do not go away feeling that you are alone. The attitude and perspective that you represent has been put to us more than forcefully by a number of submissions and by a number of witnesses. We have taken some

stern criticism for the terms of reference being entirely mechanical. It is not our view. But, if it was beforehand, a lot of people are shaping our view in another direction. In your submission you talk about the way information is provided to a mother. On page 2 you say:

A sensitive GP, midwife or obstetrician will provide 'negative' information in a most positive, open ended and encouraging way, others are inclined to use the information or results (largely unconsciously)—

a brave claim—

to control or berate and, in effect, undermine a woman's confidence.

We had evidence in Melbourne from a wonderful doctor, Jane Fisher, who suggested that it is terribly important that research be done—I think she has done some but would like to do more—on how information is passed to the woman and whether or not it does what you claim. I just wanted to give you that information to suggest that there are other people who are equally concerned about the way the communication is done and whether that then qualifies the outcome.

I also want to draw your attention to the evidence. Because you have appeared before us as a witness you will be provided with a copy of the *Hansard* so that you can check that everything you said is what you did say. If it is not what you meant to say, you can always write us a letter. You will also be allowed to look at the rest of the *Hansard*. That means that you can have a look at the very useful contribution Professor Newnham made this morning, which Senator Knowles referred to—in particular, that stress on a woman during pregnancy may in fact contribute to foetal damage.

I did ask the professor if he could say whether glowing satisfaction of a woman during pregnancy equally contributed to a healthy baby. He said that the research cannot tell that yet. But he did agree that maybe it was a very good question to ask. I think that the evidence that some people are giving that satisfied, contented mothers get through pregnancy comfortably and easily and then go on to provide the best kind of care for their babes is something we should be aiming at. So, rest assured: we are not confined to caesarean sections and things of that sort. Senator Knowles wanted to know whether 'hostile' was the word; I was wondering whether it was 'zealous'.

Ms Rawlings—Or 'obsessive'?

CHAIR—Certainly not; I did not use that word. Do you feel that there still needs to be people who are zealous on behalf of women-centred pregnancy and childbirth?

Ms Rawlings—Very much so. I think there is a great need for women-centred birthing. For that reason, I am a great advocate of the doula assisted birth.

CHAIR—Senator Gibbs has raised this question on a number of occasions as I have sat listening to her. What we seem to be talking about is a cultural situation about childbirth, where the culture in our country still says that you are more likely to go to hospital, that it is a good thing to go to hospital and even a culture that says, 'I'll have a caesarean section. It is no problem; just get it out very quickly.' I think her reference to 'zips up tummies' has pertinence here. But what you are saying is that you are still, all these years later, struggling

to change the culture of childbirth to make it women centred. Is that a fair assessment of what your submission says?

Ms Rawlings—Yes. I do not believe the decisions being made around childbirth are women centred. We have a quarter of the panel here.

CHAIR—He is simply here to do the bidding of the other three. We have it right on this committee.

Ms Rawlings—Well done.

CHAIR—Elton Humphery is our secretary, but he is of course entitled to an opinion—we welcome it. I am sorry; I am not sure why you made that point. Was it that a women-centred Senate committee might listen to women-centred childbirth? Is that your thesis?

Ms Rawlings—No, not at all. But I do believe that many of the crucial decisions around childbirth over the last 80 to 100 years have been made by men. I think there has been a lot of suffering on the part of women as a result of that.

CHAIR—We have had a lot of evidence or newspaper articles drawn to our attention of women demanding caesarean sections. Could you comment on that?

Ms Rawlings—I think that is as a result of the representations of childbirth out in our community and the assumption that it is painful, complicated and difficult, and one might as well get it over and done with in a safe way. That is why I look so much at the representations and seek ways and means of changing the representations in our world. I think there needs to be someone looking at what is happening on the television. There needs to be education in schools, so that young women get to know from their puberty that they can choose to see birth in a way which does not have to have the difficulties as part of the experience.

I think that is our problem. We all expect for there to be complications and interventions in childbirth. That is what is happening. Certainly, from my own experience, when I have spoken about the birth of my first two children—both of them born at home; both of them born very easily—I often found in circles of women that, when the talk came around to childbirth, much more notice was paid to the women who had a big story to tell about how many stitches they had, how long the labour was, how many drugs they had and this, that and the other. That is a really big story, and you feel sorry for them, et cetera. The natural, uncomplicated experience of childbirth is not very good media.

Senator KNOWLES—Isn't sexy?

Ms Rawlings—It is not sexy. I think that is our problem.

CHAIR—I am not sure whether we have to sexy it up or not, but we do have to finish. Ms Rawlings, thank you very much. If there is anything further you wish to provide for us, feel free. You can pass it straight through to Mr Elton Humphery, secretary of the committee.

[2.26 p.m.]

GEE, Ms Vivien, Coordinator, Maternal and Child Health, Health Information Centre, Health Department of Western Australia

HODGINS, Ms Bernadette, Purchasing Manager, General Health Purchasing, Health Department of Western Australia

JONES, Dr Dorothy Ann, Medical Director, Clinical Casemix and Purchasing, General Health Purchasing Division, Health Department of Western Australia

CHAIR—I welcome representatives from the Health Department of Western Australia. 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 submission No. 179. Are there any additions or alterations you would like to make to that?

Dr Jones—We have some additions that we will provide to you, including some extra data and a copy of the booklet.

CHAIR—Thank you very much. I now ask you to make a brief opening statement and then field questions.

Dr Jones—I will start by making some brief opening comments. Firstly, the Health Department of Western Australia welcomes this particular Senate inquiry. We hope that it forms yet another avenue for us to be able to investigate and also support change within the system to improve outcomes for women who are having children. I think our interest has been demonstrated by the fact that we are here for the day, and we have been listening with enormous interest to the submissions and will follow up your other submissions.

I want to touch on a couple of points that I have heard this morning to try to add value to what you have heard today and to try to give you some context around Western Australia's perhaps unique features. You are aware of our size, our distance and our particular demographics, and I will not go through those again for you. The important thing to understand is that Western Australia has some particularly difficult issues in relation to remoteness and tyranny of distance. I think it is important for the committee to understand that there is a very big difference between remote and rural here and that we have, as you heard earlier today, a particularly centralised metropolitan service delivery model with only one teaching hospital. That, of course, for the Western Australian community means that we need to develop some different and innovative ways in order to be able to provide accessible services for women.

One of the things that I want to bring to your attention is that we probably have done a little bit more than perhaps some of your other witnesses have implied. We have been triggered to implement some of those policy initiatives by not only the 1991 ministerial task force report in Western Australia but also Dr Turnbull's report which was tabled in parliament in 1995. In particular, the alternative birthing program that you heard about

before lunch is a federally funded program which is currently funded to the value of \$270,000. It was piloted in Fremantle and has been providing a community based service to 70 women. It has priority in our submission at the moment for the 1999-2000 financial year. There is a commitment by the state to put another \$230,000 into this program so that we can expand it to more women. We are hoping to provide a service for 150 patients in the coming financial year. I am afraid I cannot let you know today whether that has finally received cabinet endorsement, but we are indeed hopeful. As soon as we are aware of that outcome, I will provide that information to the committee.

I have given you a copy of this booklet, but I wanted to draw your attention to it. This was one of the most significant recommendations in Dr Turnbull's report. In particular, we wanted to let you know that, of the 35,000 copies that were printed, we have only 3,000 left. It has been received extremely well by both consumers and practitioners in this state. It allows women to start the process of gaining some information about the process of birth. There have been a lot of suggestions about changes, and what we hope to do over the next period of time is review this particular booklet and keep it being published.

To sum up my opening remarks, I want to allude to some of the solutions that not only states but also Australia needs to be looking at in terms of how we go about solving some of these particular issues. I think those solutions are complex and they need to perhaps be considered in a system context. That is where the health department is able to perhaps facilitate what we often talk about as being interface medicine. I think you heard this morning that, very often, the woman or the mother is the glue that holds the system together—she is the single person who has the continuity of her own care. As we start understanding the complexities of care models and understanding the patient in this context, we have to think about ways of assisting the patient with that glue, and I think that is the responsibility of clinical leaders and policy makers.

CHAIR—Do you wish to make any further comments at this time or should we go direct to questions?

Ms Hodgins—Direct to questions.

Senator GIBBS—Going through this booklet, I would just like to say that having a glossary of common terms in the back is excellent. I think that is absolutely brilliant. A lot of people would understand this, but a lot of people would not, particularly first-time mothers.

CHAIR—Far be it for us to critique your little booklet, but it fell open at page 12 where it says:

Postnatal depression is a genuine mental health problem.

I would certainly recommend that the word 'genuine' be removed. It gives the impression that there are all these other people who are claiming it is not. That is just my bloody-minded way of reading things. It is real, isn't it?

Dr Jones—Your comment is noted.

Senator KNOWLES—It is a genuine health problem. I do not think we should underestimate the fact that it is genuine.

Senator GIBBS—No, as opposed to people saying that it is not a problem—I can understand that.

CHAIR—I can see why you have it in. I also have the sense, though, Senator Knowles, that having the word in there conveys perhaps the sense that it is often regarded as not being genuine. But I will bow to wiser minds.

I think it is very interesting that one of our witnesses—I think it was Professor Michael—was not so sure that the recommendations from the Turnbull report had been implemented. Dr Turnbull was very clear that this was probably the most important of her recommendations. I wonder if you would care to comment on that. Do you have evidence that suggests that this is a critical factor in better outcomes for childbirth?

Ms Gee—I was on the committee that formulated that report. It has not really been out long enough for us to be able to evaluate that aspect of it. We realise it has limitations, but it had to be something that would address all women. I am sure I do not have to say to you that there are women in our community who have different levels of literature understanding, so we had to keep it very simple. That was the main aim of it. One of the biggest problems we have is getting it to the women before they are pregnant or when they are first pregnant. It is a little bit like closing the door after the horse is gone if we provide it to people in an obstetrician's waiting room. It needs to be distributed. Our main thrust has been to get it to the birthing population of women prior to perhaps conception so that they have some prior understanding.

CHAIR—Because I do not want to spend time on it now, could you provide on notice for us answers to the following questions. How much did this booklet cost? How many more will you run? Will you evaluate it first? How are you going to evaluate it? Where can I find it? Can I find it in my letterbox, or when I get the pill at the family planning centre—called, 'What happens if you don't take the pill carefully; read this book?' Will it go into schools, et cetera? I do not want to spend too much time on this because I want to ask you a couple of other questions, particularly about the alternative birthing funding. That program is federally funded. When did you first get funding under the Alternative Birthing Service Program? Can you tell us how far back?

Dr Jones—I cannot tell you exactly how far back. As far as I can recall, the Fremantle program began in 1993. What I thought we could do is provide you with follow-up information about the alternative birthing program in this state, and in that we can give you more comprehensive detail about it.

CHAIR—That would be very helpful, particularly if you could provide us with any information about the broadbanding of the public health money from the Commonwealth, which includes cervical cancer, breast cancer, women's health, family planning and immunisation. A lot of that is broadbanded, as I understand it, from the Commonwealth to the states. So when we are talking about the states increasing their funding, I would like to

know whether the states are increasing their money or whether they are just reallocating some of the Commonwealth broadbanded funding.

Dr Jones—Perhaps I could just clarify that for you. We tried to follow that information up in the lunch break, so we will provide that to you later. More specifically, this extension of the community based alternative birthing program is in fact funded by the state from the purchasing pool budget. In our purchasing process, which happens on an annual basis, there are pools that are allocated towards projects and programs. This was a submission that was made and was supported by the department. This is money, if you like, which comes over and above other moneys that are going into the alternative birthing program. It will be a recurrent state commitment.

CHAIR—If you could give us a fuller setting out of those figures that would be great. I got a bit muddled with the ‘purchasing pool’.

Dr Jones—In this state, the framework for the acquisition and then distribution of funds to health services is within a purchaser provider separation model. The department acts as a purchaser. I guess the best way to conceive of a purchaser is where policy, planning and then the distribution of moneys into an output and outcome framework is worked towards.

CHAIR—You have blown me away, Dr Jones. At this stage, my eyes and brain are glazed. If you can put that on a bit of paper, I would be enormously grateful. I will study it in the privacy of my own room.

Dr Jones—I will provide that.

CHAIR—It is actually a new way in which the bureaucracy—state and federal—is looking at or describing health dollar allocations. I am still staggering around in the back of my brain to understand it, because the words have specific meanings and I need to be clear.

Dr Jones—And they have a specific meaning in Western Australia. I guess it is an international and a national phenomenon. Perhaps the simplest way to understand it is that it is a way of trying to get away from the previous input driven historical basis of saying, ‘Yes, we fund that particular bricks and mortar,’ towards ‘Let us think about where our money is being spent. Let us make issues around value for money clear and let us think about what we are buying in terms of outputs,’ and hopefully—and we are still very new at this—‘Let’s think about how we can purchase outcomes.’ I think we are all learning that at the moment and we are trying to improve the way we do it.

CHAIR—On pages 4 and 5 of your submission you actually confirm data that we have got from a number of sources that there is a difference between private and public patients when it comes to caesareans, spontaneous vaginal delivery and other interventions. I take it that the department is concerned at the high rate of caesarean sections and the higher rate for private patients as opposed to public patients.

Dr Jones—Yes.

CHAIR—To what extent? To the extent that you would be looking at ways in which those caesarean rates could be reduced?

Dr Jones—The department is interested in supporting clinicians, in particular, to think about the current situation in Western Australia. We have a quite variable practice. It is certainly fair to say that, from the department's perspective, we are interested in variations in clinical practice wherever they occur, not simply in this particular arena. But in this particular area, it is quite visible. We see variations in practice across sectors whether you are insured or not. We also see variations in practice—and you have heard that eloquently this morning—in terms of the change in intervention rates in Geraldton.

From our perspective, the role of the department is evolving rapidly here—and I think the role of any department is—that is, the people directly involved in the care of patients are the doctors, and we need to be able to support doctors to understand what is appropriate or best practice and how they can be supported to be able to behave in ways that provide that outcome. I think that involves leadership, that involves courage, that involves various levers. We have looked in other program areas at how you can support clinicians in that behaviour. I think that the department can take a leadership role in being able to support some of those activities.

CHAIR—That is interesting. So there is a leadership role at the state level.

Dr Jones—I think so.

CHAIR—We have been talking about best practice guidelines, and there has been a strong push from a number of witnesses who say that we would need to have national best practice guidelines with initiatives from the federal government. You are nodding. Can I have it on the record that you are agreeing with that?

Dr Jones—Yes, I think that there are leadership roles at many levels, and certainly there is a need for a leadership role at a national level. The issue about guidelines, which we have seen across all disciplines and in a variety of arenas, is that whilst you can have national best practice guidelines and whilst you can have a lot of effort and a lot of resources go into developing guidelines—particularly when you are trying to accumulate evidence based guidelines, the amount of research required is really very large—we need to be clever about the use of our time, resources and dollars in developing guidelines because they are expensive to do. They need to be maintained; they need to be kept recent. So you need to have a process. You cannot just do them and leave them alone; it is a continuous process.

CHAIR—It is a good line, Dr Jones. In fact, a lot of people would say that that is exactly what has happened, that time and time again we have had good guidelines. In fact, some of the witnesses this morning have said, 'There are those guidelines.'

Dr Jones—Practice changes; research changes.

CHAIR—That is true, but I wanted to ask you about the next point, which I think was what you were just saying and is such an important point: it is well and good if maybe a group of professionals from federal-state related professions draw up the guidelines, but

whose responsibility is it to see that they are implemented? Does the department see it has a role in checking that best practice guidelines are adhered to, or is that something that the professionals themselves would have to see?

Dr Jones—It is clearly a professional obligation and responsibility.

CHAIR—And if they do not do it?

Dr Jones—We need to look at a variety of supportive ways to ensure that guidelines become part of clinical practice. The other point I was going to make about guidelines is that, in fact, they have to be adapted for local use. There is a lot of evidence around that other people's guidelines need to be adapted or reviewed by local practitioners. I would say that that is certainly the case in Western Australia. So where we have started looking at how you take off the shelf, so to speak, a set of guidelines, we then need to be able to have a process whereby they are regionalised or localised.

The other thing you have to understand—and I know you do, in fact, from comments I have heard today—is that a set of guidelines that is applicable for, for example, this tertiary institution are not necessarily applicable in the north-west. So it is important to understand—and I think Professor Michael made this point very clearly—that guidelines are just that: they are guidelines. I think the point is that for many women those guidelines will be appropriate, but there also needs to be attention paid to those patients or those mothers who do not necessarily fit into guideline categories. That is when individuals need to be supported and trained and capable of dealing with those particular situations.

CHAIR—One of the things that interests me about evidence based medicine—and it is now the sexy approach, I suppose; not before time, I would have to say—is that a lot of wonderful things are discovered, researched and brought forward and so on, but it may take five or 10 years before any of that actually becomes practice in an institution or in an undergraduate training course or in a specialist training course or whatever. So it seems to me that evidence based medicine is actually trying to hurry the good research into the practice arena. Do you think I am saying something that is right at this time, that that is the intention?

Dr Jones—It is one of the ways in which you can enhance the translation of evidence into practice.

CHAIR—What role does the department see it has in the introduction of evidence based best practice into the arena?

Dr Jones—It is a critical role because we have to think—dare I say it—about evidence based policy. That is why we cannot do it without our clinical colleagues, without working very closely with them. Having been in the department for three years, I can only speak about what we have been trying to do in these last few years. We have had to have very clear partnerships with clinicians—by clinicians, I am now talking in the broader sense and not just about doctors—in developing policy that stands up and is applicable in the real world. We cannot be disconnected as far as policy is concerned. We are still learning how to do this. Then the challenge is not only in translating what is best clinical practice into

everyday reality but also in best practice policy. The policy can then be translated into—as an example of what it might be for us—what type of activity and intervention we would purchase or what kind of thing we would want to buy for the state.

CHAIR—There are a lot of things I would love to ask you about, particularly that vulgar thing called the dollar. Most witnesses have come here and given us good reasons for why you, the department, could spend more money in this area to get better practice. However, Dr Innes, from the Royal Australian College of General Practitioners, did say:

Information from the HIC indicates that we spend more per year on diagnostic imaging procedures than on clinical antenatal care.

Professor Michael added to that claim by saying there was more money spent on diagnostic imaging than on the whole of obstetrics.

Given that is a fair chunk of money, is it something the department recognises and will go away and have a look at? It seems to me that you are the arbiters—at least in the near area—of how we choose to give how much money to Professor Newnham. The claims are all valid on the face of it. How do you work out where to put those dollars, and when do you decide that too much money is being spent on diagnostic imaging, for example, so that you can get some savings from there? Just in a word.

Dr Jones—Again, this is an area that we are just beginning to look at. If we wanted to put that into technical jargon, from a policy perspective we would call it ‘allocative efficiency’. I am happy to provide some written comments about that for you.

CHAIR—That would be very useful.

Dr Jones—From a policy perspective, we are interested in two things in health care. One is technical efficiency—or the simple way to understand it: value for money. You are buying X. Are you getting a good deal on X? Is X what you thought you were getting? Is X okay? Are the outcomes of X all right? That is the technical efficiency. Having been a doctor, I have to say that coming to terms with some of these health economic issues has been challenging. It is important we all begin to share an understanding of them because we have to not only know where we are spending our money but also raise the point you have just raised on allocative efficiency. Is X what we want to buy? I think that is the question you are asking. How do we know that X is what we want to buy? Should it be more? Should it be Y?

Those issues bring me back to some of my opening remarks—that they are system wide issues. They are not only at the subsystem of the state. From your perspective our state would be a subsystem; from my perspective, our state is the system and it interacts with some other systems. That is the question, and we are only just beginning to think about those issues. Those issues have to be debated not only within the professions, within the policy arena—and certainly within the political arena—but within the community as well.

CHAIR—I was wondering if you would take on notice—let us know if it is not possible—not only the funding for the Alternative Birthing Services Program but also the

Commonwealth-state funds which support the family birthing centres and the Community Based Midwifery Program. If I came to you, say, as chief whizz of the College of Obstetricians—as apart from Ms Linda Rawlings from the Birthplace Support Group or the Australian College of Midwives—to talk to you, the department, about allocative efficiency, who would get a better hearing from the department? Would it be the College of Obstetricians or the College of Midwives? How do you actually listen to the pleas from both of those? What is the mechanism for allocative efficiency in Western Australia? And do all those groups get the opportunity to knock on your door?

Dr Jones—They do through a process called ‘purchasing intentions’. I am terribly sorry to throw all these jargonistic words at you.

CHAIR—This is wonderful—purchasing intentions before allocative efficiency.

Dr Jones—That is a document that comes out, and it is quite explicit in seeking submissions. Government principles around what sort of health care we want include innovative service models. I cannot speak for the whole department, but I think we have indicated to the state to consider spending an extra \$230,000 on expanding an alternative birthing program from an extremely tight state budget. That tells you fairly clearly that that group has been heard and that we will continue to listen to people. I certainly think this is an issue where we need to listen to the range of opinion that is in the community.

CHAIR—If you can provide us with any data about the purchasing intentions or the allocative efficiencies—that is, what is the costing and how is the department dealing with it—that would be extremely helpful, as well as the other questions I have given you on notice. I wonder, too, if you could just tell us a little about the department’s role in funding Aboriginal women’s health and birthing. Do you have to match the federal money? Are you the distributors of the federal money? To what extent are the state and the Commonwealth intertwining or overlapping here? When you have dealt with all of those—I am sorry, I should have asked you one question at a time—is the department interested in things like Aboriginal women’s midwife programs?

Dr Jones—In one word, yes. In fact, a lot of the work over the last few years has been in the rural arena. There is another document here, the *Rural Obstetric Midwifery Guidelines*, which I will provide to you. Certainly, since Dr Turnbull’s report, I think it is fair to say that our focus has been not only on looking at the consumer guide but also on looking at the rural area. You heard Dr Innes earlier today. We have had a lot of very hard debate and soul-searching about how to ensure that women in remote communities get appropriate access to safe obstetric services. That is an extremely difficult and complex debate to have. There is one program that has been introduced into the north-west where we have taken a Northern Territory developed program called Strong Women, Strong Babies, Strong Culture. You have probably heard about that.

CHAIR—We have heard references to it. What are you doing with that in Western Australia? Is it the same model or do you have your own flavour?

Dr Jones—It is a model which we use in a community development model working with Aboriginal communities around the state and also in a variety of areas. Essentially, it

revolves around empowering the community, community development, and using Aboriginal women and midwives as peers, teachers and advocates for their community. It is about working in a way that is appropriate for that community. Might I add that one community's way is not necessarily another's. It is about thinking about the sensitivities around how women or people in that community would like to have their service delivered. For example, some communities will choose a different option.

CHAIR—What would happen if, as a Pitjantjatjara woman or an Aboriginal woman from somewhere around the Western Australian border, I decided I was going to the Alukyra Centre in Alice Springs to have my baby because, with lots of other Pitjantjatjara women there, I would feel I would get a little more sympathetic treatment there. As a Western Australian, can I go there?

Dr Jones—Yes, you could. Speaking for north-west women, if you live in a north-west community, essentially you will need to go to Derby some weeks before the delivery and you will need to wait in Derby until the onset of labour. Those arrangements are not easy for you: you are away from your family; they cost you money, and they are difficult. Then you will need to be transported back to your community after the birth. It is not ideal.

CHAIR—I did hear that, if I were pregnant, the department flew me to hospital and bussed me back with the baby. It did cross my mind that maybe you should reverse that.

Dr Jones—A variety of modes of transport are used.

CHAIR—What happens if Western Australian women want to have their babies at a health service in the Northern Territory? Do you have to buy those services from the Northern Territory government or do you just leave people to go where they like?

Dr Jones—No. There are clear cross-border arrangements. I have worked in the Top End of Western Australia for a few years. There is a whole other land in Australia, which is the Top End, and borders are sometimes not there for people who live in those communities. We now have at a state level reconciliation processes in place to sort that out.

CHAIR—Could you also provide to the committee, or at least for my interest, the difference between 'rural' and 'remote' in Western Australia? Is that a simple little map? I am sure Senator Knowles could tell me, but I would appreciate it if you could put it with your bit of paper, if that is possible.

Dr Jones—We will certainly talk to you about what 'remote' means to us.

CHAIR—To the department.

Dr Jones—Yes.

Senator GIBBS—I am really interested in what you are doing within the Aboriginal community. Coming from Queensland, I can understand 'remote'. We are not as large as you are, but we are fairly large—larger than the others. This is a real problem, isn't it? For any government of any persuasion, the health of Aboriginal people is a real and crucial

problem—particularly the health of Aboriginal women giving birth. I am terribly interested in anything that you are doing that I can take back to Queensland and say, ‘This is what they are doing over there.’ I think you actually took a leaf out of our book from the Cape York area. Some of the other witnesses were saying that you took what we were doing around Cooktown and were using that. Maybe the two states could compare: ‘This is what we are doing. You might like to try it,’ and vice versa.

CHAIR—I have one last question for you to take on notice. I wonder if you could tell us if the department has any breakdown on the costs of babies delivered through homebirthing and/or birthing centres as apart from the more traditional doctor-centred health delivery. I appreciate that might be very difficult because a lot of that gets into Medicare allocation for doctors.

Dr Jones—Yes. The numbers are small, too, for trying to break down costs.

CHAIR—I am not asking the department to do a PhD of information for us. If you can get us some information easily and some dot points, that would be good. We do not really wish to put you to great efforts of cost and time. I think we would be assisted if you could provide us with any of that easy-to-dig-up difference in costing and outcomes.

I would like to thank you very much for your clear intention to be interested and to participate by being here all day listening to other witnesses, for your contribution to our hearing, and for your preparedness to find us some further information. If there is anything you would like from the committee, please feel free to ask us. Thank you very much indeed.

[3.00 p.m.]

THOROGOOD, Ms Carolyn Mary, Member/Fellow, Australian College of Midwives (WA)

CHAIR—Welcome, Ms Thorogood. Do you have any other comment to make about the capacity in which you appear today?

Ms Thorogood—I believe that part of the reason why I have been asked to represent the midwives today is that I have been considerably active in midwifery and maternity services, both as the coordinator of the midwifery programs at Curtin University and also as part of my doctoral studies, which is on a political analysis of homebirths in Western Australia. I am evaluating the Alternative Birthing Services Program in this state in regard to homebirths.

CHAIR—The committee prefers all evidence to be given in public, but should you at any stage wish to give your evidence, part of your evidence or answers to specific questions in camera, you can ask to do so, and the committee will give consideration to your request. We have before us your submission, which is submission No. 62. Do you have any alterations or additions you would like to make to that?

Ms Thorogood—No.

CHAIR—Would you like to make a brief opening statement before we ask you some questions?

Ms Thorogood—Thank you. In a wealthy country like Australia, or a relatively wealthy country such as ours, the majority of child-bearing women should be healthy, and they should be able to give birth with a minimum of intervention. The Australian College of Midwives in Western Australia believes that maternity services should reflect this. Australian women deserve the very best of maternity care. They deserve to have access to care; they want effective and affordable care which is appropriate for their specified needs.

We know, and there are numerous studies to support it at local, national and international levels, that women want choice, control and continuity of care and continuity of carer. Women want to know what options are available to them. They want to be able to choose from a variety of birthing choices. They want to be able to say who will attend their births and probably, more importantly, who will not. They want to have a good, trusting relationship with their midwives. They want to know who is going to be with them in their births and afterwards; therefore, they want continuity of care and continuity of carer.

We also know that when women know who their care giver is going be, the level of obstetric intervention tends to decrease and the level of satisfaction with birthing services increases. But, having said that, it is very difficult to properly assess satisfaction with care. It is a very complex thing to look at.

We do know that midwifery led services for specified populations have as good an outcome as any other model of care that we have found so far in Australia. We also believe that not all women have the same choices as others. For instance, the only women who are able to have a homebirth in Australia at this time, with a few exceptions, are those who are able to have the highest level private insurance or who can pay the \$1,700-odd for a birth. So, therefore, homebirth tends to be for the relatively affluent.

We also know that there are certain groups of women who are deprived of other choices. For instance, it is most unlikely to find midwifery led services in rural and remote areas, and there are no birth centres in rural and remote areas. There are only two birth centres in Western Australia: the first one is at the King Edward hospital—it is very successful; the second one is at the Swan District Hospital—it has not had such a high success rate, and I believe it may close relatively quickly.

In fact, some women in rural and remote areas are deprived of maternity services altogether and that is of great concern to us. Some women have to leave their homes and families and fly to Perth or other regional centres, and anecdotal evidence suggests that these women will actually request intervention. They will want a caesar or an induction of labour purely and simply so they can get it over and done with, and then they can go back to their families. This is especially so for women on farms who just cannot get away from that sort of business.

We also know that maternity outcomes for women living in these areas are not as good as for those living in metropolitan regions, yet there are some instances when we know that outcomes and models of care can be very successful. One example is Kalgoorlie Regional Hospital. There the midwives, the obstetrician and the GP have worked together incredibly successfully to develop a collaborative model of care. Their maternal and neonatal outcomes are very good, and their caesarean section rate is very low. Work satisfaction for all parties is very high, and the women who use these services evaluate them very well indeed. Therefore, it can be done, but it needs a close working relationship between all parties.

The ACMI, the Australian College of Midwives, is very concerned about the implications of high levels of obstetric intervention. We believe that the high costs associated with this deprive some women of fairly basic services. Some women have barely credible antenatal and postnatal services. We believe that, if money were shunted into these services, there may be less intervention. Obviously, that is a guess.

We are also concerned about the routinisation of services. Many years ago, when I first became a midwife, foetal monitoring was only just being developed. We used it purely and simply for women with a high risk of complications or for those who would develop complications. Now, in many instances, foetal monitoring is used routinely, and it is not associated with improved outcomes for well, healthy women. In fact, it probably makes some of the outcomes worse because there is a greater incidence of caesarean section and other interventions.

We are also concerned about the anticompetitive behaviour of some of our colleagues. I think our submission shows that some of our colleagues have made it very difficult for midwives to enter the market of purchasing services.

CHAIR—What does ‘colleagues’ mean in that sentence?

Ms Thorogood—My medical colleagues.

CHAIR—Do you mean obstetricians, general practitioners or both?

Ms Thorogood—I mean mostly obstetricians, members of the AMA and some general practitioners. There are also some general practitioners who are very keen to work in collaborative models of care with other service providers. It is by no means all. We also believe that many women make choices about their care which are not based on informed decisions. We believe that a lot of information which should be made available to women is not. We assisted in the development of a health department pamphlet on choices. We believe that it did not really give a true picture of some of the choices that are available.

We are also concerned that funding bodies, including state health departments, make their decisions based on what I would call fairly outmoded levels of care—the biomedical models of care—and are fairly reluctant to look at the psychosocial or social health perspectives of care. Therefore, most funding goes to services which are closely tied to medical models rather than to other models like maternity services. Thank you.

Senator GIBBS—Ms Thorogood, you said that homebirth is basically for the affluent. Do you believe that, if there were a Medicare rebate for midwives as there is for doctors and other professional people, more women would choose to have homebirths or, indeed, actually use a midwife, even if she chose to go to a hospital or into a birth centre?

Ms Thorogood—As I understand it, there is no evidence to support what I am going to say but, having been part of the team which evaluated what was then the Fremantle community midwives project, I believe that there is evidence that if homebirths are publicly funded, there will be increased demand. But only time will tell in that regard. From my experience, many of the women who choose to have homebirths obviously want to have a birth at home, but they often do so because they want to have access to the midwife of their choice. Therefore, a homebirth will provide that sort of model.

Senator KNOWLES—What is the cost of a homebirth?

Ms Thorogood—The cost of a homebirth varies. In Western Australia at this time the majority of midwives charge about \$1,700. In other states, it may be slightly less or slightly more. In the community midwives program at Fremantle, I believe it is \$1,700. Many women cannot afford that. In my doctoral thesis I found that some women will actually pay it off—they will sell the car or mortgage their house—to get what it is that they really want. Some midwives are paid in instalments. It may take 10 or 15 years to pay off the homebirth, but they will do it.

Senator GIBBS—King Edward here obviously has a midwife team.

Ms Thorogood—Yes.

Senator GIBBS—How does that work? Do people come here to the hospital and then, if they want the midwife to care for them in their home, can they have that, or do they have to keep coming here to the hospital to see the midwives who are employed here?

Ms Thorogood—As I understand it, the majority of care is based at this hospital. So the team operates mostly from here. There is a domiciliary aspect to it where the women can be visited at home, but the project is attached to the hospital. It is not home based midwifery care, by any means.

Senator GIBBS—I have not seen the birth centre here; I think I missed out on that. You were saying that the one at Swan is closing down—because of lack of support?

Ms Thorogood—As I understand it, the birth centre at Swan District was an Alternative Birthing Services project and it was funded for the length of time covered by the Alternative Birthing Services Program. I think the funding is just about over. The Swan District birthing centre has never really taken off in that there has been a reluctance on the part of general practitioners to refer women to the centre and a great reluctance on the part of obstetricians to do that, plus I think many women are unaware of that sort of service. I believe that it is true to say that a large number of women, perhaps the majority of women in this country, believe that they cannot give birth without the aid of medical intervention—high levels of intervention from obstetricians and maybe general practitioners. Therefore, the concepts of birth centres, maternity care at home, domiciliary care, homebirth, are really quite foreign to them.

Senator GIBBS—Can you explain to me, because I do not come from Western Australia, where exactly the Swan District birthing centre is?

Ms Thorogood—It is in one of the eastern suburbs of Perth, so it is still metropolitan.

Senator GIBBS—Basically, you put it down to the fact that the GPs and the obstetricians were against this and did not recommend women to go there?

Ms Thorogood—I think it is one of the factors. I do not believe it is just because GPs and obstetricians will not refer to it. But I do know from my own work in the evaluation of the Alternative Birthing Services Program that the majority of women, when they first believe that they are pregnant, have their pregnancy confirmed by a medical practitioner. At that visit, the medical practitioner decides with the woman who she will visit for the rest of her pregnancy. With few exceptions, the birth centre here at King Edward, homebirth or other midwifery managed services are not mentioned. Doctors tend to refer to other doctors. Many GPs tend to refer to obstetricians if they are not going to practise obstetrics themselves.

Senator GIBBS—I also noted that you said—which I found quite interesting—that people, say, from farms or living out in the country prefer to have a caesarean section, get it over and done with and go back home. Isn't that a contradiction? If you can have the natural birth, you can actually get up and walk the next day, whereas if you have a caesarean you are lying there; it is major surgery.

Ms Thorogood—I would agree with you. However, I think that one of the advantages of induction of labour and what I would term social caesarean sections is that women can choose the date and time of the birth, so they can actually plan for somebody to come and help with the milking or the seeding—those sorts of things.

Senator KNOWLES—Time management.

Ms Thorogood—Yes, it is.

Senator KNOWLES—It has nothing to do with the time that you leave the hospital; it is the time that you can manage it in your diary.

Ms Thorogood—Also, one of the other things is that labours do not often occur when they are supposed to, so a woman may be sitting in a metropolitan region waiting for two or three weeks for the baby to turn up.

CHAIR—Ms Thorogood, you are the person who can tell us: what are the figures these days? Are five per cent of babies born on the so-called due date and 90 per cent within two days either side of that?

Ms Thorogood—Maybe my colleagues at the back can tell me. I think it is only five per cent; it is very few.

CHAIR—I think so, too, but it is a very big percentage within a couple of days either side of that. So we are within a week. I do appreciate that if you are planning to harvest a crop or seeding, you would need to be a little more accurate than within a week, especially if you live far away, but if anybody could provide to the committee the latest figures on how many babies are born when, vis-a-vis the due date—or the claimed due date—the committee would welcome that.

Ms Thorogood—One of the other problems, I believe, is that some of my medical colleagues now estimate that the due date is at 38 weeks gestation. Therefore, women are told that at 38 weeks of gestation they will be due, when in actual fact the baby is probably not due until the 40th week of gestation. Therefore, she is actually waiting two weeks, because in my work it is quite common to see large numbers of women having their labours induced for what is called post-dates, when in actual fact they are what I would call 38 weeks and two days; in other words, they are not term. In my practice throughout the metropolitan region, it is quite rare to see women who have actually gone the full 42 weeks before they are induced for being post-dates. I think that compounds the problem. That increases the waiting period quite considerably.

Senator GIBBS—With respect to this problem that midwives have with some obstetricians and some doctors, we have met quite a few doctors who are very keen to work with midwives and they believe that is the natural process; that they are there in the background just in case something goes wrong. In South Australia, they were talking about introducing a midwifery course—a university or TAFE course—of a duration no shorter than four years, after which you would end up with a degree or a diploma. Do you think if this educational program is introduced in all states of Australia, where they say, ‘You are a midwife and not

a nurse who has done one year's midwifery,' you would have more recognition and more status in the community and you would have more recognition from the medical profession?

Ms Thorogood—There are two trends in education at the moment. The first one is for what I call a double degree, so after four years the student does half a nursing degree and half a midwifery degree—

Senator GIBBS—No, this is totally separate.

Ms Thorogood—We are talking about what is called a direct entry midwifery?

Senator GIBBS—That is right. If I want to stop being a senator and become a midwife, I can go along and do this four-year course and become a midwife; I do not have to be a nurse first.

CHAIR—But a nurse can do it.

Senator GIBBS—Yes, anyone can do it.

Ms Thorogood—It is the same program as we find in New Zealand and much of Britain. Quite frankly, no. I believe that, in general, my obstetric colleagues do not wish to participate in egalitarian relationships with midwives, so it does not matter what courses we introduce and how we do it, the relationships are still going to be very strained indeed. There are many reasons for that. One is to do with gender. Part of it is also turf wars—who wants what part of the cake. But I do not think it is going to get better; not in the short term, anyway.

Studies in Britain have shown quite clearly that even when these three-year direct entry programs have been introduced, the models of care with which the students work are hospital and medically oriented, so the outcomes are almost the same, as are the relationships. So I think it is going to take fundamental changes to the way we fund and treat the health care system before we get any long-term changes, but it may help a little in the short term.

Senator KNOWLES—I only have one question for you, because I think there is going to be an increased trend towards midwives in the foreseeable future. But I am reliably informed that the average age for midwives in Western Australia now is about 46. While I think that specific age is incredibly young—that is another issue altogether—how do you encourage younger people to get into midwifery?

Ms Thorogood—Senator, I would argue that the problem is multifaceted. The students coming through my course, on the whole, are in their early twenties. The problem seems to be that the adequate number of students are being educated in universities but they do not stay in the profession. The only ones who stay are the ones who are in their forties—the older ones.

Senator KNOWLES—Why?

Ms Thorogood—Obviously, one of the reasons that they leave is because 95 per cent of midwives are women and they tend to get married and have babies, so they leave for personal reasons. Also, I believe that a lot of midwives do not find working in the hospital system particularly satisfying. We have seen those same trends in general nursing courses. If students are going to have to pay to do their midwifery education and be full-time university students, they need to find a career which is extremely satisfying and which is going to give them professional as well as financial rewards. Midwifery is not doing that.

Areas like Kalgoorlie have a vast number of young professional midwives. I would say that one of the reasons they have those midwives there and that they do not suffer from the dreadful shortage of midwives that other rural and remote areas have is because of the quality of care and the collaborative relationships that they have with the medical as well as the midwifery staff.

Senator KNOWLES—Are younger people not going on with it for much the same reason that a lot of general practitioners do not want to go on with it, and that is a lifestyle issue? When young people do get married and have their own families and so forth, they do not want to be called out in the middle of the night or on weekends when they have other responsibilities.

Ms Thorogood—I think that is it.

Senator KNOWLES—It is part and parcel of it?

Ms Thorogood—Yes. It is still most common for women of child bearing age to work part time. The number of part time and casual staff employed in hospitals is really quite phenomenal. I think that is partly the choice of the midwives, but it is also a funding choice. I think the health department is encouraging that sort of purchasing agreement.

CHAIR—Do you have a view on, let alone any experience of, midwives being on the books at a public hospital—salaried, wage earners or whatever—who are then able to do community midwifery on an outreach from a hospital?

Ms Thorogood—I believe there is a small scheme in Denmark that operates like that but it is very small and receives very little publicity. There were midwives in private practice—and I use that term advisedly—in Perth, who were accredited to the birth centre here at King Edward. They could bring their clients to the birth centre at King Edward, the women could birth there and then they could go home. But I believe that initiative has been shelved for a while. The visiting privileges for independent midwives in Western Australia have been removed. There have been moves to get around that, whereas I think there are only two hospitals now in this state which will employ the midwives on a casual basis. So if a midwife is planning to work with a woman to have a homebirth and the woman needs to be transferred to hospital, once they arrive in hospital the midwife is then employed as a casual employee and she may continue the care of that woman. But by and large, in Australia, very few hospitals have granted visiting privileges to midwives.

CHAIR—That is interesting. We were told in South Australia that midwives may apply; but the other side of that equation is that they are not necessarily granted. At the Queen

Elizabeth Hospital, what you describe is the case: midwives who are working on the books at the Queen Elizabeth Hospital can go into the community and do antenatal visits or care through community health programs or even home visits, and then follow people into the birthing centre and to the labour ward if necessary, where they of course do not have the supervisory or care role because, at that stage, it becomes a labour ward management. I think usually by then the medicos take over. It depends a little on, say, if it goes to the labour theatre, then clearly that is in the hands of a doctor; if it goes to the labour ward, out of the birthing centre, then certainly the midwife follows and stays as that continuity of carer person. You sound a little bit gloomy.

Ms Thorogood—That is because I have nearly finished my doctoral studies.

CHAIR—That is good. So it is not because you are in despair about getting midwives fair recognition?

Ms Thorogood—No. Well, that is partly it, too, but I believe we are now at the crossroads where we really can forge ahead and make great headway. I do not necessarily believe that the way we have been doing it has been particularly successful. I do not believe that trying to establish close collaborative relationships with obstetricians is going to work in the short term, or probably in the long term. I think we have to look at other initiatives.

One of the problems I think there has been is that many of the services which utilise midwifery tend to be ‘as well as’—in other words, we still have a medical model of care and then we just slot in a midwifery managed model as well, so they are an adjunct to a medical care. That is one of the reasons why I think we have complaints from funding bodies saying that midwifery managed care is very expensive. It is considered to be a luxury for an elite group. My premise is that we should now move forward and that midwifery managed care should be ‘instead of’ rather than ‘as well as’, so that we develop completely different models of care which move quite away from the ones that we are using now.

CHAIR—I am just a bit confused about the costing of this. We do not wish to publish your PhD before you get all the plaudits from here to eternity for doing so, but the committee would appreciate any figures you have on the cost of midwifery. What we mainly hear is that private midwives offering homebirths charge somewhere between \$1,500 and \$2,000. This means it is only affordable by some. On the other hand, we hear of midwives who may have a variety of training, but quite often they are—in old-fashioned language—‘double certificated sisters’ who do a lot of midwifery in birthing centres. The models, certainly at the Women’s and Children’s in South Australia, the Queen Elizabeth, the Flinders, and at other places too, are entirely midwife managed.

Senator GIBBS—In conjunction with the doctors, there is not a problem at all.

CHAIR—Let me say that I would not have said that. I thank Senator Gibbs for adding ‘in conjunction with the doctors’. But I wanted your words on this: before we actually need to seek the specialist’s help or involve the medical practitioners, there is a good working relationship, but the alternative birthing centres are in the hands of the midwives.

Ms Thorogood—Yes, and it is extremely difficult to compare the costs and benefits of two different models of care because it is like comparing apples with oranges. The work that I have done and the work that I have seen shows that midwife managed care is cost effective. However, there is what I believe is a mythical belief amongst funding providers—as well as my medical colleagues, who have an enormous amount of power as to who funds what, when and how—that midwife managed care is an elite service and a luxury and therefore should only be used when there is plenty of money around. What is believed is that the money should be used for services which are considered by some to be far more important, such as ultrasonography.

CHAIR—I expect you are pretty attuned to the language of attack from wherever it comes. Would dismissing midwifery as too expensive not be anything more than a good example of that?

Ms Thorogood—I should think so. The problem is in persuading funding bodies to take into account these different models.

CHAIR—They are sitting behind, and they are all ears. And they are all women.

Ms Thorogood—It is all very well for me to sit here and say what funding bodies and organisations should do; they, too, face their own constraints. Again, most of the senior bureaucrats in many of the health departments are medical practitioners. It is therefore very difficult for them to change their alignments and perhaps cooperate or collaborate with midwives.

CHAIR—This is a Senate inquiry with a federal perspective. Midwifery is not a capital-letters, big sexy item for the federal government. Would you urge this committee to look at it in that way?

Ms Thorogood—Yes, I would. It is imperative for service provision as well as for funding.

CHAIR—Should the question of midwifery be an issue for the federal government? Should there be a Commonwealth led set of guidelines or push for midwifery?

Ms Thorogood—I would like to see the Commonwealth examine a whole variety of models. It would be dangerous to go into, ‘This model is better than this model,’ but I believe that midwifery led services are among a number of models which have been shown elsewhere to be extremely effective. Therefore, I hope that the Commonwealth sees that and makes moves in that direction.

CHAIR—What do you mean by ‘elsewhere’?

Ms Thorogood—The UK, New Zealand, Holland and some parts of the United States.

CHAIR—I thank you all very much for your participation and contribution.

Committee adjourned at 3.33 p.m.

