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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Childbirth procedures

TUESDAY, 14 SEPTEMBER 1999

SYDNEY

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SENATE
COMMUNITY AFFAIRS REFERENCES COMMITTEE
Tuesday, 14 September 1999

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

Substitute members: Senator Denman substituting for Senator Evans

Senators in attendance: Senator Crowley, Senator Denman, Senator Gibbs, Senator Tchen

Terms of reference for the inquiry:

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

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

- (i) the adequacy of information provided to expectant mothers and their families in relation to the choices for safe practice available to them; and
- (j) the impact of the new Medicare rebate provided for complex births, including the use of the term 'qualified and unqualified neonates' for funding purposes, and the impact that this has had on improved patient care and reduction of average gap payments.

WITNESSES

BARCLAY, Professor Lesley Margaret, Council Member, National Health and Medical Research Council and Member, Health Advisory Committee, National Health and Medical Research Council	412
BARCLAY, Professor Lesley Margaret, Principal Investigator, Australian Midwifery Action Project	379
BARCLAY, Professor Lesley Margaret, Principal Investigator, Midwifery Practice and Research Centre	432
BLATCH, Ms Julie Christine, Director, Policy, Planning and Service Delivery, New South Wales Pregnancy and Newborn Services Network	458
BRODIE, Ms Pat, Senior Research Midwife, Australian Midwifery Action Project .	371
CHAMBERLAIN, Professor Marie Elizabeth, Clinical Chair in Midwifery, University of Sydney and Northern Sydney Health	385
CLUNE, Ms Lynne Maree, Member, National Association of Childbirth Educators	398
EVANS, Mrs Lynn, Clinical Midwifery Consultant, Royal North Shore Hospital ..	475
FISCHER, Ms Wendy Elizabeth, Health Services Manager, Research, Planning and Policy, New South Wales Pregnancy and Newborn Services Network	458
GREEN, Mrs Pauline Elizabeth, Member and Trainer, National Association of Childbirth Educators	398
HENDERSON-SMART, Professor David John, Member, Health Advisory Committee, National Health and Medical Research Council	412
HOMER, Ms Caroline Susan Elizabeth, Senior Research Midwife, Midwifery Practice and Research Centre	432
MAHER, Miss Catherine Ann, Midwifery Educator, Royal North Shore Hospital .	475
McCANN, Ms Yvonne, Divisional Nurse Manager, Royal North Shore Hospital ...	475
MYORS, Ms Karen Anne, National Vice President and New South Wales State President, National Association of Childbirth Educators	398
PESCE, Dr Andrew Francesco, Staff Specialist, Division of Women’s Health and Newborn Care, Westmead Hospital	487
TRACY, Ms Sally Katherine, Senior Research Midwife, Australian Midwifery Action Project	371
.....	385
WESTHORPE, Dr Rodney Neil, President, Australian Society of Anaesthetists ...	445

Committee met at 9.06 a.m.

BRODIE, Ms Pat, Senior Research Midwife, Australian Midwifery Action Project

TRACY, Ms Sally Katherine, Senior Research Midwife, Australian Midwifery Action Project

CHAIR—I open this session today of the Senate Community Affairs References Committee continuing its inquiry into childbirth procedures and I welcome representatives from the Australian Midwifery Action Project. The committee prefers all evidence to be given in public, but should you wish to give your evidence, part of your evidence, or answers to specific questions in camera, you may ask to do so and the committee will give consideration to your request. We have before us your submission, which is No. 45. Are there any alterations you wish to make to the submission?

Ms Brodie—No, but we do have a supplementary paper which we wish to provide at the end of our presentation.

CHAIR—Fantastic. If you would like to make a brief opening statement and then field questions.

Ms Tracy—Thank you for the opportunity to speak to the written submission which was lodged with the Senate committee. My name is Sally Tracy and I am a senior research midwife on the Australian Midwifery Action Project. Australia sits in a rather shameful position on the world stage with regard to health funding, according to the WHO. We do not even get a mention among the countries described as having systems that most equitably share the health financing burden and allow equal access to care for people with comparable need.

The written submission has drawn your attention to the evidence which supports the view that the cost, both in economic terms and from a quality of life perspective, to women who undergo operative intervention in childbirth is neither justified nor should it continue to be supported. Health funding policies which encourage the overuse and indiscriminate use of technology should be revised. In particular, the fee-for-service model, which we have here, is not tied to any regulation on usage, volume or quality and therefore creates incentives for abuse.

We think that a system of prospective payments—that is, a system where a fee is paid prospectively for the care given—allows for a great deal more to be achieved by rewarding practice that is aimed towards achieving health gains in the population. Funding for maternity care could be accurately quantified since the episode of maternity care per woman is a finite amount. The Canadian and the New Zealand models work on this system of prospective payment, a system of national funding for maternity care not fee-for-service as we have in Australia.

It is clear that the method for funding maternity services in Australia has encouraged the overuse of diagnostic technology and surgical intervention in childbirth whilst not promoting the efficiency and service quality which might be gained from a prospective model of

payment. The current method of funding in Australia, which rewards and creates incentives for extravagant and wasteful care through overuse of diagnostic services and excessive surgical intervention in childbirth, does not encourage women to access care which is focused on a community, wellness and woman centred philosophy. One of the consequences of this lack of appropriate funding in maternity care has been the lack of access for women to midwifery care and the consistent lack of information that is available to the population regarding the health and safety of midwifery care. During the past 30 years there has been a strong and relentless push for women to undergo excessive diagnostic and surgical intervention during childbirth at an acute care or tertiary level. Women have been ministered to in a sickness model, and childbirth has become wholly a pathological event. I will now hand over to my colleague.

Ms Brodie—My name is Pat Brodie and I have been a midwife for 20 years. I am currently employed as the research midwife on AMAP and as a consultant midwife to St George Hospital in Kogarah, Sydney.

CHAIR—Excuse me, what is AMAP?

Ms Brodie—The Australian Midwifery Action Project. The second message that we want to get across to the Senate inquiry today is our concern with the organisation and structures of maternity care across the country. My statement here is with reference to the mainstream public health system. Generally speaking, that system is fragmented, inequitable, inefficient, not based on evidence or state or national policy direction, generally is not meeting the needs of women, and is out of step with the rest of the Western world. As we see it, this is because of a lack of any overall system of care.

Healthy women with no sign of medical risk receive the same amount of care or, in some cases more care, as women with problems. The medicalisation of childbirth is supported by funding structures that reward intervention and morbidity. Whilst there are a few excellent exceptions, there is little or no continuity of care. Most particularly, there is an underutilisation of midwives in the care of healthy women. It has been estimated that most women in the public health system would encounter on average approximately 30 different health care providers—from first booking at the hospital until going home with their baby on day three, four or five. Unacceptable long waiting times in the clinic and brief visits with a range of different care givers leaves women dissatisfied and disempowered and not ready for birth and mothering.

Postnatal care has almost disappeared with the declining length of stay in hospital and with the lack of support and recognition of community based postnatal care. Within our current system, there are inter and intra professional rivalries that result in a dissatisfied and in some cases deskilled work force where midwives cannot practice to their full capacity and provide a full range of skills and where doctors, who may wish to work in new ways, are hampered by the lack of structures that support innovation. I seek permission to table a supplementary paper that offers a potential framework for the reorganising of Australian maternity care.

CHAIR—Is it the wish of that committee that be included? There being no objection, it is so ordered.

Ms Brodie—The framework that we have provided is focused on the concepts of continuity of care, collaboration between all maternity health care providers, cost effectiveness and community based services. Thank you.

Senator GIBBS—On page 2 of your submission you talk about birth educational classes. We have heard quite a lot about birth educational classes and the lack of suitable instruction. What changes would you like to see in these classes?

Ms Brodie—I take it that you are talking about the antenatal classes?

Senator GIBBS—Yes.

Ms Brodie—There is a lot of work being done around the country to try to change the system of childbirth education. There are some fantastic centres that are doing good work, but the majority of childbirth education classes are pretty much based on the model that you would have seen 15 to 20 years ago where particularly couples turn up—single women do not necessarily turn up because they are pretty much intimidated by the structure. About six, eight, 10 or 12 couples turn up and are provided with a series of six to eight weeks of classes, two hours a week on a Wednesday night, and generally the focus of the information they are given is on how to get through labour and with lots of emphasis on choices around what is available for pain relief. There are some good classes that would emphasise the skills required for parenting, but generally the structure is not conducive to promoting community support and to women supporting each other. I guess my interpretation is that the classes prepare you for the experience that you are going to have in hospital rather than the experience of becoming a mother.

Senator GIBBS—When we were in South Australia, the midwives there were saying that the antenatal classes were geared more to hospital procedures rather than to the natural way of giving birth. Women were being told in the classes, ‘You can have epidurals, you can have the caesarean,’ and that sort of thing, which is quite intimidating. Is it the same here in New South Wales?

Ms Brodie—Generally speaking, yes. Some good work is being done at St George Hospital, the Royal Women’s Hospital and King George V Hospital where midwifery and childbirth educator leaders have been trying to change that system. But if you move outside some of those good centres, you would see that primarily, particularly in the rural areas, not much has changed in that regard. There has been no development or improvement. That was my point: women are being prepared for what is going to happen to them, what is going to be done to them and how they might go about accepting that.

Senator GIBBS—Yes. We have heard a lot of evidence that women are actually demanding caesareans and in the early stages of their pregnancy they are saying to their doctor, ‘I am going to have a caesarean and that is it,’ and most of them change their minds afterwards. Do you believe that if women were told of all the dangers—what can happen to them, what can happen to the child, what will happen afterwards—and given comprehensive information that women would go more for the vaginal birth and the natural way of things rather than having all of these instruments stuck in them?

Ms Tracy—The point we are making in bringing forward the midwifery model is that, rather than describe women in terms of risk, they have the information about pain in childbirth, which as midwives we even dispute is something that needs to be treated the way it is. We have moved down a surgical path where we treat pain in childbirth as something that has to be eliminated. There is good research at the moment which shows that the pain of childbirth is something that women possibly in hospitals—associated with fear—actually feel a lot more than women who have a continuity of care giver or who are cared for in an environment where that fear cascade has not kicked in.

We have several issues: we have one where we feel women possibly are not getting all the information that they need to make good decisions. The next issue is that midwifery care is not accessed as readily by all women where having a midwife with a woman during her labour often eliminates that need for serious surgical intervention—and by this I mean an epidural.

Ms Brodie—So it is the context of care as well. We cannot just look at childbirth education in isolation. A properly developed maternity service that promotes continuity of care by midwives and an opportunity for women to form a relationship with midwives decreases their anxiety, increases their trust in their bodies, increases their trust in the system and basically enables women to approach childbirth in a completely different way. In some models of continuity of care childbirth education classes may not be necessary.

Senator GIBBS—Do the midwives in New South Wales have this problem? In other states we have learnt that there are a lot of independent midwives out there and whoever can afford the independent midwife hires her and they then have this continuity of care. But when they are ready to go to the hospital to give birth, the midwife in some cases is not allowed in and in other cases is allowed into the room as her support person. But the problem is that there is a lot of professional jealousy and enmity between midwives and obstetricians.

Ms Tracy—In 1989, Shearman's report actually said that we should have access to this continuity of care. That is, if someone was being attended by a midwife in the community then she should have that access to hospitals. That was 10 years ago and there has not been a lot of movement on that. Pat has worked on this latest framework for maternity care and there certainly is not a change in that. That is one of the issues. We are saying that the funding is so inequitable that the women who can afford it will always be able to afford private midwifery care. We are seeing now in the western suburbs—for example, Nepean Hospital—where staff obstetricians do not want to work necessarily in those areas because it is not lucrative. There is not a lot of private health insurance and a lot of the antenatal care is now being run by midwives. But they are also constrained because they are not funded in a true midwifery model where they could offer continuity and, for example, see teenage mothers right through their pregnancy.

CHAIR—I am going to have to gently encourage the questions and the answers to be a little shorter so that we can cover more ground.

Senator GIBBS—Just one more question. I notice you mention in the submission that women who are in private hospitals have higher caesarean section rates than those in the

public sector. How do you account for this? What is your reasoning for this? We have heard many excuses.

Ms Tracy—At the moment I am working on a report of privately insured women as opposed to women with no insurance giving birth in either a private institution or a public hospital. Yes, the preliminary figures show that, for whatever reason, it is higher amongst privately insured women. That is all forms of operative delivery—elective caesars, emergency caesars, episiotomy, forceps and vacuum.

Senator GIBBS—But we do not have any data at the moment or evidence to show why?

Ms Tracy—No. At this stage we are looking at just the fact that this cascade occurs. We do not have any causal data at this stage.

Ms Brodie—But, as a midwife with 20 years experience in the public health sector, I would have to say that it is medical dominance.

Ms Tracy—In table 6 in our submission you will see that right across the board where you have this continuity of care by a midwife team in several models—those models are all over the world—it shows that when you have this midwifery model of care all those interventions are lower and often significantly lower than even just ordinary care.

Senator GIBBS—Thank you.

Senator DENMAN—On page 6 of your submission you speak about psychological distress not being given the status it deserves. Can you elaborate on that for me?

Ms Tracy—Can you direct me to a heading?

Senator DENMAN—I might have written down the wrong page. It was pertaining to psychological distress.

Ms Tracy—After operative birth?

Senator DENMAN—Yes.

Ms Tracy—Basically we do not have a lot of research that has looked into the effect on women of operative birth, except to say that there are studies by Creedy and Jane Fisher in Melbourne to show that women do go through some sort of psychological stress. There is certainly research being done at the moment into that.

CHAIR—It is the last paragraph on page 7.

Ms Tracy—Starting ‘Recent work from Creedy’—yes. She is about to publish her doctoral thesis which says exactly this: that women are going through quite a lot of post-traumatic stress type illness after this operative birth.

Senator DENMAN—So there is not a lot of counselling available for that stress?

Ms Tracy—No.

Ms Brodie—Again it is the context of care. A woman having a caesarean even within a midwifery model does not necessarily have increased stress. It is the whole package of care where women are well prepared, well supported. That is the critical factor in this continuity of care model. Women can have extremely difficult labours and births and come through triumphant and exhilarated with a scar on their tummy but absolutely delighted with the outcome primarily because of the whole experience through pregnancy, labour and afterwards. But, again, particularly for women after caesarean the postnatal care is inadequate.

Ms Tracy—For those with private insurance, and I think probably with the women who write these articles, they do have the care because they can afford the care in a private hospital very often.

Senator DENMAN—Just one more quick question: are there any figures to indicate whether one state is using midwifery services more effectively than another in Australia?

Ms Brodie—We have not yet done that work but we intend to do that through the Australian Midwifery Action Project. We cannot look at that state by state but, within individual units, there are some units that are much more what we would say ‘midwifery led;.

Senator DENMAN—I am interested because on the north-west coast of Tasmania where I come from midwifery is used quite freely amongst some of the population, and that is what prompted that question.

Ms Brodie—In our supplementary material we have given a slightly updated version of a table where we are basically summarising midwifery-led care. While it is unpublished data and not for public release yet, the work that we are doing at St George Hospital that you will hear more about from the Midwifery Practice and Research Centre has involved a very large study of community based continuity of care where we believe we will get improved outcomes. It is the largest study done anywhere in the world and it is about to be released.

Senator TCHEN—Just a quick question to Ms Tracy. You made a statement that childbirth has become a wholly pathological event. I assume from what you have said that some childbirth should be regarded as a pathological event.

Ms Tracy—Absolutely. It is shown that 20 per cent of women in childbirth could experience difficulties. What we are saying is that for the primary model of childbirth—if we get back to being sensible about it and seeing it as a fairly physiological event—for 20 per cent of our population we need to access tertiary care or obstetric care. We have already changed the focus from the whole pathology to being something that is not pathological, but at times we may need to access services that address that.

Senator TCHEN—What proportion of that 20 per cent of potentially difficult births can be picked up before the onset of labour?

Ms Tracy—The whole issue is dynamic. Some women may look to be at high risk—what is considered to be high risk—but have a completely normal outcome. What we are suggesting is that the model of care should be that midwives always work in collaboration with this consultative tertiary level of care, so that you are caring for a woman until you realise there is something that needs that referral. Then there should be easy access to that level of care. At the moment there are so many barriers to this sort of care. The reason we are suggesting that we need to overhaul the whole service is that it does not focus on that sort of outcome of care.

Senator TCHEN—I asked that because it seemed to me that a lot of evidence that has come before this inquiry has implicitly promoted the idea of homebirth as a preferred model or as a best practice model. Although I do not recall anyone actually putting that forward, that is the implication. But homebirth obviously would involve risk where you might have events which are actually pathological.

Ms Tracy—In Australia at the moment homebirth is a hot potato, so we are not advocating homebirth per se. We are advocating that a woman should be able to choose to give birth at home if she wants to. There is research data from the Netherlands and from England that shows that those projected risks are not perceived risks, and the research evidence shows that it is not as risky as we have always perceived. We have been caught in a movement where women have gone for diagnostic care to a hospital and then gradually over the last 30 years the care of all women has been moved to the hospitals. That may or may not be the way it needs to be.

Ms Brodie—If I can clarify something: it is important that when we talk about midwifery-led models of care we see that as not necessarily independent midwifery. Independent midwifery is just one type of a midwifery model. What we are really talking in today's submission is the reorganisation of public health maternity services where the majority of women will give birth in hospital, and it is that seamless kind of collaboration that we are after between midwives and obstetricians.

Senator TCHEN—I am still trying to focus on how you deal with a situation where an apparently low risk birth suddenly turns high risk. I do not know what proportion it would be.

Ms Tracy—If you have a woman that is giving birth with a midwife and she suddenly has a bleed—this is one of the things that can happen quite out of the blue. If she is with a midwife and that midwife has access to being able to consult an obstetrician, then the crisis is averted. She has been attended right up to the point of needing help by a midwife who has that ability to be able to consult with the obstetrician. So the woman may be in hospital. In New Zealand where midwives have become the lead maternity carer, women do deliver in the hospital with the midwife, but when that consultative care is needed then it is accessed. We feel that is the correct usage of that level of care.

Senator TCHEN—Do you agree with that?

Ms Brodie—Yes, it is the context of care that we are trying to describe so that it is the safest possible environment for women. We need midwives who are skilled and competent to provide these models of care.

Senator TCHEN—Just two short points, one was the research work by Creedy that Senator Denman asked about earlier. Do you know whether her research base was a global survey or was only a selective survey?

Ms Brodie—It was several hundred women. I do not have the paper in front of me.

Senator TCHEN—Were they random samples or selected samples?

Ms Brodie—I believe that Professor Barclay knows a bit more about this paper.

CHAIR—It might be useful if Professor Barclay just stepped up to the table.

[9.33 a.m.]

BARCLAY, Professor Lesley Margaret, Principal Investigator, Australian Midwifery Action Project

Prof. Barclay—I am the chief investigator attached to AMAP that the two researchers are describing and talking to you about. I was also one of the examiners of this thesis. Because of some of our other research, I am very aware of some of the psychological distress, depression and anxiety that occurs in women after childbirth. This thesis is the most carefully conducted study that I am aware of that has occurred internationally on a well-drawn population based sample that demonstrated the psychological impact of intervention during childbirth on women. What was surprising to the researcher and to those of us who have read the paper was that, while we are aware there is an increased level of distress, anxiety and depression in women post childbirth, we were not aware of the extent of post-traumatic stress syndrome that she found in the population which was much higher than you otherwise might expect. Because of the carefully designed study she was able to tie this to intervention and not feeling as if people were properly consulted or involved in the decision making by obstetricians and midwives.

Senator TCHEN—So it was a random sample selected from the global population?

Prof. Barclay—Yes, the global population of Queensland but it was properly drawn sample. It was a prospective study that followed these women over a period of time. It was supplemented by qualitative data where she did in-depth interviews of a number of women which actually described the emotional and psychological experience that they had following the birth. It is a very fine piece of work.

It is not inconsistent with other pieces of work. Jane Fisher's work that the team referred to earlier is an important piece of work because it showed a persistence of low self-esteem and lowered mood in women following operative delivery. That concerns us in a lot of the work that we are doing, because this is a time when women need to feel confident and strong. They need to not be exhausted and recovering from major surgery. They need every bit of resilience, strength, energy and confidence that they can get—as do their partners—as they take on the responsibility of a small baby. I think her work is also important. What is really exciting for us as Australians is that they are both Australian studies that are very important.

Senator TCHEN—Madam Chairman, I was wondering whether this work might be made available for the committee.

CHAIR—Absolutely. Could the committee be provided with a copy—if not of the whole paper then at least the detailed summary?

Prof. Barclay—Yes. Dr Creedy's award has now been granted. She has given us a summary of that material, and we will get it for you.

CHAIR—Thank you.

Senator TCHEN—On page 13 when you are talking about home birth, you describe a study of meta-analysis. What do you mean by that?

Ms Tracy—It is the meta-analysis by Olsen. This was a preview done for the Cochrane database. She has gathered together all studies on home birth to do a meta-analysis where possible.

CHAIR—What is a meta-analysis? We are not all hot to trot on the latest research jargon.

Ms Tracy—Meta-analysis is where one draws together studies that have been done in a particular area with a set protocol. So the methodology has to match a set protocol. The methodology itself is actually—

Ms Brodie—Consistent.

Ms Tracy—Yes, it is consistent but it is not consistent across different databases. You now have databases of systematic reviews where people are gathering together all studies done in one area and are trying to make some sense of the outcome measures. So there is a strict methodology for a meta-analysis.

CHAIR—Who worked it out? Who has actually defined what meta-analysis criteria might be?

Ms Tracy—If you look at the Cochrane database, the Cochrane Collaborative Group has set out the methodology for how one can achieve a meta-analysis of studies.

CHAIR—Should we ask you about that or somebody else?

Ms Tracy—Probably somebody else.

CHAIR—I think I have it marked as a question for somewhere else.

Ms Tracy—Professor Henderson-Smart is coming today. He is an absolute whiz on the Cochrane database.

Prof. Barclay—That would be a good chance to do it, because we are both talking to the NHMRC submission and part of the NHMRC submission is about measuring the quality of evidence that is available on which we make decisions.

CHAIR—Okay, we will leave it until then. First of all, thank you very much for your submission because it is research based, thoughtful and deliberative. It is not just the latest anecdotal stuff, so we are very much assisted by this. I was interested to read who AMAP is. How long have you existed?

Ms Tracy—Since the beginning of April—five months.

CHAIR—What drove you to get formed?

Prof. Barclay—This study was initiated by concerns about what might be happening to the quality of midwifery education, and a national group started to talk about this. Then Womens Hospitals Australia, who are responsible for 30 per cent of the births in this country, approached me and asked if we could do some research for them because they were wanting to ensure the quality and standards of midwifery care within their organisations. So those two groups came together. We gained the support of two state health departments and the Australian College of Midwives and put together a submission to the Australian Research Council to undertake a three-year funded study that has two goals: first, to describe what is going on in a very fragmented and poorly described situation—that is, maternity care in Australia and how midwifery contributes to it—and, second, to try to stimulate processes to bring people together so we do it better.

CHAIR—Who are the two health departments?

Prof. Barclay—New South Wales and South Australia.

CHAIR—I will resist any temptation to ask why it was those two departments—some of us would say it is because they are the best but others would say personal connections. How much money do you have?

Prof. Barclay—We asked for \$340,000 and we got \$300,000. It is relatively cheap considering the value of the work, but we are quite biased about that.

CHAIR—Over how long?

Prof. Barclay—Three years, and we are within the first year of starting. But fortuitously—I do not know whether the constellation of the planets is just right—a lot of things have happened this year that have enabled us to contribute perhaps earlier than we anticipated but in ways that, hopefully, are helpful to wider fora that are looking at the same sorts of issues that we are all concerned about.

CHAIR—I think this is all extremely interesting. It seems that there are a number of planets falling into alignment. Can you discuss the seeming contradiction between the arguments that might be put against early discharge—its cost shifting, we do not know the outcome, it may contribute to postnatal depression—versus homebirths where you are up and walking around an hour later and homebirthing type deliveries in a hospital where a mother will be going home a day later. Those two streams seem to me to be extremely contradictory.

Ms Tracy—To give a short answer, what we are saying is that not enough has been done to move the funding from the hospital situation to the community where postnatal care can be offered by midwives—you will see in these models that this is all part of that—plus Australia has a history of not actually caring very much about women postnatally. I think we are a country that has the least amount of postnatal care in the Western world. Most countries go up to 28 days—

Ms Brodie—Six weeks in some cases.

CHAIR—Meaning you get one weekly or daily visit?

Ms Tracy—A midwife can visit over those 28 days where necessary. She may not need to be visited that much. If you have someone who has three children, she will wave to the midwife at the front gate. But you may have another episode of care where the midwife may need to come twice a day for the first week.

CHAIR—Paid for by whom?

Ms Tracy—If the funding for maternity care is, as we are proposing, from a prospective model where midwifery care is funded, then that comes in that same package.

CHAIR—So what you seem to be saying is that early discharge is not a problem if there is adequate postnatal care?

Ms Tracy—Yes.

Prof. Barclay—Excuse me, may I just interrupt here. We are conducting a population based pilot study in the South Eastern Sydney Area Health Service of 400 women to study postnatal outcomes. We have applied for funds next year to do a larger study to understand what it is women want and need from postnatal care, to understand how it is delivered and to test ideal models of postnatal care. This study is unique in that it will be following outcomes for women and their infants for up to 12 months. Our concern is that we do not understand the long-term impact of the sorts of care that women are currently receiving both in and outside hospital. The purpose of this study is to do that and to try to bring some research base so that we can design the sorts of models of care that people require.

Ms Brodie—I understand that you have the framework document submitted by the New South Wales Health Department. I was involved in the development of this work where we surveyed every maternity hospital in the state to ask them what sort of service did they have—call it what you will—early discharge, community midwifery or outreach postnatal. I am looking for my reference here, but the results were that, of the 130-odd maternity units that were surveyed, some 45 or 50 did not have a structured program. So women went home from hospital on day two or three or four—it is on page 17 of the submission. It was found that, of 101 public facilities providing maternity care, only 72 reported the availability of any form of outreach or community based postnatal program. We know that these programs mostly cease after about day five or six, which is generally when women need them most.

CHAIR—I have about 10,000 questions. I wonder if you could take on notice—only if it is reasonable to answer because I do not want to put you through another PhD—these questions on childbirth classes: who runs the classes; where are they provided in the community or in the institution; and are any of them free or, if not, how much do people pay? If you have been talking to all the maternity hospitals around the state, it might be that you can get that information reasonably. If you cannot, please let us know and do not do it.

Prof. Barclay—We actually have another PhD student who has not put in a submission but who is studying antenatal education. She is reviewing and doing operations research on

improving antenatal education. Her work is about halfway through now, and it has resulted in some significant shifts in the way antenatal education is provided.

CHAIR—If it is possible to get that information without disrupting that thesis, we would welcome it. Antenatal education and childbirth classes have a different ring in my head—if they are the same beast you might explain that to us.

Prof. Barclay—They are the same.

CHAIR—Can you also briefly comment on notice—I want to ask you one last question on the record—about a direct entry midwifery course that we have been advised of. Nurses may go to such a course but it will not be a requirement that people need to have a nursing degree or qualification before they enter such a course. You nod as though you acknowledge it exists, but if you could just make a comment about whether you think it is a good thing or a bad thing.

Ms Tracy—Good.

CHAIR—We have had very disparaging comments about double certificated nurses. I think the only person on the committee who is using that language is me, but that is because I am old enough and probably that much out of date. But the comment has been: ‘They have just done one year of midwifery, what would they know?’ So there is a big disparagement of nurses who have done their midwifery and then get to be called midwives.

Prof. Barclay—We could provide to the committee an issues paper that we have prepared on this issue in relation to the shortages in the qualified midwifery work force. In that paper we have argued a case and modelled the numbers that would be necessary if we continued to prepare midwives only through gaining a postgraduate qualification in nursing.

CHAIR—If I could interrupt you there: if you could drop us a few lines on that, that would be great. I just wanted to ask you on the record a very important question in my head. Best practice suggests some kind of measurement of criteria by the midwives or the professional providers. Best practice guidelines are often drawn up by the profession—teachers, flying aces, whoever—the people who have claim to the body of knowledge that draw up the best practice guidelines. You state:

Implementation of ‘Best Practice’ in maternity care, which is a service provided in the main part for healthy women, requires service providers to actively incorporate consumer’s needs . . .

I wonder if you could tell me how a professional body incorporates best practice guidelines that include the consumers’ needs without just writing patronising words on a bit of paper.

Ms Brodie—I will have a go at answering that.

CHAIR—In 30 seconds because we are out of time.

Ms Brodie—The problem is that the professional bodies are somewhat dislocated and separate from each other. What we need is a coalition of midwives, obstetricians and

consumers that work together on a national maternity framework to develop best practice. There are too many vested interests.

CHAIR—How can consumers make any serious contribution to best practice? They are not in the position. They do not know what expert information is. They cannot really know what the information is against which best practice guidelines are drawn up.

Ms Brodie—If we look at the New Zealand model where consumers have been very strongly part of the movement, the consumer is not involved in looking at the best professional practice; the consumer is there to advise the practice model about what they see as the strongest needs of the consumer. Maternity care is one of those areas where we absolutely cannot separate the midwife from the mother in understanding each other's needs.

CHAIR—If you could give us 10 lines on that, that would be very useful. I am afraid that we are dreadfully over time. Thank you very much for a very useful contribution.

[9.50 a.m.]

CHAMBERLAIN, Professor Marie Elizabeth, Clinical Chair in Midwifery, University of Sydney and Northern Sydney Health

TRACY, Ms Sally Katherine, Senior Research Midwife, Australian Midwifery Action Project

CHAIR—I welcome Professor Chamberlain. Thank you for appearing here today. Do you have any comments to make on the capacity in which you appear?

Prof. Chamberlain—I would like to think that I am speaking on behalf of child-bearing women, although I am not at that stage myself.

CHAIR—The committee prefers all evidence to be given in public, but should you wish to give evidence, part of your evidence or answers to specific questions in camera, you may ask to do so and the committee will give consideration to that request. We have before us your submission, which is No. 154. Do you wish to make any alterations to that submission?

Prof. Chamberlain—Just on your last question, I am wondering if it might be helpful—I originally came from Canada where I worked on a direct entry midwifery program, which is now very effective in Ontario. I could offer to send you a few lines on that, if it would be helpful to the committee.

CHAIR—That would be most welcome, thank you very much. If you would like to make a brief opening statement and then field questions?

Prof. Chamberlain—I just want to apologise for my colleague who unfortunately cannot be here today because her husband is having major surgery. She sends her apologies.

CHAIR—Our sympathy.

Prof. Chamberlain—Madam Chair and members of the committee, I thank you for inviting me here today to speak on behalf of the University of Sydney and Northern Sydney Health. It is gratifying to know that the Senate is taking the initiative to inquire into birth practices in Australia, because I believe it is very timely.

Maternity care in Australia, as I am sure you have already heard, is based on the medical model. The focus is on the physical health of the mother and on risk detection with little attention paid to the psychosocial aspects. This model is not appropriate even when there are problems because it always assumes the worst and is becoming ever more invasive. It reduces the ability of a woman to birth naturally without intervention. The medical model of health funding ensures that expensive interventions and costly screening procedures, which may have little effect on the outcome of pregnancy and birth, will continue to be subscribed and ever increase. Lower cost models of care, such as outreach programs, community antenatal care and continuity of care, will continue to be denied to consumers.

There must be an evaluation of technology and services used in birth care. This should include a review of alternative models where the doctor is not the primary care giver. We need to develop regulations to permit new technology only after adequate evaluation and a demonstrated need. We need to provide support for the use of social and nutritional interventions to increase birth weight. We need to give adequate public information to expectant mothers and their families in relation to choices for safe practices that are available. This is in accordance with a recommendation made by the NHMRC in 1996.

The situation for rural, Aboriginal and Torres Strait Islander women needs to be addressed. We need to know how we can improve access, choice and clinical outcomes for these women. There is a great need for the development of current evidence based guidelines for the conduct of all maternity care in Australia. I believe these objectives would best be arrived at by the consensus of groups encompassing equal numbers of consumers, health professionals, local government representatives and other key stakeholders. Such a consensus would allow for socially and culturally sensitive care. It would also be economically efficient because it would address alternative models and reduce costly interventions. All of this would be based on ongoing appropriate research and evaluation.

CHAIR—Thank you. I am not wishing to start a fight but I am very interested in this statement on page 2 of your submission:

In Australia the health service paid in one year \$60 million dollars for ultrasound scans during pregnancy. This compared with \$50 million dollars billed for all antenatal, intrapartum and postpartum care for the same women (Newnham, 1992).

Whereas our previous witnesses had different figures on their page 2. They said:

. . . ultrasound for 1997/98 was \$39 million, in comparison to \$54 million . . . (Beech 1998).

I know that you cannot really turn around and sort it out with the witnesses behind you, but I am just a bit concerned at the difference between the figures of \$39 million and \$60 million—a \$20 million difference. Newnham's 1992 figures put a much higher figure on ultrasound. Is it that, in fact, ultrasound has fallen? I would like you, firstly, to comment on the discrepancy in the figures and then, secondly, to get to the more serious point that you are making which is that ultrasound is costing probably as much as—if not more than—the whole of the rest of obstetric care.

Prof. Chamberlain—Obviously, that is a discrepancy that needs to be addressed. This seems a bit of a cop-out, but I am afraid that that piece was actually entered by my colleague.

CHAIR—Please do not worry. Could you take that on notice and, say, talk to the previous witnesses?

Prof. Chamberlain—Yes, I will.

CHAIR—They are two different studies. They are both sourced, so I am not suggesting that this is a wild claim by you.

Ms Tracy—It is difficult to get the information—

CHAIR—Are you suggesting that you would be able to get some information?

Ms Tracy—The information is available, but it is very difficult to access. I have been trying in the last two weeks to get just that figure because I am interested to know.

CHAIR—Thank you for that. I will ask Professor Chamberlain because she is our current witness, but any witnesses down the back who happen to hear this question are also welcome to act on it—that is, can you make any sense comparing Newnham's 1992 figures and Beech's 1998 figures? It may be that we need to have a look at what was counted. It may be that the number of ultrasounds is falling. That is not the evidence that we have been given. I would be very interested if you could comment on that.

I also want to thank both of you for putting that in. This committee does have to deal with the best allocation of precious taxpayers' dollars. It is quite a shock to discover that the cost of the whole of childbirth—antenatal, intrapartum and postpartum—is about the same as is spent on one antenatal intervention. One thing I wanted to ask on that is: does ultrasound tell you whether there is a placenta praevia?

Prof. Chamberlain—A selective ultrasound would. We have general ultrasounds which we use to assess gestational age. In some places they are actually done around 12 or 13 weeks to actually assess whether the pregnancy is viable. This always seems a little strange to me because, if it is not viable, there is nothing we can do about it anyway because it is going to abort itself.

CHAIR—For the record, I should say that, loosely translated, placenta praevia occurs where the placenta has established itself in the uterus down across the cervix and it is therefore likely to be associated with bleeding when the birth process starts.

Prof. Chamberlain—I think the issue is that, basically, there are very general ultrasounds that will pick up rough estimates of what is happening, but you often need more specific ultrasounds if you want to see specific things like disabilities or placenta praevia.

Senator DENMAN—I have a couple of questions. Because the consumer demand is high for ultrasound, do you think it should be available just because the consumer wants to have an ultrasound?

Prof. Chamberlain—I think that is an excellent question. I do not think we really have enough information on the value that women place on seeing their infant. We certainly know that women and their partners do really love to see the infant. It really seems to set up some kind of relationship slightly earlier than would probably otherwise be the case if she did not see it.

Senator DENMAN—Is there any work being done on this?

Prof. Chamberlain—To my knowledge, not in terms of the woman developing the relationship.

Senator DENMAN—Who owns the ultrasound machines—doctors, hospitals or conglomerates of doctors?

Prof. Chamberlain—The hospitals, but they often give the woman the picture of the ultrasound.

CHAIR—She gets the photographs?

Prof. Chamberlain—Yes, she carries them around with her. If it has a psychological advantage I think I would probably have to say that the first one would be beneficial, but if it does not have a psychological advantage, I am not sure.

Senator GIBBS—I am interested in what work you have done with the Aboriginal women. We have heard from other witnesses in other states that Aboriginal women do not go to antenatal classes—they might show up once—because of their cultural background or because they are uncomfortable. So they do not take advantage of the hospital system. In your studies, what have you found that we can do to address this situation?

Prof. Chamberlain—I have done a fair bit of Aboriginal work in Canada in the Northwest Territories with Inuit women. We actually set up a birthing centre because they had a very similar situation to here, which is that women get sent many miles away from home and their communities for birth. I actually worked on Thursday Island in Northern Queensland in my other life.

Senator GIBBS—I come from Queensland.

Prof. Chamberlain—We had the midwifery model up there, so we had a lot of Aboriginal women. At the time I do not think I recognised how desperate things were. We actually brought women in at 28 weeks to wait for birth because there was a lot of venereal disease and syphilis.

Senator GIBBS—Venereal disease on Thursday Island is a huge problem.

Prof. Chamberlain—I guess what I am saying is that having to come in so early for treatment and then having to sit around and wait when they are removed from their families is a big issue.

Senator GIBBS—Obviously, if a pregnant woman has venereal disease it is not good for her health but does this in any way damage the child?

Prof. Chamberlain—Syphilis can if it is untreated. Gonorrhoea can have some effects on unborn children.

Senator GIBBS—What can governments do with regard to Aboriginal women? Should we be embarking on a program where we actually train Aboriginal women to become midwives—those who are living in the community—so that the women can birth at home and so they can give the mother other sorts of education as far as antenatal programs go?

Prof. Chamberlain—Yes, most definitely. I think that is really the way to go. The birthing centre that we had in the Canadian Arctic was extremely effective. We had two midwives who did not actually come from Canada giving care but they were very culturally sensitive. They also had an Inuit maternity worker who a lot of the consumers believed was an Inuit midwife, and they actually complained that she did not have a sufficient involvement in the care. One of the things that came out very strongly for me at that time was how important it was to have somebody who speaks your language when you are going through labour. Even though you may have had 10, 12, 15 years of speaking the English language, at a crisis time such as labour, you need someone who speaks your language and knows your culture. I think this is what is missing from a lot of the Aboriginal health care out in the remote areas.

I think your original question was about my involvement. I have become involved with the remote area of New South Wales in terms of Aboriginal care. Last year we received money from the Department of Health to actually exchange midwives between Northern Sydney Health and the remote area. We found some very interesting things when we visited there. For instance, in a community called Walgett, which is quite a disturbed community in many ways, women were sent many miles to Dubbo for health care and were not getting any maternity care there even though they actually had four midwives working in the local hospital. It was because these four midwives had not been able to give antenatal care for so long that they felt that they were not competent to give it any more. As a result of this exchange program, we now have them setting up an antenatal clinic for the local community.

I guess the next step is to try and encourage the Aboriginal women to come in because there are some racial problems in some of those areas. Often there is not a good relationship between the non-Aboriginal community and the Aboriginal community which may, even if we set up the clinics, impede their access to maternity care. So I think we need a lot more cultural sensitivity workshops and whatever with health care workers in those areas.

Senator GIBBS—That is interesting. Thank you. Just one last question, Professor: do you agree with this idea of having a four-year university course for midwifery? You do not have to be a nurse with one year's midwifery—

Prof. Chamberlain—You mean direct entry?

Senator GIBBS—it is a university course and then they come out—

Prof. Chamberlain—Totally. I have to point out that, in Canada, we have been doing a three-year full-time academic year; in other words, a three 11-month year academic program in midwifery which is a direct entry program, and it is very successful. And, as a result of this program, women are actually going to midwives and saying, 'Can you tell me when I can conceive so that I can get on the waiting list for your program?' And this is a country that was not familiar with midwives. Up to that point, there was no exposure to midwives, apart from a few independent midwifery practitioners. The government salaried midwives to provide a practice and, as a result, they also had hospital privileges. I think this is an important point: homebirth midwives need hospital privileges so that women who want midwives and are willing to pay for that but who may, for whatever reason, not want to birth at home can come into hospital with that midwife and birth there.

Senator GIBBS—Has this had any effect on the health budget?

Prof. Chamberlain—That is a very good question. I am not sure. It is probably something I could investigate. I certainly know that the last government, which has just been retained—

CHAIR—Are you talking state or federal?

Prof. Chamberlain—Province in Canada, but basically the state. The Ontario government is very money focused, so I am quite sure that if it was not saving money it would have been eliminated.

Senator GIBBS—That is very interesting. Thank you.

CHAIR—I visited Ontario just a few years ago. I smile, Professor, for all that you have not said. I just want to check and get on the record these figures on page 3. The overall caesarean section rate was 16.9 for the state. I do not know what year that was.

Prof. Chamberlain—That was the last year. It was published in 1998. I believe it was 1997.

CHAIR—That is curious because we are usually told that New South Wales is about 18.6—or the latest data says so. You also talk about:

. . . Kareena Private Hospital 30.3%, King George V Memorial Hospital for Mothers and Babies (a tertiary referral hospital) 19.8% and Bankstown-Lidcombe Hospital 11.4% (mainly midwifery care in labour) . . .

These figures are beginning to be glaring in their differences.

Prof. Chamberlain—I think that the fact that there is such a variation demonstrates that there is not a need for the high level of intervention that we have.

CHAIR—In South Australia we were able to ask the question: does South Australia have the highest rate of caesarean sections because it has the highest number of specialist obstetricians? There was some difficulty in answering this question, but there does seem to be an extremely high likelihood of correlation, seeing obstetricians are the only people who can do caesarean sections. Do you think that the same thing could be concluded from these figures, especially as the lowest one is midwifery only?

Prof. Chamberlain—If you look at the figures, for instance a couple of years ago Liverpool, which is right on the periphery of the west and where it is about 85 per cent midwifery births, has one of the lowest rates of caesarean section, whereas in an area like North Shore, where we have a large number of visiting medical obstetricians, we have a rate of about 29 per cent at the moment. That actually was higher but we now have managed to separate our figures because we have a private hospital that has opened and separate data figures.

I have worked in several countries and even in England I found that where you have 24-hour labour ward coverage with medical staff you have a higher intervention rate.

CHAIR—You also refer to babies born to Aboriginal and Torres Strait Islander mothers who are 1.5 to two times more likely to die at birth or in the first month compared with babies of non-Aboriginal mothers. Are they Australia wide figures?

Prof. Chamberlain—The worst figures are in the Northern Territory, but it is much higher in every state.

CHAIR—It is actually remarkably good from one perspective and that is that I have been around too long. In about 1983-84 there was an Aboriginal project—Women's Work, I think it was called; I am not sure—but the figure then was that they were five times more likely to die. While our colleagues abuse us for doing nothing in our years in parliament, one of the things that has dropped significantly since the early eighties until now is the neonatal mortality or perinatal mortality of Aboriginal children. That is now down to two times, by some studies—and here 1.5 times—when previously it was five times. No-one would settle for it. In this country it should be clearly comparable. It is still far too high, but it is significantly better than in 1984.

Prof. Chamberlain—We have certainly found in Canada that there are areas where you will always have a slight increase because of the remoteness of the area, and that is one of the risk factors. But, even so, we would like to lower it more than that.

CHAIR—What is the main reason for that fall in Aboriginal infant mortality and perinatal mortality?

Prof. Chamberlain—With Aboriginals?

CHAIR—Why has it come down so much?

Prof. Chamberlain—Do you mean Aboriginal or general infant mortality?

CHAIR—Aboriginal mortality. It was previously five times the non-Aboriginal rate. We are now saying that it is 1.5 to two per cent. That is a very big drop. It is not good enough yet, but it is a very big drop. Can you tell us what in your view is the most significant contributor to that fall?

Prof. Chamberlain—I do not know that I have any hard evidence and I think it is multifactorial. I think that in some areas there has been improvement in social circumstances and I believe social circumstances play a large part in this. I also believe there are some very creative programs, such as Congress Alukura that I mentioned to you in Alice Springs. I know that there are programs elsewhere—outside of Alice Springs—in Western Australia where midwives are doing very good work with Aboriginal women, and I think it is starting to pay off. But unfortunately it is not widespread enough yet.

CHAIR—On page 6, you say, in a fantastic paragraph:

Women are not educated in the risks of the various interventions which create a flow-on effect. For example, a woman is induced because she may be slightly over her expected date of delivery; the induction fails so she has her membranes ruptured; she then has to be given intravenous syntocinon because ruptured membranes cannot be left for longer than 24 hours because of infection. The syntocinon creates strong contractions so that she requires an epidural anaesthetic to relieve the pain. This reduces sensation in the lower body and extremities, she is confined to bed, labour slows, her pushing reflex is reduced and she requires forceps or a vacuum extraction to remove the baby. An instrumental delivery requires an episiotomy which could extend to a third degree tear creating postpartum morbidity. She may instead require a caesarean section because the baby is too distressed. The baby, if distressed will require resuscitation and careful monitoring by staff. This will involve admission of the baby to the neonatal intensive care unit. This cascade effect results in increased workload for the staff, increased costs, extreme distress for the parents with possible mental health problems due to the interventions, painful birth and the pain and difficulty in breastfeeding and attachment to the baby.

If I read a medical textbook would I find the same description? Could I be clear that this is a description that would be ticked off as being actually the case by obstetricians, gynaecologists and midwives?

Prof. Chamberlain—I think it is the case—I should not say ‘I think’; I know it is the case—but I think in a medical textbook you would find it in different chapters.

CHAIR—We are talking about continuity of care.

Prof. Chamberlain—Yes, I am putting it all together for you because this is really the flow.

CHAIR—It is extremely interesting to have it spelt out like that because there are extremely interesting differences between the caesarean rates. On some evidence we are told that there is not much difference between elective caesars—that, randomly, the pre-eclampsia will happen or the haemorrhaging will happen or what have you, but if you are looking at the major difference, it is in the elective caesarean rate. The caesarean section that might follow here, is that elective or urgent?

Prof. Chamberlain—In this case I think it would be an emergency. But one of the other issues, certainly in some hospitals that I know of, is that once a woman has had a caesarean section the obstetrician is very reluctant to let her then have a trial of labour with the second pregnancy, so she is more than likely to be booked for an elective section the second time around.

CHAIR—When we were in South Australia the other day, particularly at the Queen Elizabeth Hospital, but not only there, we had some fascinating data that suggested that it is useful to go in the other direction.

Prof. Chamberlain—You mean to have a second elective section?

CHAIR—No, to have a trial of labour.

Prof. Chamberlain—Yes.

CHAIR—There are very good results.

Prof. Chamberlain—Extremely good, but many women are not aware of those and the obstetrician is often reluctant to suggest it.

CHAIR—What can you tell the committee about the fear of litigation being a causal contributor to the high caesarean section rate?

Prof. Chamberlain—It is certainly a not uncommon statement from physicians that no-one gets sued for doing a caesarean section. They feel that women are fearless if they have done their best, if they have done a caesarean section. I would like to make a statement here that I have not made in my paper, and that is that some of the issues around interventions are that there is not always good clinical supervision of either midwives or physicians in training. I am talking more about interns and residents. They are often left in a trial and error situation where they try the best thing to see what happens. They may actually be doing a forceps delivery for the first time in some circumstances where they are not supervised and have not been shown how to do it. We get those kinds of problems, where they fail to do the forceps delivery and then they have to do a caesarean section. For them, once they have learned how to do a caesarean section, it is the easiest method for them.

CHAIR—How is a caesarean done? Is it a horizontal or a vertical?

Prof. Chamberlain—Vertical. It is usually the lower abdomen. Sorry, horizontal. I have not had my coffee this morning.

CHAIR—From left to right.

Prof. Chamberlain—Below the umbilicus.

CHAIR—Leaving a bikini-covered scar?

Prof. Chamberlain—It depends on how low the bikini is.

CHAIR—Can you tell us what is defined as early discharge, postnatally?

Prof. Chamberlain—It is usually about 48 hours. Some women ask for earlier discharge. Usually we find that women who want to go home earlier are usually well prepared to do that. I would support my colleagues' statements here that there is very little support for women going home. I believe women should be evaluated on their ability to go home after 48 hours and look after a newborn child. There are a lot of issues, such as breastfeeding, that have not been established by the time they go home and may not even be established with four or five visits because certainly our early discharge program does not usually visit after day eight.

CHAIR—In their report *Options for effective care in childbirth*, the NHMRC recommended that a leaflet should be published outlining options for maternity care. We were told in Western Australia that, following their childbirth inquiry, they have done the major recommendation: the production of such a leaflet of information—it is almost a booklet. Yet other witnesses have disparaged the report somewhat, saying that it was useless. All it has done is produce a leaflet with some of that information. That does not quite do

justice to the subsequent witnesses, but there was a sense that leaflets with information was pretty wimpy. Would you care to comment on it? You said here that ‘there is a need to investigate the extent’.

Prof. Chamberlain—There has certainly been differing research on how valuable written information is. Obviously, you have to have people of a certain level of education to make use of it. I believe pregnancy is a time when women search out information. It is a very good time for that. I just want to refer to a situation with World Health in 1985. After a review of having a baby in Europe, they produced recommendations for what women should know and be aware of. One enterprising Italian lady took these recommendations and put them on posters, which she posted in very obvious places. Women picked up on this and demanded information. Someone in Britain who saw this did the same thing, and then someone visiting from France also did the same thing. So women in Europe became much more aware of things that they should be asking about and things that they should know about. It was a very effective way of putting information to women. I think we underestimate the value of posters at train stations and bus stations, and things like that, that are written in a very easily understood language.

CHAIR—That is very interesting. It dawns on us from time to time that if you are, for example, wanting to maintain a high level of immunisation, you probably need a campaign every five years. We used to say every 10 years, but it is becoming clear that you probably need big public health campaigns every five years. We probably need to have a good economics one every five years, too, to prevent the next depression! Forgive me straying into wrong territory. It is beginning to dawn on me that we need the same kind of public health campaign about childbirth and the whole business of pregnancy and postnatal care every five years, too. Do you think that our public health system on the whole childbirth process will need to be modified because there are far fewer children being born in, for instance, Australia? There are not kids all over the place and people do not grow up rearing their little brothers or sisters or their nephews and nieces. There seem to be fewer babies around, so more mothers are new at the game of parenting, if you know what I mean.

Prof. Chamberlain—Yes. We have been going through that for some time. With the immigration into Australia as well, we have a lot of mothers who are dislocated from families in other countries, which also adds to the problem. We have been under the influence of a lot of myths such as ‘breastfeeding is natural’, ‘child rearing is natural’ and ‘mothering is natural’. It has denigrated the value of mothers in large families teaching their siblings how to behave with other children. We do have to focus on that.

CHAIR—I would like to be clear, for the record, that you are not suggesting that breastfeeding is not natural but that an element is missing—that the introduction or the establishment of breastfeeding often had supporting parents or people around who are not there now.

Prof. Chamberlain—I am saying that the myth has generally been that a mother could stick a baby on the breast, away it would go and there would be no other problems. Women are now recognising that there needs to be some support for breastfeeding, because they are not always able to do it straightaway all by themselves.

CHAIR—It does not always work like that.

Prof. Chamberlain—That is what I meant by ‘natural’.

Senator TCHEN—Professor Chamberlain, I have a thousand questions because you are the first witness I have come across who is in, in my view, an impartial position.

Prof. Chamberlain—Thank you. I hope I am.

Senator TCHEN—The other witnesses all came from one direction. I am not saying they are biased, but they all came from one direction or another. On a lighter note, you mentioned the Ontario provisional government. You commented that there might be more focus on money.

Prof. Chamberlain—There is a very strong focus on money.

Senator TCHEN—I was wondering whether you know of any government which is not money focused?

Prof. Chamberlain—No!

Senator TCHEN—On page 5 of your submission you said that the New South Wales government has funded an innovative program for remote area midwives. Can you tell us where and what this program is and what the outcome has been?

Prof. Chamberlain—This is the one that I mentioned earlier. This is the one where I obtained some money to do a midwifery exchange. There were two areas of interest there. One was to get midwives from the remote area to come to northern Sydney hospitals and begin to get the skills that they felt they were deficient in and to give them a sense of confidence that they were able to carry out maternity work. The other was to encourage midwives from the northern Sydney area to take their places to get some exposure to cultural issues in those areas and possibly even to think about a career there.

Senator TCHEN—I see, so urban area midwives go out to the remote area as well.

Prof. Chamberlain—And the remote areas come in. We have not finished the evaluation yet, but the midwives from the remote area are generally extremely pleased with it, are very supportive and want it to continue. That is obviously an issue, because we had money for only one year. In addition, we are setting up an antenatal clinic in Walgett, where there was not one before.

Senator TCHEN—So this program is no longer going?

Prof. Chamberlain—Yes, it is still going. It has just taken longer than we anticipated because some midwives were not able to do the exchange at the time we hoped. It will be completed in late October.

Senator TCHEN—Do you have any idea whether the New South Wales government is likely to follow up this program?

Prof. Chamberlain—I am not sure. I would put in another submission, but I am not sure. When I talked to the government last, they were not even sure that there would be any more money for this particular program, which is called Alternative Birthing Services.

Senator TCHEN—Earlier in your submission—just before that paragraph—you refer to particular problems faced by remote area mothers because of the non-acceptance of midwifery practice by doctors and those sorts of difficulties. Has this exchange program, in the way that it was applicable, eliminated some of those problems?

Prof. Chamberlain—That is an excellent question. I must say that we have not focused on the GPs in the areas. The reason that we are doing so well in Walgett in setting up the antenatal clinic is that one GP has recently retired and the other one does not have an obstetric diploma, so there is no competition. It was just that the midwives had not done antenatal care, because they did not feel competent. There are other areas where we know GPs have said, 'I will do all the antenatal care,' and what happens then is the midwives get deskilled over a period of time. Then if that GP leaves, the midwives do not feel confident enough to give the care, so the women actually suffer.

Senator TCHEN—Earlier witnesses commented that their preferred model is cooperation between the professions. It seemed to me that what you are highlighting is a certain lack of cooperation. I wonder whether this program you refer to might help to overcome some of that.

Prof. Chamberlain—That was not the focus, to be honest. The focus was to upskill midwives, but that is an issue that needs to be addressed. We do need to work on a shared care model. One of the things that I think it has been helpful with is that the midwives have got contacts in the northern Sydney area with obstetricians, women's health physicians and what have you. They have someone they can access when they have difficulties, and I think that was lacking before.

Senator TCHEN—And perhaps when they go to the remote area they can take this particular culture of communication with other professionals with them.

Prof. Chamberlain—Yes.

CHAIR—Do you have any more questions, Senator?

Senator TCHEN—I have three more.

CHAIR—Can you put them on notice? We are way over time, I am sorry.

Senator TCHEN—Okay. Professor Chamberlain, on page 5 and page 7, you refer to practices and education. On page 5 you say:

There are many practices that have been demonstrated not to be sound, and in some cases harmful, which are still in use in some hospitals during labour and birth.

I would like to know whether you can expand on that and see why those practices which have been proven harmful are still being taught. I want to raise another question. On page 7 you say:

A factor which has an impact on childbirth practices is the paucity of clinical education for midwifery students and medical residents and registrars in hospitals.

That is at the top of page 7.

CHAIR—You did refer to trial and error in your report.

Prof. Chamberlain—Yes.

Senator TCHEN—Could you indicate to us, perhaps in a written submission, how they can be improved and how the changes can occur?

CHAIR—And can these be dot points, Professor, not a 10-page PhD? We do not want to put you to massive work on notice.

Senator TCHEN—There have been a lot of comments about the difference in caesarean rates in different hospitals. It seems to me that one other possibility is that some specialists in private hospitals have higher caesarean rates because more obstetrician specialists are registered and practise in those hospitals. The public hospitals may have fewer specialists registered. Also, later today we will hear evidence from a witness from the anaesthetists society. They will refer to the difficulty of getting anaesthetists to attend emergencies. Is it possible that that availability of specialists in certain hospitals would increase the rate of intervention in those hospitals in the sense that patients would be referred to those hospitals?

Prof. Chamberlain—Yes. That is a definite factor. I think the causes of different caesarean section rates are multifactorial. Women ask for caesarean rates for whatever reason, and Debra Turnbull in South Australia has done some interesting work on that. But if you look at the rates across New South Wales, the places that have the largest numbers of obstetricians have the higher rates.

CHAIR—However, our very large public hospitals, which are state-of-the-art maternity care, have a lower rate overall than private hospitals up the road.

Prof. Chamberlain—Yes. I should qualify that statement in that there are specific obstetricians who are very well versed in evidence based practice who have lower rates as well.

CHAIR—That is interesting. Thank you very much.

[10.37 a.m.]

CLUNE, Ms Lynne Maree, Member, National Association of Childbirth Educators

GREEN, Mrs Pauline Elizabeth, Member and Trainer, National Association of Childbirth Educators

MYORS, Ms Karen Anne, National Vice President and New South Wales State President, National Association of Childbirth Educators

CHAIR—Welcome. The committee prefers all evidence to be given in public, but should you wish to give your evidence, part of your evidence or answers to specific questions in camera, you may ask to do so and the committee will give consideration to your request. The committee has before it your submission, which is numbered 75. Do you wish to make any alteration to the submission?

Ms Myors—No.

CHAIR—We are now greatly behind time. I ask you to make an opening statement and stress that brevity is the soul of wit. Then we will ask questions.

Ms Myors—The National Association of Childbirth Educators, known as NACE, is a professional body with the aim of promoting professional standards and supporting childbirth and parenting educators throughout Australia. This is achieved by producing a national journal and having a biennial conference as well as state newsletters and seminars. Whilst NACE has had standards of practice since the early 1990s, there are no national or state agreed standards for childbirth and parenting educators. Our concern is that anyone can call themselves a childbirth educator without any specific training and that many maternity units still roster midwives untrained in group processes to conduct these educational courses.

This concern was emphasised in the New South Wales Standing Committee on Social Issues inquiry into parent education and support programs, which recognised that the primary professional training of an individual does not necessarily prepare them with a knowledge of adult education principles. NACE is currently developing a certification system where members are recognised for their professional development and classified as a basic educator, advanced educator or trainer. To enhance this system, a national training scheme is also being developed, emphasising adult education principles and promoting best practice.

Senator DENMAN—You made reference to not having national standards. How would you go about addressing that?

Ms Green—The problem as far as NACE is concerned, if I can just put a word in, is that not all people who are involved in childbirth or parenting education belong to NACE. So NACE, as an organisation, has developed standards, and we are taking it from there. But, to do it on a national basis, we would have to have some backing to say that all childbirth educators need to belong to NACE to be able to practise within the community. But, as you may be aware, at this point in time anybody who wanted to could set up their little ad in the

paper or their shingle outside and say, 'I'm a childbirth educator.' So we do not have any formal backing, apart from our own promotion.

Senator DENMAN—It sounds as though you probably need registration and accreditation, the sorts of things Senator Crowley did in child care.

Ms Green—Some kind of accreditation, yes. I suppose some of us working in various health areas within the Sydney area, the metropolitan area, are setting our own criteria. We are starting to ask the people we employ as educators for proof that they have some qualification, some further education from their primary professional grouping in the way of adult education principles and standards.

Ms Clune—I am also the area parenting coordinator of the South Eastern Sydney Area Health Service and we have just instituted some minimum standards for childbirth and parenting educators. All educators are undergoing baseline training and will be accredited in-house or in-area as of the beginning of 2000.

Ms Green—And we are doing similar things within the Central Sydney Area Health Service as well, of which I am the coordinator.

Senator DENMAN—So it is beginning to happen.

Senator GIBBS—You talk in your submission about fee charging for weekend and day and night classes. Could you give us some indication of the level of fees charged for these classes?

Ms Clune—The level of fees vary greatly across the state and from hospital to hospital. For instance, in south-east Sydney, it is \$170 at one hospital and it is \$50 at another hospital.

Senator GIBBS—So how long are the classes for?

Ms Clune—The \$170 is for seven weeks of classes.

CHAIR—One class a week?

Ms Clune—One class a week.

CHAIR—Two hours a class?

Ms Clune—Two hours a class.

Senator GIBBS—And what about the \$50 one?

Ms Clune—The \$50 one is for four weeks—of 2½ hours.

Ms Myors—Another example is that, out at South Western, a seven-week course is \$50 and another course that is six weeks is \$20. So there is a \$50 course and a \$20 course. These are within public hospital systems, so there are huge differences.

Senator GIBBS—Why is that? Do any of you know?

Ms Green—We have only a limited number of staff involved in these areas and many of us were told that if we wanted to run or expand our options and offer different times and different programs for couples coming to the classes or for single women on their own—some of them do not have the support of a partner—we had to make it pay. That was why many of us now have some paying classes and some non-paying classes. I have no-one in my department who can run evening classes or weekend classes when they are paid by the hospital. So anything that I run has to be budgeted for and the clients pay for that.

Ms Clune—Certainly in a couple of facilities in south-eastern Sydney the parenting educators are casually employed.

CHAIR—By whom?

Ms Clune—By the coordinator of that particular program through the area health service.

CHAIR—In other words, they are paid for by the state government?

Ms Clune—No.

Ms Green—Anybody I pay on a sessional basis for running classes in the evening and on the weekends are paid for by the clients who come to the groups because I cannot employ them unless I have the money to cover their desk salaries.

CHAIR—We will get into the facts in a minute.

Senator GIBBS—So you pay them?

Ms Green—Out of that. It goes into a special cost centre and it is from that cost centre that—and Lynne and Karen are probably in a similar—

Ms Clune—No.

Ms Green—Different?

Ms Clune—Yes.

Ms Green—It is slightly different from place to place. But I know I have to pay that money.

CHAIR—Perhaps we should get your description, Ms Clune.

Ms Clune—As far as I am aware, all the income from parenting classes in south-east Sydney goes into the big black hole called revenue for the area health service. Each hospital has a limited budget for health education or parenting education. Most antenatal or parenting education is invoiced by the educators. They actually invoice the hospital and then they get paid from the area health service.

Senator GIBBS—Has the introduction of fees had an influence on the size of classes?

Ms Green—I cannot run enough classes.

Ms Clune—We have waiting lists.

Senator GIBBS—You have waiting lists even for people quite willing to pay?

Ms Clune—Yes.

Ms Green—For some there are. I have a few day classes that are free, but I do not have enough of those either.

Senator GIBBS—Do you have an accreditation process for your educators? Are the people who run the classes well trained?

Ms Green—A bit dissimilar to what Lynne said earlier, we are just starting. Until now, it had been people with their own professional experience within the childbirth and parenting field running short seminars and courses to teach them group processes and adult education principles.

Senator GIBBS—What sorts of professional services—what did you say?

Ms Green—Training programs.

Senator GIBBS—What sorts of professions do they have to qualify them for training?

Ms Green—All the people that I employ are either midwives or physiotherapists. Lynne has a bit of a different area.

Ms Clune—In the South Eastern Sydney Area Health Service, it is midwives, physios, early childhood nurses. There are actually what we would call lay educators, but they have been privately trained through independent childbirth and parenting groups who do training such as the Childbirth Education Association, CEA, or the National Association of Childbirth Educators, who do their own diploma of childbirth education.

Senator GIBBS—Do you have classes for non-English speaking people?

Ms Green—I have some. I am limited because, again, Central Sydney has been knocked back for funding several times for this area. At the moment I have Mandarin Cantonese groups by courtesy of the hospital, which provides me with a midwife with those skills one day a week. At one of the other hospitals in Central Sydney where we have a maternity unit

there are two midwives—one speaks Korean, and she runs groups for the women at Canterbury Hospital, and one speaks Mandarin Cantonese again and we run those. But there are big gaps within the system which we would be looking to fill for Central Sydney, in particular, and I am sure that is repeated in other areas around the metropolitan area.

Ms Myors—Out in Liverpool in south-west Sydney, where there is a very large NESB group, we employ a Vietnamese health education officer. But that is just a Monday to Friday position and she runs groups for her clientele. We also have ethnic obstetric liaison officers, but they actually work across hospitals. They cover two or three hospitals, which makes it quite difficult in that they are stretched very thin as well.

Senator GIBBS—So there is an actual problem in finding educators who can speak these languages?

Ms Green—For some, but I have more of a problem with funding. I do know that there are people out there whom I could use, but neither the hospital nor the area health service has funding.

Senator GIBBS—So it is basically geographic, like in your area, where you have the non-English speaking people, you can find—

Ms Green—I can find some—because, let us face it, we are rather a multicultural society; it is not just two or three languages we are talking about here—but in other areas there is a drastic shortage.

Ms Clune—South-east Sydney has just done a review on women's needs in their reproductive years. While there are three EOLOs, ethnic obstetric liaison officers—two speak Mandarin and Cantonese and one speaks Arabic—there are other emerging groups, such as Indonesian and Filipino women.

Ms Green—And Vietnamese.

Ms Clune—South-east Sydney is actually looking at the bilingual community educator program as a program to run postnatal parenting groups. They are small groups of women, but they are emerging groups, so we need to access these new and emerging languages. It is a proposal of south-east Sydney that the bilingual community educator will take on that role in the postnatal phase.

CHAIR—You are the National Association of Childbirth Educators. I do not know anything about your organisation. How old is it? How did it come to be, and why is it called 'national'?

Ms Green—I do know that there were several attempts, going back into the eighties, where the organisation—

CHAIR—The 1980s?

Ms Green—Yes. What did I say?

CHAIR—You said ‘the eighties’. I am just being a soupcon flippant.

Ms Green—No, not that long ago. There was quite a lull where the organisation certainly did not function—or functioned in very limited ways—for a period. It was early in the 1990s that things began to build up again, and the group changed its name to indicate that it was a national body.

CHAIR—Is it?

Ms Clune—Yes, it is.

Ms Green—It is now.

Ms Myers—Except we do not have members in the Northern Territory.

CHAIR—Who belongs? Is the South Australian Association of Childbirth Educators a member of your national organisation?

Ms Myers—Yes, they are.

CHAIR—Who are the head honchos? Are you?

Ms Myers—There would be state presidents. There is the national body, with representatives from each of the states.

CHAIR—Where does the national association reside? Are you it?

Ms Myers—No, we are not it. Because we all come from different states, we have a post office box but we do not have an office. We do not have the funds to do that.

CHAIR—How many members of the National Association of Childbirth Educators are on your books?

Ms Myers—About 160.

CHAIR—Is that the actual educators themselves?

Ms Myers—Yes.

CHAIR—So you are thin on the ground.

Ms Myers—Yes, it is a small association.

CHAIR—Are you the only one? Are you parallel to others or is there is just lots of childbirth education of one sort or another going on but only one group called the National Association of Childbirth Educators?

Ms Myers—Yes.

CHAIR—And that is your organisation. Are you the New South Wales representatives of that organisation?

Ms Myors—Yes. We are all from New South Wales, so we are in the New South Wales state organisation.

CHAIR—I just need to be clear: under what heading do you claim to be National Association of Childbirth Educators representatives? I know the Victorian Art Gallery calls itself a ‘national gallery’, and I just want to know that the New South Wales Childbirth Educators are not doing the same thing here.

Ms Clune—No.

CHAIR—I have discovered that, but I want to know: are you here as members of the New South Wales Association of Childbirth Educators or as members of the National Association of Childbirth Educators?

Ms Myors—I have two hats on. I am the national Vice-President and also the New South Wales state President, so I am here wearing both of those hats.

CHAIR—I am beginning to understand this.

Ms Myors—As New South Wales members, Lynne and Pauline are also national members.

CHAIR—Through the membership of the national—

Ms Myors—The membership is national, and then it is aligned with the states.

CHAIR—When did you get started? In the 1980s?

Ms Myors—Yes.

CHAIR—I keep saying I have lived too long, but some years ago there was a flourishing childbirth education association in my state of South Australia, and years before that there was something pretty okay for women in Victoria. Are you telling me that childbirth education has become unsexy and dropped off the agenda and that you are now trying to get it back on?

Ms Green—Probably what you are referring to is the community-type organisations of CEA, the Childbirth Education Association. Consumers got that together and working. It works in New South Wales and, I gather, in other states as well. It was a very consumer oriented group. They set up groups in a lot of areas of Australia, and it certainly was very strong here in New South Wales. They are still functioning as a group, and we have contact with them. Some of the educators that I have had working for me have also worked for that group.

CHAIR—If you are not consumer oriented, what are you?

Ms Green—We are consumer oriented, but that was consumer run. I should have used the terms ‘consumer run’ or ‘consumer driven’. That group does still function. Some of the people who teach and are involved in that group also belong to the National Association of Childbirth Educators. Anyone who is involved in running these kinds of programs can apply to join NACE.

Ms Clune—I take your point about dropping off the agenda. I think that was one of the major impetuses to get the national association up and running. Recruiting for members has been important in the last couple of years, because it sort of dropped into the background—though people are starting to talk about outcomes and putting more money into parenting and so on. A small group of us have been working behind the scenes with limited budgets, limited resources. I think the national association came together because we all were in similar circumstances across Australia and it made more sense to come together as a national group to try to gain some lobbying power.

CHAIR—Do you get any funding from government?

Ms Myors—No.

CHAIR—So you run out of a shoe box on the smell of an oily rag?

Ms Myors—Yes.

CHAIR—It sounds like a women’s organisation.

Ms Green—You are right, exactly.

CHAIR—Except that it is really like memories of times past when we are revisiting something that was there and is no longer. Senator Denman, you are nodding. Do you wish to ask a question at this point?

Senator DENMAN—No, I am just agreeing.

CHAIR—I thought that there had been childbirth education in the past. I happen to know there was. It was not community-based or community organised; it was a very officially run childbirth education program, and all sorts of people went to it. It was in the health centre, and it was free for parents to front up. Not all parents went, and that was one of the problems. It was regarded as decently middle class, and lots of lower income parents did not get to it. Can you tell us who your clientele are? Do you get them from the top end of town, the middle and the bottom or just the middle?

Ms Green—I do.

CHAIR—You do what, Ms Green?

Ms Green—I get them from both ends of the scale. I run groups for teenagers. We have special clinics, and I run special education programs.

CHAIR—How do you get to know about them, and how do they get to know about you?

Ms Green—Anybody who books into the hospital is automatically seen by the team with which I work.

CHAIR—Which hospital?

Ms Green—King George V in the city. I make sure that I go to the clinic, partly so they get to know me so that when I invite them to something they are being invited by a familiar face.

CHAIR—Say I am 16, I front up, I am pregnant, I go to the hospital, they check it and prove that I am. I have decided that I am going to have this kid, and I book into the King George V. Do you suddenly appear around the corner of the screen?

Ms Green—No.

CHAIR—How do you get to know about me?

Ms Green—The clerks at the desk know that anybody in a certain age group gets booked into a clinic which I and the team that I work with will be at.

CHAIR—So they are actually referred to your outpatients' clinic to see the doctor again, and while they are at that clinic they will also have the opportunity to see you?

Ms Green—Yes.

CHAIR—Do they know they are going to see you?

Ms Green—Not necessarily. They do not know who they are going to see when they come, but they see the team that is looking after that age group.

CHAIR—How many of the 15-, 16- or 18-year-old mums who indicate that they are pregnant and going to have a baby at King George V actually come to your classes?

Ms Green—About 50 per cent. Others I see on a one-to-one basis, if they wish. I offer them the service, and they can choose.

CHAIR—Ms Clune, in answer to the question of who is your clientele, do you tell the same story?

Ms Clune—A very similar sort of story, yes, because south-eastern Sydney covers—

CHAIR—Which are the south-eastern suburbs?

Ms Clune—South-eastern Sydney covers from Watsons Bay down to Garriwarra, so it is down the coast.

CHAIR—How far is Garriwarra? Near Wollongong?

Ms Clune—At the top of the mountain before you go down to Wollongong, so it is quite a big area. It is a very big geographic area.

CHAIR—Where does it start? At the Georges River or—

Ms Clune—At Watsons Bay.

CHAIR—Where is Watsons Bay?

Ms Clune—At the Heads.

CHAIR—Oh, the Heads.

Ms Clune—Yes. There are 750,000 people in the area health service.

CHAIR—That is a fairly big territory. How many of you are there?

Ms Clune—There would be about 60 educators in all.

CHAIR—How many hospitals are in this territory?

Ms Clune—Three public and about eight private with maternity units.

CHAIR—Do all of the hospitals, when they book in a woman to have a baby, refer her to you or tell her about you?

Ms Clune—Most hospitals do it through their admissions system. So when women get information about the hospital, once they have booked in, they then will be sent some information about parenting education classes. It is their choice then whether they take that up. I would hazard a guess, though, that it has become part of the culture of being pregnant that you go to classes.

CHAIR—If it is the culture, what percentage of people are actually living out the culture?

Ms Clune—There have been some studies on that. About 60 per cent of first time parents come to the classes.

Ms Green—It varies a wee bit on the age group as well. But, if you look at that middle kind of class, you would see that it is fairly educated.

CHAIR—What do you mean about the age group? Are you more likely to come if you are 15?

Ms Green—You are more likely to come if you are 30 than if you are 16, unless you are encouraged by someone.

Ms Myors—The adolescents are more likely to go into a specific program than into the mainstream programs.

Ms Green—And if they are encouraged. They feel alienated.

CHAIR—Are you aware of the new push for continuity of care and, in particular, continuity of carer?

Ms Green—Yes.

Ms Myors—Yes.

CHAIR—Will this do you out of a job? It should not.

Ms Green—Not at the moment.

Ms Clune—We are actually looking at a process at south-eastern Sydney—we have discussed it—where the parenting educator is actually part of the team, so that that educator will then go with them to the postnatal part of their classes, actually moving the educators out of the hospitals so they are fairly fluid between the community and the hospital.

Ms Green—Between teams.

Ms Clune—Yes. That is a model that is being looked at at this point with some interest.

CHAIR—Where do you get your money from, Ms Clune? You seem to suggest that some of your funding came from the hospital.

Ms Clune—I know that in two of the public facilities the fees from the classes pay the educators, and in one of the facilities the hospital budgets for an education department.

CHAIR—Are the funding arrangements different if the patients come from a private hospital as apart from a public hospital?

Ms Clune—To attend the group classes?

CHAIR—Yes.

Ms Clune—You will find that private hospitals run their own.

CHAIR—So the childbirth educators are not involved with private hospital patients?

Ms Clune—No.

Ms Green—They have their own educators.

Ms Clune—There will be some crossover. You will probably find the same faces that educate in the public educating in the private as well.

Ms Green—Because they very often work on a sessional basis.

CHAIR—Tracing down a system is an extremely difficult thing. What you are saying to me is that the childbirth educators who provide childbirth education in the private hospital system are not members of the National Association of Childbirth Educators—

Ms Green—They may be.

CHAIR—but indeed the same persons may step out of doing childbirth education in private hospitals, do it in the public hospital, and under that heading are members of your association.

Ms Green—No.

CHAIR—Good. Put me right, please.

Ms Myors—To be a member of the National Association of Childbirth Educators, you just need to be practising. You can be practising in a public hospital or in a private hospital or be an independent educator.

CHAIR—So some of the people who are delivering childbirth education in private hospitals are also members of your organisation.

Ms Myors—Yes.

CHAIR—I think I have that clear. How many private health funds cover the cost of childbirth education, if any?

Ms Green—Some refund if the clientele belong to a certain level in the health fund. If they just have basic cover, they may not. There are some fairly outstanding ones that come to mind that do not. Over the years we have, as a NACE group and as individuals working within the system, written many letters to private health funds asking for that. With some we have had success and with some we have not. Ones that come to mind particularly are Medibank Private, which still does not refund anything, NIB, which does not refund anything, and there are a few others. I personally have had a good response from HCF, MBF and a lot of smaller funds such as the Teachers Federation. However, there are still a few which, even though they belong to a higher level scale, are not agreeing to refund anything.

Ms Clune—Some only refund if the educator is a physiotherapist, not a midwife.

CHAIR—We have had criticism of childbirth education on the grounds that it is just preparing people for the medical model or at least the dependency model. What you are doing is learning what is going to happen. You need to be ready for what is going to happen so you know how to cooperate optimally with the process, usually a hospital centred process. Would you care to comment about that? Would you also care to comment why, if parents are freely choosing to turn up to these courses and are wanting to find out this knowledge, it is sometimes associated with the charge of making people dependent?

Ms Clune—The first charge is true in the past. I would hazard a guess that in the last 18 months to two years there have been great philosophical shifts in the way childbirth and parenting education is run. I prefer to call it parenting education, because the move now is to look beyond the birth and beyond the hospital model to look at adults' decision making skills, the amount of information they get, their conflict resolution skills and their psycho-social skills that will enable them to feel competent parents. Certainly, the little research that has been done at the moment—which is another issue altogether—is looking towards outcomes that are occurring six months down the track postnatally. It is looking at parents' perceived competency in their own parenting, their satisfaction in their own parenting, their satisfaction in their relationships—that sort of area.

CHAIR—Can you comment on two things. Firstly, are you or your organisation interested in talking to some of the witnesses whom we have already spoken to who are clearly competent to do very good research? It would seem to me that it would be a very interesting project. Does your organisation contact them and say, 'Please can you research this?' Secondly, can you comment on the point that has been made in other places that during pregnancy the main concern of parents is the safe delivery of a healthy baby, and that it is only when they have a babe that they are really fit for parenting education?

Ms Green—No, I would not agree with that. We do a lot of evaluations on our groups that we run. Over the last two years, we have changed our program based on those evaluations. Out of two years worth of evaluations, one of the most satisfying things that came through about the groups that we were running was that of meeting other parents or prospective parents and gaining that support system. The other thing was that more information was needed about what parents were going to do with the child after they have it. These evaluations were done at the end of the program before they had been through the birth process. So we started to change our program, particularly in the early relationship changes and parenting. Can I pick up on the first question you asked about joining with people who are doing research?

CHAIR—Yes.

Ms Green—I think you will find that we are very closely linked already, and that many people from places like UTS have already spoken to you about their programs and their research. Jane Svensson's name might have been mentioned. At the moment she is doing a project which is looking at coming up with what clients perceive their needs are both before and afterwards.

CHAIR—But research is happening?

Ms Green—Yes. Jane is a member of our organisation.

CHAIR—We are running out of time. I appreciate those answers. Did either or both of you wish to make a comment about those points?

Ms Myers—I would like to make a comment in regard to just focussing on birth, which I disagree with. Being out in south-western Sydney, where we have a lot of isolated new parents, we very much focus on the networking process so that when the main caregiver—

mainly the mother—is at home she will have other support, apart from professional support, for her to contact when she is at home. There are a lot of new strategies being used like gender groups, where we are splitting up the males and the females, giving them the opportunity to discuss their own concerns and issues and identifying those within their own gender.

CHAIR—The south-west region covers?

Ms Myors—Bankstown to Bowral, which is a large area.

CHAIR—It sounds like a great line of poetry. I can feel something coming on.

Ms Green—We should have provided you with a map.

CHAIR—It sounds like a Cobb and Co. route. We are very concerned, and we have had a lot of evidence touching on the importance of the antenatal process, including childbirth education. So we are very much assisted by your contribution this morning. Thank you very much.

[11.15 a.m.]

BARCLAY, Professor Lesley Margaret, Council Member, National Health and Medical Research Council and Member, Health Advisory Committee, National Health and Medical Research Council

HENDERSON-SMART, Professor David John, Member, Health Advisory Committee, National Health and Medical Research Council

CHAIR—Welcome. We have before the committee your submission, which is No. 76. Do you wish to make any alterations to that submission?

Prof. Henderson-Smart—No.

CHAIR—I now invite you to make an opening statement and then field questions.

Prof. Barclay—It has been a very interesting and a very valuable experience for me personally to be on the Health Advisory Committee. One of the issues that is perhaps of relevance to the committee is that, as members of the Health Advisory Committee, we were asked to respond to a request from Women's Hospitals Australia. They are a major player in the delivery of birthing services for the Australian community. They are responsible for 30 per cent of the births in the country. They tried to introduce some regulation on the provision of antenatal surveillance and testing. They tried to do that by seeking our assistance to develop with them guidelines about what should be done in the way of screening and testing of women during pregnancy.

What was very interesting to me personally about that was that Women's Hospitals Australia consists of leadership that crosses professional boundaries and management. This group themselves had taken enough initiative to come to the Health Advisory Committee and go to NHMRC and ask for support and guidance in developing the guidelines that would enable them to monitor the amount of tests that were done during pregnancy and the nature and type of tests.

To me, one of the things that is of relevance to the committee is that, whilst the Health Advisory Committee recommended unanimously that that should be done, it was not possible to find the funds within the department to do it. Despite the fact that people providing the services knew that this needed to be done and were happy to assist with the process, despite the fact that the Health Advisory Committee of the National Health and Medical Research Council said it should be done, we were not able to move forward with developing guidelines that these hospitals would implement to establish some degree of regulation on what was done in the way of testing women antenatally.

CHAIR—The 'department' in that sentence means?

Prof. Barclay—The Department of Health and Aged Care.

CHAIR—The federal department?

Prof. Barclay—Yes. That is one of the issues that I think is relevant. The other issue that is of relevance is that the NHMRC has taken some responsibility over a number of years in providing evidence, in monitoring standards of care, and the reports that it has prepared to do that are listed in the submission. The council has taken a responsible, concerned and evolved stance in these issues, but it does not have power in and of itself to ensure that its recommendations are taken notice of. One of the things that has been particularly interesting is that many of the recommendations that I have heard so far this morning that you are having around Australia have been substantiated in the Effective Care document put out by NHMRC, which recommended that many of those things be done.

Since 1996 there has not been a take-up of those recommendations for a variety of reasons. Both the council and the Health Advisory Committee are very concerned about these issues. They have done a lot in these areas to this point in time, but they have a lot more to contribute to the quality of evidence and the quality of guidelines that are available to practitioners and organisations trying to work safely and well in the Australian community. That is our role. We can ensure that quality, and we can endorse from a technical expertise and research point of view what is the best practice.

Prof. Henderson-Smart—I would like to endorse that last point. One way to put it would be that the committee has very much worked around trying to develop the best evidence for knowing which direction we should go in. This, for example, applies also to developing information for consumers. One issue before the committee is the need to develop a pamphlet for women outlining the pros and cons of caesarean section. The difficulty with that is that there is not a systematic review of the literature to underpin it. The danger would be that we could ask someone to write something down. We have consulted with the consumer groups about what they would like to have produced. We are very keen that, whatever we do and whichever direction we are going in, it is based on the best evidence. The reason for that is the last thing we need is more uncontrolled human experiments. Medicine is full of uncontrolled human experiments—

CHAIR—Please elaborate, Professor.

Prof. Henderson-Smart—Medicine is full of uncontrolled human experiments where things are driven by fashion rather than going cautiously down a track. What happens is that, once you start something, it is very hard to stop doing it. It is like monitoring in labour, monitoring antenatally or doing tests for screening—it is very hard to stop. We advocate that, whatever models of care and whatever types of intervention are looked at, it is done in a concerned way so that you know what you are going to get.

Some uncontrolled human experiments work quite well. For example, the SIDS story, cot death, has worked quite well. There was evidence that you could reduce the risks so that instead of doing a randomised trial, which would be in the gold standard and was going to be impossible to do, people were told to sleep their babies on their side or back instead of on their front. It made a huge difference across the world and there is overwhelming evidence that it was effective. But it could have gone wrong. There is always a danger in introducing uncontrolled forms of care that may not be underpinned by good evidence.

CHAIR—I have 5,000 questions. In response to that, what is harder—introducing controlled human experiments, introducing good practice or getting rid of bad practice?

Prof. Henderson-Smart—Changing behaviour is very hard, period.

CHAIR—Quite so.

Prof. Henderson-Smart—A number of people around Australia—in fact, a group met yesterday to try to form an Australian Effective Health Care Network—are working towards that research into transfer of knowledge, changing practice and changing behaviour of clinicians. We do not know a lot about how to do it, so there is a need for more research on how to change behaviour. For example, we are doing a project for the NHMRC at the moment about admission of babies to special care nurseries because there is a huge practice variation. How do you change behaviour—with audit and feedback or with opinion leader? The NHMRC's Strategic Research Committee has given money to try to get some work going in that area.

CHAIR—I am very concerned that you say NHMRC, which has drawn up guidelines in the past, has no capacity to implement. So you can talk or write until you are black in the face and nothing is going to change seems to be what you are saying. Would you comment on that. Would you also tell the committee about the Australasian Cochrane Centre and this whole look at obstetric practice. Where is the Cochrane Centre, is it based anywhere? I know that I have opened a Cochrane centre at Flinders Medical Centre so I have a sense of what we are talking about here, but I would like you to bring me up to date on what the big focus of Cochrane is in the whole childbirth area.

Are you talking about changing behaviour on evidence-based evidence, if you know what I mean? I would like you to tell us a bit about Cochrane, evidence based practices and what might be good. If you could throw in, too, a comment on how midwives get a guernsey when the obstetricians are doing all the talking—if they do. What does it say about the NHMRC if it is saying, 'We have no capacity to implement'? There seem to be a lot of contradictions there.

Prof. Henderson-Smart—One of the problems with NHMRC is that it is sitting in a rarefied atmosphere producing high quality reviews. There is some good empirical data to show that if you develop guidelines on how you can get good quality evidence. But just giving people information does not change their behaviour, you have to have a behavioural involvement. The NHMRC, the clinical colleges, the Australian Health Care Council and the heads of various state departments of health are the ones who have to act it out, yet they may not be involved in the actual development.

The NHMRC has produced that suite of guidelines but, on reflection, the current Health Advisory Committee has said, 'We would be better off providing the tools for clinicians to develop the guidelines. These are the rules of how to systemically review.' There is a document which has been completed—we could ask the chairperson if you could have a copy—which describes what a systematic review is and exactly what it is about.

CHAIR—That would be appreciated if you could, thank you.

Prof. Henderson-Smart—It is missing that middle component. Professor Barclay gave an example of the Australian hospitals group that are, if you like, in that middle component. They are the people who have to act out the guidelines as well as develop them. In our submission we give you some examples of the toolkits, of how to do it, so that be you the college of GPs, the College of Midwives or a group of practitioners working in a physiotherapy department you can use those tools to evaluate and improve your practice.

There have been some suggestions of a way forward, and in our submission we talked about a joint consultative committee of the clinical colleges, which sort of exists. But it really only consists of the obstetricians and the midwives and, in fact, the committee does not meet. But Professor Barclay and I think this may not be necessarily the way to go because we cannot always trust the colleges to look after the people as opposed to themselves. We think that something more at the health ministers type level—people who are responsible for the care of people in their state—might be a better level of things. We need multidisciplinary involvement.

Before I get on to Cochrane, I will just describe a useful framework in which to think about this. In looking at quality health care, we have tended to put technically proficient and safe on the top. In fact, if you go back to Judith Lumley's review that was published in 1990 in Victoria, women do put that right at the top. Then we could put: based on best evidence, prevention focused, well managed—all of those things that are part of a good health care system. But where does the people focus fit in? Whereas it came somewhere down the line before, I think we are about putting it at the top but not missing the other things such as technically proficient, safe, based on best evidence and things like that. So it is a change in focus. I guess it is a change in focus from 'medicine by the doctors for the doctors' to 'medicine by the doctors for the people'.

The Cochrane Collaboration is an international collaboration which started in Oxford. I was involved in those earlier times before it was called the Cochrane Collaboration, when it was purely pregnancy and childbirth oriented. Since then it has spread to all branches of medicine. There are a number of review groups—I belong to the Neonatal Review Group and to the Pregnancy and Childbirth Review Group—that deal with collecting the evidence, summarising the evidence in a way that is as precise and as complete as possible and presenting it in a way that people can understand it.

The Pregnancy and Childbirth Review Group has a particular emphasis on involvement of midwives in that they play a very big role right from the word go. In fact, Iain Chalmers, the originator of this collaboration, has actually been made the vice-president of the College of Midwives in the UK for his emphasis on their being involved. They also have a consumer network so that if I am involved in writing a review, as I do with people in Oxford, that then goes to the consumer network who comment about all aspects of it—not only the language but also the science. We try to re-form it into a form that is not just available for clinicians but also for consumers. There is now a compulsory synopsis which should summarise the review in a very simple way. Hilda Bastian is the international Cochrane member who is dealing with those synopses.

In Australia, there are a number of review groups. There are no review groups based in Australia that are pregnancy and childbirth—they are based in the UK in Liverpool—but

there is a Cochrane Centre. Originally, it was all in one place in Flinders University in the Department of General Practice with Chris Silagy as the head. Caroline Crowther, who is in the Women's and Children's, is the deputy. Chris Silagy has moved to Monash University, and the centre will be based there. What we have done is to split it up into some different functions: Hilda Bastian, looking after the consumer network, is still at Flinders; Caroline Crowther is still at Women's and Children's; and we hope that the NHMRC is going to fund some core activities around Australia promoting the gathering and summarising of evidence.

I should say that they are looking after one little niche in evidence. If you are looking at interventions, it is the highest level evidence and that is randomised control trials. They are not summarising any other evidence. In relation to what happens every day in medicine and midwifery and everything else, there is a huge amount of evidence which is not randomised control trial evidence. People have tried to get them to do that and they have said, 'It is hard enough to do this properly,' because once you have done a systematic review, you can then use the mathematical method of doing meta-analysis to try to get a general summary of how things work. So the meta-analysis is not the review; the meta-analysis is just a mathematical tool.

We are working through. There are something like 250 reviews in the pregnancy and childbirth area, and there are another 80 in neonatology. It is far and away ahead of anything else in any other branch of medicine, surgery or anything else. It is a multidisciplinary group; it is not purely driven by medical people.

CHAIR—That certainly helps me. It actually leads to more questions, but I would like to call on my colleagues.

Senator DENMAN—I have got a million, like you, but I will be very brief. You mentioned that since 1996 none of your recommendations has been taken up. Do you find that really frustrating?

Prof. Barclay—Some have been taken up. For example, some of the research that was recommended in the 1996 report is now being done by the Midwifery Practice and Research Centre that will present to you later on, and that work is being funded by NHMRC.

There are pockets around the country of innovation, of development, of excellent leadership and excellent collaboration in the care that is being provided for women. The trouble is they are exceptions to the rule. They are dependent more on good leadership, goodwill and high professional standards than they are on any systematic process of a health system requiring these sorts of things to be available to women at a high quality in a rational and well-organised way.

The concern that I would have—following on from what David said—is that there is no national system of assessing the quality of care that is provided within the health system, monitoring it or with any authority. At the moment, states determine how many obstetricians or midwives they will train. Nurses Boards, without necessarily the appropriate qualifications, say whether that program in midwifery education is adequate or not. Some of them are not good enough. We have proliferation of some specialties. We have an

undersupply of some specialties. We have rural and indigenous women who have major problems. There is no link, there is no—

Senator DENMAN—So we need a national standard?

Prof. Barclay—And we need a maternity care committee at a national level that is beyond and incorporates state positions and professional positions but that advises the health ministers so that they can make decisions and put in place the sorts of standards that will ensure all Australian women get an opportunity for good care. They are the people who could take the NHMRC guidelines and say, ‘These must guide the standard of care in your hospitals that are providing maternity care.’ This could be dependent on funding.

Senator DENMAN—Do you think that the NHMRC, along with clinicians and consumers, would be the best people to put in place the guidelines?

Prof. Barclay—No, because I think the NHMRC’s role is technical. It is technical in its policy advice but the implementation belongs to the world of health departments, policy makers, funders, politicians and clinicians who are employed in services or subject to professional goals. Probably the strength and the safety of our advice from NHMRC is that it does not have a vested interest, so it does not have an accountability or responsibility for the services that are provided.

Senator DENMAN—So we have to break down those state barriers before we are going to get anywhere.

Prof. Barclay—Yes.

Prof. Henderson-Smart—And, I think, hospitals. For example, the new Children’s Hospital at Westmead, which used to be called the Royal Alexandra Hospital for Children, has actually made one of its missions, as part of the hospital policy, to use the best evidence available in the treatment of children in their hospital, incorporating it in normal functions so that it is not seen as something being supersimposed from the outside but as something that has become part of normal process.

For example, with regard to education, the graduate medical program at the University of Sydney is a new program. So there has been an opportunity to ingrain, all the way through that process, looking at the best evidence and trying to apply it. There is an attempt to develop a national curriculum for the training of medical students in obstetrics and gynaecology. There are some things happening which, hopefully, in the years down the track, can produce some people coming out with a different approach to things.

Senator GIBBS—Who are we going to get to implement these national best practice guidelines? Who exactly are we going to get who will formulate this on a national basis if you guys do not do it?

Prof. Barclay—We can do the guidelines. The NHMRC Health Advisory Committee have measures in place, standards and procedures, that could come up with guidelines on antenatal testing and criteria for various sorts of interventions. Those guidelines, part of

which have been done, would need to be updated. Some of them have not been done. Some of them could be done collaboratively. They would be monitored, and there would be quality controls. But we must have something such as a maternity care committee that works with governments, state and federal, to ensure that those guidelines are implemented—but more than those guidelines: that educational systems and that other systems are in place to ensure those guidelines can be implemented and will be implemented well.

Maternity care affects somewhere between 255,000 and 270,000 women a year. It is the single most important cause of hospitalisation. There is no national approach. There is no national dataset on the number of workers. We cannot tell you the number of midwives in this country who are currently in practice. We cannot tell you reliably the deficiencies in practitioners in particular areas because there is no national dataset to guide wise, political decision making at both state and federal levels. While some states have worked really hard within their own boundaries to try to take control of these issues, because they are affected on a nationwide basis, we cannot get anywhere unless we start to pull beyond individual professional territoriality or individual state government and see this as an issue of national concern, national priority and national commitment.

Senator GIBBS—Do you anticipate any opposition to this approach? I ask this because when we were visiting other states we brought up the idea of best practice guidelines. Some clinicians said that would be absolutely fantastic—I am talking about obstetricians, professors, midwives and the rest of them. Others said, ‘No, you could not do that; you would have to implement it hospital by hospital.’ So obviously there was opposition to it. On the other hand, there were quite a few who agreed that there should be, because we were talking about the high rate of caesarean sections. Do you envisage any sort of opposition to this or can you simply give this to the federal health minister and say, ‘Here it is,’ and he implements it?

Prof. Henderson-Smart—It depends who is taking responsibility for the implementation. What Professor Barclay was pointing out was that if it was in the chief health officer’s job description to ensure that the people in their state were getting the best practice care, and then each of the area CEOs have in their job description that they have to ensure within their area that these things are happening, it becomes part of normal monitoring that then has to occur: ‘Are you using this appropriate treatment or have you abandoned this inappropriate treatment in your setting? How come you have a much higher rate of this intervention versus that intervention? Please explain.’ But that needs to be ingrained in normal function. If you just produce the book it goes on the shelf. There might be a few interesting things and you might go and look it up from time to time, but it does not change day-to-day clinical practice.

Senator GIBBS—But it really should, shouldn’t it, because it was suggested to us that if you were actually questioned by your peers on why you did that caesarean section at that time, or why you did not, then this would make a lot of doctors more aware, whereas now, we have been told, women are demanding it—it is easier, it is quick and all of this sort of thing—and that, with the epidurals, they bring it on. To me, being questioned by your peers—let us face it, there is nothing more terrifying than being questioned by your peers—should be the practice, surely?

Prof. Barclay—That is the practice in many large centres, but it is not sufficient to control a system that is so fragmented. For example, in hospitals you will have visiting medical officers who are paid on a particular basis to provide particular coverage. You will have staff specialists who are often salaried—no incentives or disincentives to work in other than the ways that the policy of that hospital offers. You have an extraordinary mix of people, even in the public sector, who are providing care with a different ethos, with different investment, with different financial gains, or otherwise, attached to the provision of care.

I do not think we can run away from the fact that something such as a maternity care committee would have as its first task to collaboratively work out funding incentives and disincentives tied to the models of providing best practice. At the moment we are not tying funding mechanisms to best practice; we are tying them to the professionals' interpretation of what they would prefer to do at this point in time.

There may be some way to argue that or defend it within peer review processes. They are not universal, nor are they necessarily of high quality. They do not necessarily change practice. But funding incentives and performance agreements that were nationally agreed, that were then built in as part of structures, could make a difference. I realise how difficult this may be.

Senator GIBBS—That is very interesting because it pulls together a lot of the questions that we have been asking. If it is tied to the monetary value, instead of the monetary value being put on what the surgeon or the obstetrician performs, maybe we could have incentives for the vaginal births where they wait it out. They can go home and simply be on call. They can go and play golf, they can take their kids out. They might have to come back a day or two later but does that really matter when women could go through the normal process of childbirth?

Prof. Barclay—All providers know that a far better outcome for women and infants is to go through a normal vaginal birth.

CHAIR—On what evidence, Professor?

Prof. Barclay—On evidence that has been put forward by the World Health Organisation and NHMRC itself, plus numerous subsequent studies to those reports coming out in the last few years.

CHAIR—If you could exhibit a bit of paper with the footnotes to that claim I would love it.

Prof. Barclay—All right. For example, infants that are subjected to vaginal delivery have a three times lesser rate of admission to neonatal nurseries than infants who are delivered prior to normal birth.

CHAIR—That is really very useful—not only said, but if you can give us a couple of other references—

Prof. Barclay—I have people writing this down and we will give it to you.

CHAIR—You should not worry about that, either. The *Hansard* is provided to each one of you as witnesses. If there are any questions that you have agreed to answer, or think you might like to answer, you can read through and add to that.

Prof. Barclay—We can give you the abstract of that report today. I believe we have it with us.

Senator GIBBS—That is wonderful.

Prof. Henderson-Smart—When you were saying that I was thinking about uncontrolled human experiments, because you would want to be careful that you do not make the incentives so much in that direction so that when someone who ‘needs’ a caesarean section does not get one because the incentive is in the other direction. We would have to carefully give instruction about the limitations around that, but I do not think you can tie it to that funding. You need a cultural and behavioural change, that is the critical thing.

Senator GIBBS—Surely the cultural and behavioural change should be that a woman is given a caesarean section only when it is absolutely necessary—that is, there is a danger to her life and a danger to her child. In other words, we go back to the old days when we did it that way.

Prof. Henderson-Smart—Yes. Just one other comment, coming back to Cochrane, I went to the Cochrane meeting in Oslo about six years ago. It was the first of the international meetings on health services research and practice—that might not be the exact title of the meeting, but it happens every two years. In fact, another meeting is happening in three weeks time in Toronto. These meetings have been largely driven by the NHS in the UK who are very interested in saying, ‘Here’s the evidence. We have a funder/provider split. We can only fund operations that work’ and all those types of things. When I got on the plane, Iain Chalmers, who is the originator of all these things was on it, and the committee got off the plane looking ashen. They were terrified that the bureaucrats had decided to take the evidence and do things with it.

One of the difficulties is that if you are a researcher—not if you are a clinician—you have to realise that there is no such thing as the truth, only peers 0.05: it is probability. When things are so overwhelming it is fairly clear but, quite often, there are difficulties there and people could overreact and stop people doing things—‘You can’t do this procedure because you haven’t got the evidence’ as opposed to ‘You should stop doing this procedure because, overwhelmingly, there was no reason to do it in the first place’. Shaving women in labour is an example.

Prof. Barclay—We have to see this within the context that we have evidence that the caesarean section rate, according to the World Health Organisation, should be about 10 per cent in the population so that you could tolerate a plus or minus of some percentage points before you would start to question the practice. At the moment, in Australia, our caesarean section rate is, in many places, double that. In some places, it is quadruple that. This is for privately insured women. I cannot accept that no-one is called to answer for that.

At the moment, no-one will take control of that and we have no process to deal with it, which is even more disturbing. Many of those extreme figures for caesarean sections occurred in private hospital obstetrics, without the peer review process. When it works well it exemplifies good public sector practice because there is a scrutiny of individual practice. There needs to be some mechanism, and I do not believe it will be simple. If we could get a maternity care committee, what it should first do is recommend how we can produce some rationality.

The reason I think a maternity care committee should be multidisciplinary is to precisely deal with some of these issues that David raises—that there are a number of vested interests, none of whom have the right answer and none of whom have sufficient knowledge. It needs to be a coming together of the policy makers, the bureaucrats, the researchers and the clinicians. It is only in that coming together, I think, that we can look at the systematic problems that we have in our current service and come up with a better model.

Senator TCHEN—I am afraid I am going to break a rule here: I am going to ask a question for which I do not know the answer! I was told that on committees you only ask questions when you know the answer.

I will direct my question to both professors, keeping in mind what Professor Henderson-Smart has said that fashion is hard to halt. Supposing you come up with a national standard, how do you know this national standard is not based on a fashion?

Prof. Henderson-Smart—You have to develop that standard very carefully. There has been a history of developing the standard by finding the lowest common denominator—that is, the economic rationalists have said, ‘This is the benchmark and you all have to follow this.’ You have to look at the population that you are dealing with because all hospitals are dealing with different populations of people. Let us say you are dealing with a particular disease or disorder or even a normal pregnancy. You need to look at the evidence to see what is the best evidence about antenatal care, screening, intrapartum care and postnatal care and come up with some standards based on that evidence.

It does not have to be all randomised control trials. It is fairly obvious that you need to be nice to people. You need to talk to them and say, ‘Hello, I am Doctor so-and-so’ before you do something awful to them. There are some fairly obvious things that can be incorporated in that. The difficulty is deciding who should do that, and it is all to do with carrots and sticks and things. All of the research on behavioural change says that you need to develop the guidelines or ways of doing things with the people who have to implement it. At the moment we are developing guidelines at a top level, of high quality, but they are not necessarily believed or implemented because it is just passing out information, and they get information all the time.

Prof. Barclay—It intrigues me that some of the things you have probably heard most about are some of these fashions that have come in without evidence—for example, ultrasound, the prolific use of epidural and electronic foetal monitoring in labour. We had a technology and we needed to find a market for it. If you track those developments, you will see that, without any evidence, we had introduced things that have cost a fortune. It seems to

me quite outrageous that, even when the evidence exists, we are not in any way interested in monitoring it.

Ultrasound is a wonderful example. Some countries have now started to take control, 15 years after the horse has bolted, of something that is providing the first family baby photo on the public health purse, because it is of no more value in most cases than a baby photo. In fact, it is more exploited and provides more opportunity for monetary gain, without any rational outcome in the way it is being used, than just about anything else we do. To use ultrasound wisely and well requires high levels of ultrasonography skills. There has not even been a formal course in this country to train these people.

Obstetricians have bought this expensive equipment for their rooms, and they are doing weekly ultrasounds, which are paid for by the public purse and which are not necessarily being read wisely or well, and the technology is not being understood. If we as a society had said that it is a justifiable thing to do, to provide pictures of foetuses in uterus for families, at about \$140 a time, repeatedly during pregnancy without altering outcome—unless there is clinical significance of the need for an ultrasound—that might have been a reasonable thing to do. However, there is no social benefit, other than cosmetic, or physical benefit from something that has gone totally out of control.

We talk about the difficulty of changing something based on evidence but this fashion is unethical. We have a report that has been produced by the perinatal unit, which is funded by AHIW, on indigenous women. The outcomes for indigenous women and their babies in Australia are absolutely appalling. They are Third World standard and yet this country is continuing to fund ultrasounds that are of no benefit. What is more, we are getting to the stage where women who go along for their first examination, when they think they might be pregnant, are having vaginal ultrasounds because their doctors think that might be a nice thing to do. There is no monitoring or regulation about whether that is appropriate behaviour.

CHAIR—I have to ask you to stop there because we are running out of time.

Senator DENMAN—If people want ultrasound, just to get a photo of the baby, surely it ought not be paid for under the public health system.

Prof. Barclay—Absolutely.

Senator TCHEN—Just to follow on from my question about the national standards, I assume that NHMRC is working on this national standard or guideline now.

Prof. Barclay—No.

Senator TCHEN—I thought you were, I am sorry.

Prof. Barclay—We have to be given a mandate and a budget to do that.

Senator TCHEN—I see. That was not clear.

Prof. Barclay—No, I am sorry. We are only able to respond through the health advisory committee of NHMRC to a request from government or other body when they believe a standard is necessary. At the beginning, I raised the issue that Women's Hospitals Australia believed a standard was necessary for antenatal testing. We were unable to do that because we were not able to have the funds necessary to go through the process of developing the guideline.

Senator TCHEN—Maybe that is something that should be looked at.

CHAIR—We have been told by two groups of witnesses that approaching 50 per cent of the cost of antenatal childbirth and postnatal care is for ultrasound—one figure was \$39 million to \$56 million and the other was \$50 million to \$60 million—which you have just said is of very limited assistance health wise.

Prof. Henderson-Smart—It would be interesting to look at the paper titled *A Review of Services Offered by Midwives*. That document grew out of options for effective care in pregnancy and childbirth because the difficult part to resolve at that time was what midwives should be allowed to order in terms of tests and things. James King chaired that committee and went through and based everything on evidence and said, 'These are the tests, antenatally, that a midwife should order based on the fact that there is good evidence that they work', and he did not include ultrasound.

CHAIR—Let me return to best practice standards, the difficulty of getting data and so on. I liked your expression, Professor Henderson-Smart—uncontrolled human experiments—but it reminds me of Nazi Germany. Maybe you would like to choose different words or perhaps you used those words for the pungency of the effect.

Prof. Henderson-Smart—It is related also to the economic things that are putting pressures on hospitals at the moment—early discharge, shared care. All of those things are really uncontrolled human experiments. Fortunately, some people are monitoring it. For example, Judith Lumley has been able to show that shared care can work but that there are problems and that there is less communication and continuity unless you do X, Y and Z.

CHAIR—So 50 per cent of the cost goes on very dubious ultrasounds. Who gets the money from them, by the way? Does it largely go to the obstetrician who orders the ultrasound or to the person who does it?

Prof. Henderson-Smart—It is the obstetrician or to the radiology group. It is usually done by radiology groups or obstetricians with special training in ultrasound or obstetricians without special training in ultrasound.

CHAIR—It is done by obstetricians?

Prof. Barclay—It can be. Many of them are doing it.

Prof. Henderson-Smart—Or there are ultrasonographers, who are people trained like radiographers.

CHAIR—Yes; but actually what you are telling the committee is that—

Prof. Henderson-Smart—The money goes to the obstetrician or to the radiography practice.

CHAIR—These are the people who are demanding extra money for complicated births?

Prof. Henderson-Smart—Yes. Some of the people are doing only these tests; they specialise in doing only the tests. They do not do general obstetrics. But there are also obstetricians in normal obstetric practice who do use ultrasound.

CHAIR—But you have also told us, Professor Barclay, that something like 270,000 women are involved in the birth process—before, during and after—in the course of a year, and that it is the single major cause of hospitalisation.

Prof. Barclay—Yes.

CHAIR—How much ultrasound is done in hospital? Any?

Prof. Barclay—If the ultrasound department is the one that is being used by the antenatal clinic, yes, that would be done. If someone is having private care from an obstetrician who has an ultrasound machine in his or her rooms, that is where it would be done—or they could be referred to radiographers to have it done.

CHAIR—In a large public hospital with a maternity section, there would be an expectation of that hospital having an ultrasound capacity?

Prof. Barclay—Yes.

CHAIR—And that would be funded by the hospital?

Prof. Barclay—Yes.

CHAIR—Are there different criteria for ordinary ultrasound in a public hospital than in a practice outside of hospital?

Prof. Henderson-Smart—If you are in hospital, you almost always get more tests.

CHAIR—Is that the case in this case?

Prof. Henderson-Smart—Yes, because what tends to happen is if you have a high-risk pregnancy—with high blood pressure, or threatened premature birth—there is often an ultrasound done every two weeks to monitor progression of the baby. Then there are other ultrasound observations you can do of the baby about their movement and their vigour, which can be done even more frequently to see how sick or well they are, for timing the birth.

CHAIR—We just need a window in the belly, don't we?

Prof. Barclay—Those are the ultrasounds where there is clinical justification and a very useful addition to the repertoire of the people who are supporting care. The ultrasounds that concern me are the ones that are being done without any clinical rationale for their use: it is the costs attached to those that are causing a blow-out at the same time that we are sending women home from hospital two or three days after they have had a baby, not necessarily with any community based support and, increasingly, following operative delivery. So they are going home with a new baby, recovering from major surgery, trying to take on mothering and establish breastfeeding, very often without any professional care or support whatsoever.

CHAIR—It is becoming a picture that is really very interesting. We have had so far quite a lot of evidence—and Senator Gibbs has referred to earlier evidence—that, if you really want to change the culture, it depends on one person who is going to do it. Best practice guidelines are absolutely important, and I will come back to them, perhaps in terms of criteria against which you may not be sued, for example. But where a hospital sits down and intends to reduce the caesarean section rate, this can be done if you have got the head obstetrician—usually it will be the head obstetrician; it will not be the head midwife, but it is possible—who wants to lower the caesarean section rate. Usually they are the sort of person who may be inclined to know that midwives exist or talk to them, and it is a much different climate in such a hospital.

We have been told of hospitals that have done that and have then interestingly seen the figures drift up again when that person moves on or runs out of energy, or something. So perhaps what we need is both: the best practice guidelines, the person to implement the culture and then somebody to see that the culture stays.

Prof. Henderson-Smart—The type of person you are describing is usually a full-time person who is dedicated to work in that hospital and is usually involved in teaching and research as well—whether they call them a staff specialist, or an academic and things. I think that for a long time Australian obstetrics has not been driven by that group of people but has been dominated by the visiting medical officer people, who are fee-for-service private practitioners, and that causes a lot of the variation.

CHAIR—That is really very interesting, because we were also told about a senior obstetrician in Tasmania, some few years ago, who actually kept the statistics from Tassie—

Prof. Henderson-Smart—Professor McKay.

CHAIR—and who spoke and had many meetings.

Prof. Henderson-Smart—The level stayed low like that until he retired.

CHAIR—And then the caesarean section went through the roof, so to speak. It is really extremely interesting because, again, what you do get is a very big suggestion that the caesarean section rate is not based on clinical need. I wondered if either or both of you could comment just for the record on one of the main criteria or conditions for our inquiry: that is, that we have—do we?—the highest caesarean section rate in the world.

Prof. Henderson-Smart—No. South America, Argentina and Brazil have huge rates.

CHAIR—So we are up there with them?

Prof. Henderson-Smart—Yes, we are, with similar Western countries, I would say. But you have heard about Ireland, of course. People have quoted Ireland and Dublin and the Rotunda and things.

CHAIR—Oh, tell us more. We have not got to the Rotunda.

Prof. Henderson-Smart—It has a model of care like you were just getting at, with the opinion leader who is called the Master. I think there was a lady next in line to be the Master but it has not happened yet.

CHAIR—The mistress becomes the master?

Prof. Henderson-Smart—That meta-analysis diagram in the Cochrane Collaboration logo is actually the first review ever done and it was done by her. The Rotunda do just what you are saying. There is very tight auditing. There is a clear contract with the women about what labour and delivery is going to be about. The Master sits down every morning when he comes in and has all the partograms of every birth in the last 24 hours put on his desk and he goes through them. Have you heard about a partogram? This is the plotting of the birth—you have the dilatation of the cervix and what happened in labour and all those things. If there is some deviation from normal policy, they come and have a chat about it. There is very close interaction, with one person being responsible for the results for that hospital. I am not sure that it should be based on one person. But it is very tightly regulated.

Prof. Barclay—There is an alternative model that is also funded by NHMRC: that is the Midwifery Practice and Research Centre. Caroline Homer and I will be talking to that report shortly. That is the model of culture change rather than being dependent on one person. We can describe that as an alternative model. Some of the results that we are getting as a result of an alternative model of changing culture—

Prof. Henderson-Smart—I do not think the Dublin model can work here now, but I am saying that there is often not careful auditing. You say peer review can often handle some of these things. But, at peer review, what mostly happens is that people are criticised for not doing a caesarean section, not criticised for doing one.

Senator GIBBS—That is what we have heard.

CHAIR—We do not have too much evidence of what is within the hospital culture or within the professional culture. We have got a lot of ‘Them out there will say we’ll sue if you didn’t’, but we have not really got any sense of ‘She sat all night watching this labour and then in the morning she had to go and see the master and be asked why she did or did not intervene.’ I presume that the doctor is then able to explain why—what criteria were in her head and what were the conditions. I would presume that it is also supportive—that you do not go and see the master expecting to have your fingers cut off but expecting to be able

to be well heard for your explanation of why you chose to do this, if it was outside of guidelines.

Prof. Henderson-Smart—The master sounds like a schoolmaster but I suppose they are a bit like that. They do very clearly identify people at low risk. For example, they are having their second baby, everything is going right. Then they do not touch—just let it go—because it is going to go well. The levels of care are not always tight. When people have done things, then people have sat down and asked what is the best evidence for handling this thing. When they believe that this is the best way to go, and the registrar or the resident or someone has deviated from that track—either done a caesarean or not done a caesarean—then they look at it straightaway on that day. It is not something that comes up a month later.

CHAIR—We have been given evidence that the reason the figures are low in Ireland and Holland is because they are a homogenous population, so the heads of the babies to be born are comparable to the size of the pelvis. Whereas, in multicultural Australia, great, big, six-foot-six Australian men are having babies with tiny little Vietnamese women. The heads of the babies apparently are genetically designed by the man's contribution to the child and therefore the little Vietnamese mother is not able to push such a monstrous Australian head into the world, and so the caesarean rate goes up. Before both of you split, would you care to comment?

Senator GIBBS—We almost fell off the chair ourselves.

CHAIR—What is more, when you read the evidence of *Hansard*, you will be interested to know who proffered this contribution to wisdom.

Senator TCHEN—I understand that Asians have round heads and Caucasians have narrow heads. So actually it is the reverse.

Senator GIBBS—So there you go.

CHAIR—Better you than me, Senator Tchen. I see that you are both rendered speechless. I am interested in it because it is not just from the world out there that we are getting extraordinary myths to justify why Holland has such a low rate of caesarean section. It would suggest, too, that the person making that comment has not been to Holland recently, a multicultural country, if ever there was one. As I understand it, non-Dutch parenting is happening in Holland.

Prof. Barclay—We do have evidence about what reduces the caesarean section rate. It is midwife care. Continuity of known female caregiver and nurturing during labour will reduce caesarean section rate. Midwifery is very strong in Holland: most women get excellent midwifery care, they have maternity care aids who supplement the professional midwife and many women give birth at home. The fear cascade that I believe Professor Chamberlain described to you does not get going and you have very much more comfortable and relaxed births with a reduction in the necessity to intervene.

CHAIR—Is that a causal connection—midwife to low caesar rate?

Prof. Barclay—It is very difficult to demonstrate how the link occurs. Some of us would theorise it is to do with a fear cascade. It is to do with the sort of response that you might see in animals. If you interrupt an animal in labour and you take them away from a quiet, private place, there are likely to be difficulties and problems. That is one theory. The fear cascade is a theory—it is only an explanation; we have no proof. But we do know that we get very different outcomes. And that is not surprising—it is common sense. If you go into a foreign environment where you do not know people, where you are frightened and in pain, and things are happening to you that you do not understand and there is no constant—other than your poor partner, who is often terrified out of his wits too—to help you feel comfortable and in control, it makes sense that things are going to happen in ways that may not be necessarily normal.

CHAIR—Have you any data on birthing centres and whether they are contributing to a reduced caesar rate? We have had evidence that about 20 per cent of parents who register for a birthing centre birth will leave there during their antenatal period and about 20 per cent leave during labour. Those figures are a little up or a little down depending on where it is, but about 40 per cent of people who nominate to have their babies in birthing centres in hospitals do not finish up there all the way through. They do not necessarily all have caesarean sections but they leave the birthing centre. Do you have any data or can you point us to data that tells us the outcome of birthing centres being a contributor to a lower intervention rate?

Prof. Barclay—We can actually provide you with the evidence.

CHAIR—That will be great. Heads are nodding. If you can take that on notice, that will be great.

Prof. Barclay—We have another reference to the issue of support and continuity of care. It is a Cochrane review—Hodnett—on the effect of the continuity of care during labour and on outcome. We will also provide you with the technical and precise reference to that.

CHAIR—Are complicated births associated with a higher rate of postnatal depression? Is there any evidence that that is causal or is it just correlation?

Prof. Barclay—Causal. I do not know how we can unravel it. It is certainly linked closely to, but I do not know that the causal mechanism has been identified.

CHAIR—I presume there is postnatal depression in women who have had perfectly lovely vaginal births.

Prof. Barclay—Of course.

CHAIR—That is one example of the evidence you would like to have a look at that says, 'Whoops!' I guess there are people who come home after one day and slap the kid on the breast and eventually breastfeeding does get established. While we might want to talk about the optimal way of doing things, there is evidence that less than optimal can work.

Prof. Barclay—Of course. And despite emergencies and high intervention care, many women, if they have good, consistent emotional and social support, will negotiate the challenges of that extremely well. But we are saying that, with the way Australia has organised maternity care at the moment, we cannot guarantee that they will have continuity of social and emotional support or even decent physical care after they go home from hospital.

CHAIR—What is the status of the NHMRC 1988 guidelines on antenatal care?

Prof. Barclay—Guidelines from 1988 would be superseded.

CHAIR—We have been told they are not current and therefore cannot be issued to us. Have they been superseded?

Prof. Henderson-Smart—They were formulated in a previous era when there were not enough clear guidelines as to how to develop the evidence. We cannot stand by the way they were developed. They were developed by consensus or opinion.

Prof. Barclay—Also, 10 years of evidence has built up subsequent to that point in time that would make profound differences to what they might have recommended at that time.

CHAIR—Can you tell us about the process by which projects are accepted for funding under the NHMRC?

Prof. Henderson-Smart—It is in the process of change. This year the process is that people apply to the NHMRC in March, then a group of people look at these applications. They get at least three, sometimes four, reviewers to comment. They each score the things for relevance and scientific validity and a number of things. A discipline committee then meets in Canberra. We are aiming for 60 per cent of the grants to go on for interview. Only 25 per cent of the grants will be funded because that is all the money there is. So, rather than bringing back that last 30 per cent to interview when they have no chance, that group gets culled out. Then they go to interview. At interview specific things get sorted out and then there is a decision made. Eventually it goes to the minister who says yes, and then financing says yes and then people are told, usually at the beginning of November.

CHAIR—NHMRC budget?

Prof. Barclay—The Health Advisory Committee does not have a specific budget other than its running costs. What Professor Henderson-Smart is talking is the budget that is allocated to project research or program research when we are approached by someone like Women's Hospitals Australia. For health policy advice and guideline development we do not have an allocated budget so that the Health Advisory Committee could say, 'These are our priorities. These are the areas where the need is greatest. We will develop guidelines in these areas.' Because of the lack of budget, we are forced to take on particular projects or requests that the Department of Health and Aged Care makes and, if there is money attached to them, it makes it easier for us to do it.

When requests come from outside bodies, such as Women's Hospitals Australia or the child health people, we have to see if the department will support that to enable us to take the next step to move into guideline development. One of the things that has inhibited the Health Advisory Committee from going ahead and developing guidelines in this area of antenatal testing has been simply that there is no allocated budget for it. If there had been a budget, then we would have been able to prioritise that against other things and make a decision about whether it was sufficiently highly prioritised to fund.

CHAIR—Is there any privatisation of projects? Are you looking for any 'out there' money?

Prof. Barclay—Women's Hospitals Australia offered to come in as partners in this and were prepared to put some money forward. Not being able to get the other side of the project funded was one of the things that distressed us considerably.

CHAIR—You were told 'no' by the department?

Prof. Barclay—Yes. We were told that there was no money to do this.

CHAIR—'No' by the department and 'no' by the minister?

Prof. Barclay—I do not know whether the department took it as far as the minister. I know the department is working within certain constraints, but there have been other things that the department has perhaps ranked more highly. We have been involved in one of those recently, which was a request to develop guidelines for GPs in prescribing in postnatal depression. This was a very interesting area. We sent it to a careful review of the literature because we had concerns that we do not have enough evidence to go about developing guidelines for its management. The review of the literature has confirmed that. Conversely, we have an area where we know we have the evidence, where we could develop guidelines on antenatal testing, but we have not been able to get the funds to go ahead.

CHAIR—We have got to stop, unfortunately.

Prof. Henderson-Smart—I have one other comment. The other deficiency in this area is that doing systematic reviews is increasingly being seen as a scientific research endeavour. But it is not recognised by the NHMRC as such, in terms of the research committee. The Health Advisory Committee has advised that we would be a lot better off if people could draw together what information is available. But if you went to the NHMRC and put in a project to do a systematic review, they would laugh.

CHAIR—The TGA produces an extraordinarily useful little book about what medications are dangerous or potentially dangerous for pregnancy. Is there any comparable booklet—I do not know of one—for drugs that may get into breast milk, for example?

Prof. Henderson-Smart—There are.

CHAIR—I must pursue it. I have got the booklet before but not the booklet after.

Prof. Henderson-Smart—The other booklet that I think is very useful is the one that the Cochrane Pregnancy and Childbirth Group have pulled together. It is called the *Guide to effective care in pregnancy and childbirth*. If you look at the Centre for Perinatal Health Services Research submission—you will be talking to them later—they draw attention to that. It has just been rewritten. In the back of it, it has which forms of care should be abandoned, which forms of care should be adopted and which ones we still do not know much about. I think that is a very useful way to put things up. It has grown out of the Cochrane type of collaboration.

CHAIR—I appreciate that there is a lot more we could ask you. The NHMRC's role is critical. You tell us that it does not have enough money. I suppose I could say, 'But all researchers say that.' However, if it is a matter of competing in the department, I can certainly think of some allocation of dollars by the federal health department at the moment that might be better rerouted.

Prof. Henderson-Smart—I think the Wills report on medical research in Australia did point to targeted research areas as being very important. I think that was a very useful start.

CHAIR—I note the comments you have given the committee—little lines like, 'This is the single major cause of hospitalisation in Australia.' This has to be big bikkies in the scheme of things. I think something like 60 per cent of the health dollar goes on hospitals—or it used to be a figure like that. Another huge percentage goes on people in the last 12 months of their lives. I presume this does not feature in these people who are probably in and out in most cases with baby, et cetera. Even so, that is a huge cost if it is that many hospitalisations. It is very interesting if it is tied to 50 per cent of that cost. The comparison of that with the ultrasound costs means that, apart from anything else, the health dollar here deserves close scrutiny.

Prof. Barclay—Absolutely.

CHAIR—We are out of time. If anything emerges, when you read the *Hansard*, that you feel we should be told we would be very pleased to hear from you. If anything occurs to us, may we contact you?

Prof. Barclay—Yes.

Prof. Henderson-Smart—On Thursday, I am going on two months study leave, via the Cochrane Collaboration, in Oxford to do some of this sort of work. Probably Professor Barclay would be the main person who you could contact.

CHAIR—Thank you and thanks for coming today.

[12.31 p.m.]

BARCLAY, Professor Lesley Margaret, Principal Investigator, Midwifery Practice and Research Centre

HOMER, Ms Caroline Susan Elizabeth, Senior Research Midwife, Midwifery Practice and Research Centre

CHAIR—I welcome representatives from the Midwifery Practice and Research Centre. The committee prefers all evidence to be given in public but, should you wish to give your evidence, part of your evidence or answers to specific questions in camera, you may ask to do so and the committee will give consideration to your request. We have before us submission No. 51. Do you wish to make any alterations?

Ms Homer—No.

CHAIR—Would you like to make an opening statement, preferably shorter rather than longer, and then we will ask some questions.

Ms Homer—Thank you for the opportunity to appear before the committee. I am sure you have heard previously and again today about the problems facing Australian maternity care. We believe these problems include: the fragmented care that women are exposed to; the lack of continuity of care; the problems with professional rivalries that are endemic; the lack of evidence based practice in some aspects of care and the cost shifting mechanisms that make it really difficult for women to receive effective, safe care that meets their needs.

There have been numerous reports—I am sure many of them have been tabled through this process—saying that there should be changes to maternity services in Australia. Unfortunately, to a large extent, that has been unsuccessful. We believe there are strategies and things that we can do that will make a difference, that will make a change. But it requires a widespread system change not just hospital by hospital or even state by state, we need to overhaul the whole system of maternity care provision.

A number of aspects within which I believe this system should be framed include a commitment to continuity of care and social support for women who are going through the antenatal period, the childbearing process and the postnatal period. We need to be committed to collaboration with our obstetric colleagues, with our early childhood colleagues and with the perinatologists. We are all in it for a good experience for the women, and the professional rivalries need to be put aside.

We need to move to community based care. Hospitals are all very well for people that are sick—for many women that is where they will choose to birth their babies—but many services can be provided well and cost effectively in the community, particularly antenatal services and postnatal services. We need to have equity and access for all women, particularly those from non-English-speaking backgrounds and, as you have heard this morning, those from Aboriginal and Torres Strait Islander backgrounds. We also need to have evidence on which to base our practice. I think Professor Henderson-Smart and Professor Barclay have provided those reasons sufficiently. In essence, we need an overview

at a national level. These are the important frameworks in which we should change maternity care towards. They are not radical; they are conservative; but they will make a difference to the care that women receive in Australia. I could go on to talk about the Midwifery Practice and Research Centre now or I could wait for questions.

CHAIR—If you could wait for questions and then, if there is something you absolutely must say, you can say it at the end.

Senator GIBBS—When you talk about the community based care, are you talking about just the birthing process or basically the antenatal care and the continuing care of the midwife and the mother?

Ms Homer—It can be at all levels. I can tell you about a study that we are conducting at St George Hospital at the moment but I would like these results to be in confidence, because the results have not been published as yet and they are preliminary.

CHAIR—Do you want to give them to us now on the record or do you just want to provide them to us?

Ms Homer—I can talk to them.

CHAIR—If you would like to provide them to us without putting them on the *Hansard* record we can deal with it confidentially. Then you can speak to them and I will leave you to set the limits of where you do not want things on the public record. However, I understand that should you say something that you then want removed, that can be a possible consideration with *Hansard*.

Ms Homer—That is fine. St George Hospital is situated in southern Sydney in a high area of cultural diversity where less than 50 per cent of the women in the area were born in an English speaking country. We did a randomised controlled trial of almost 1,100 women. So we randomised them to receive either community based, collaborative, continuity of care or standard care, which is probably what you have heard a lot about—with the long waiting times in the clinic and fragmented care.

The midwives provided care from community based centres, one in an early childhood centre and one in a family planning centre. Six midwives made up each team with one obstetrician. They went out into the community and set up clinics twice a week. They cared for 300 women a year but the antenatal care was provided in the community. Women have reported that it was much easier to get there. The parking was better. The public transport was better. The waiting time was better. They saw familiar faces—they got to see the same midwives and they got to see the same obstetrician. It was that collaboration and the continuity that was really important.

CHAIR—What do you mean when you say, ‘We saw them in the community?’—a community health centre or you opened a shopfront?

Ms Homer—It can be any of those things. In our instance, one was an early childhood centre, a community health centre, and the other one was a family planning clinic next to a shopping centre.

CHAIR—I think the idea of having your antenatal clinic in a family planning centre is particularly attractive. It is consistent with family planning guidelines.

Ms Homer—Indeed. Many of the family planning nurses have reported that women are coming back, because they see it as a safe place to come back for their family planning later on.

CHAIR—That is useful for us, thank you.

Ms Homer—So those women received all their antenatal care in the community with these two teams of midwives and obstetricians. When they came to birth their babies, they came to the hospital and the same midwives came in and cared for them. They were on a 24-hour rotation roster. After the babies were born they went to the postnatal ward or they went home, and they were still cared for by those same midwives.

Senator GIBBS—How long after the birth did they go home? Not straight away, obviously.

Ms Homer—They could go home after six hours. Most people chose to spend at least the night in hospital.

Senator GIBBS—I should hope so.

CHAIR—When they came to hospital, was it to the labour ward, birthing centre or is there no difference?

Ms Homer—To the labour ward. The idea was that this it was to be mainstreamed. It was for all women not just for women who chose to access a certain kind of care, which is birth centre care, really low risk care. Most birth centres are small. Our birth centre only has two rooms, so it could only cater for a small number of women. We wanted to make this something that was for all women.

CHAIR—In your labour ward is each woman delivered in a separate room?

Ms Homer—Yes.

Senator GIBBS—So if she wanted to do it on the floor in the labour ward, she could.

Ms Homer—Perfectly fine.

Senator DENMAN—I have seen an example up our way of the bathing birth. A lot of this sort of thing is used on the north-west coast of Tasmania.

CHAIR—We are desperately short of time. You were telling us how many came into hospital, so if you can get us back there. We are just finding out what they did when they got there.

Ms Homer—They all had their babies in the hospital. The clinical outcomes are that the caesarean section rate was lower in the women who had the community based midwifery care in the collaborative approach.

CHAIR—How much?

Ms Homer—I will provide that for you in the report. Our results suggest that the caesarean section rate is lower without any other adverse effects—the perinatal death rates were the same in each group. The reports that we have to date are that the women liked it. They liked the relationship that they had with their midwives. They felt supported. For many of them, what they liked the most was that they did not have to wait. People are busy.

CHAIR—They did not have to wait for what?

Ms Homer—They did not have to wait for their antenatal visit.

CHAIR—In the outpatients at the hospital?

Ms Homer—They do have to wait.

CHAIR—I see, thank you.

Ms Homer—That is what I mean by community—

CHAIR—They were delivered by a doctor?

Senator GIBBS—No, their midwives.

Ms Homer—The midwives were in attendance and whatever kind of delivery they ended up having—a doctor may have been involved if the woman required medical care—the midwife stayed with her. The principle was that all women require midwifery care even if they develop risks—blood pressure, bleeding or all sorts of problems—they still require midwives and they still require continuity of care. Those women probably even more than anybody require that support.

CHAIR—Did you find—a point that was made to us particularly in South Australia but in other places—that continuity of carer is as important as continuity of care?

Ms Homer—I think in an ideal world continuity of carer would be the best way to go, and the next best thing is continuity of care. In trying to change the whole public health system across the board, we may not end up with the Rolls Royce model but we may be able to put in place, which we did in this model, such things as women having continuity of carer through the antenatal period. So they only saw two or three midwives through the antenatal period and they had continuity of care through the birth. They might have had one

of the two or three they knew really well but they might have got one of the other three who had a similar way of practising, a similar philosophy. Ideally, continuity of carer would be wonderful but it may not be possible.

Senator GIBBS—But shouldn't the two go hand in hand because isn't this one of the big problems? I had my children in the public hospital system and I know I had to sit there for hours on end and then you saw a different doctor every time. You had to go through the same thing all the time. Half way through the pregnancy I wished that I could just quit it—'Let's forget this, I have had enough.' But the problem is that you see different people and it really does not do much for your emotional state. Shouldn't the carer and the care really go hand in hand?

Ms Homer—Absolutely. If you can reduce it down to two or three people—two would be nice—so that you saw the same couple of midwives every time you came to the antenatal clinic, that is far preferable than the experience that you described.

Senator GIBBS—This was many years ago.

Ms Homer—There are little things that hospitals can do. It does not have to be a whole new model of care. There are ways in which antenatal clinics can be rearranged so that women see the same midwife all the way through. They may not have that midwife in labour. They may choose a model where they do have the midwife in labour, but the next best thing might be the same midwife. In your example, if you had had the same person all the way through, it might then have been okay to have a different care giver in labour.

Senator GIBBS—I did anyway.

Ms Homer—It is giving women those options: these are the sorts of things that you can have, and you need to pick what is best for you.

Senator GIBBS—Yes, exactly. You say the public hospital salaried midwives are prevented from giving antenatal care. Is this in all hospitals in New South Wales?

Ms Homer—Not in all hospitals. Prevented from giving antenatal care—

Senator GIBBS—From providing antenatal care.

Ms Homer—In some hospitals there has not been a belief that midwives were able to provide antenatal care for women without risks.

Senator GIBBS—Is this the majority of hospitals?

Ms Homer—I am not sure about the majority.

Prof. Barclay—I do not think it is the majority these days. The interesting thing it has changed not so much based on the evidence, which is that of course midwives can provide normal antenatal care, but it has come as a cost cutting exercise when people are realising that employing VMOs to provide normal antenatal care is not a good use of the budget. It is

an interesting question. If you look at the evidence, the leading innovative places are all working with midwives providing antenatal care.

Senator GIBBS—Good.

Senator DENMAN—I have a couple of questions. For those women who go into a medical centre or a birthing room under the care of a midwife, is there a GP available if things unanticipated go wrong?

Ms Homer—What do you mean ‘into a medical centre’, do you mean into a hospital?

Senator DENMAN—Yes. Up on the coast where I am, there are a couple of what they call birthing centres that are in a hospital. But quite often young women choose to have a midwife attend them in those birthing centres. So if something unexpected occurs there is a doctor available to attend the patient; is that right?

Ms Homer—Certainly in most instances that would be the case. In rural areas it would be GPs who have obstetric training or GP obstetricians, and in the city it would be obstetric registrars and obstetricians. That is part of the collaboration of working together.

Senator DENMAN—Just getting back to the ultrasounds and caesarean sections which are recommended by the doctor in attendance—either the obstetrician or, in my case, up the coast the GP. If a midwife was able to be present at those sorts of consultations, do you think that the patient would turn to the midwife and say, ‘Is this absolutely necessary?’

Ms Homer—In my clinical experience it certainly happens that women will say, ‘What do you think I should have?’ and from my perspective it is about providing them with the evidence. I am constantly concerned that women believe having an ultrasound and having that normal report means a normal baby and that everything will be perfect. We live in a society that values perfection. We do not cope with everything else very well. It also depends on the relationship that the midwife has built up with the woman, and continuity of care facilitates that relationship. And then even more so the woman is going to turn to the midwife and say, ‘What do you think? What should I do?’

Senator DENMAN—So if there was some problem and it was recommended that there be a termination for reasons that show up in ultrasounds or whatever, do the patients also turn to the midwife then for advice and support?

Ms Homer—Indeed. It is very important that the parents are provided with all the information and supported through the whole process. They need to be told about how the termination will occur and what will happen after the infant is born.

Senator DENMAN—Then there is ongoing support after the termination?

Ms Homer—Yes. Most hospitals would have a protocol for perinatal death in terms of collecting footprints, keeping mementos and showing the parents the baby. In big hospitals there would be a protocol that would be followed. I am not sure what happens in smaller centres.

Senator DENMAN—It would be more difficult to follow that sort of protocol in smaller centres?

Ms Homer—Yes.

Senator DENMAN—Thank you.

Senator TCHEN—On page 9 of your submission referring to early discharge programs, you state:

The length of postnatal care has reduced in the past decade with little evidence to demonstrate that this is an effective or safe action.

Earlier we had evidence, actually from Professor Barclay, that to me indicates that it is not the length of stay in hospital which is important but it is the appropriate postnatal care.

Prof. Barclay—That is what we need to investigate. That is our assumption. It is the quality of care and it is not necessarily dependent on the location where it is provided.

Senator TCHEN—The alternative of having a home birth means there is a zero stay in hospital, doesn't it?

Prof. Barclay—Yes.

Senator TCHEN—In your view supposing there is this postnatal care at home after this early discharge, who should pay for it? How should it be paid for? You covered what needs to be done but you have not said who should pay for it.

Prof. Barclay—This is part of the complicated issue about what do we fund: do we fund a normal finite episode of care that is attached to expecting a healthy outcome and resolution of this? If so, postnatal care is an absolute requirement of that. One must suspect that postnatal care, because it is not necessarily under the control of medical practice, is more easily cut than some of the other areas where we have a proliferation of services that require a higher level of medical involvement. It is extraordinarily distressing that no-one is monitoring the quality and duration of hospital stay. It is very heartening for us that in the statement from New South Wales Health they rate the issue of time of discharge and nature and quality of postnatal care as one of the most pressing issues that has to be addressed, because we do not know and there are no advocates for the women and the practitioners who are providing that care now.

Senator TCHEN—Professor Barclay, I will invite you to make a suggestion: what sort of funding model should we go for for postnatal care?

Prof. Barclay—It must be attached to a whole of service care. Postnatal care is part of the whole pregnancy, intrapartum and postnatal care. We should not divide them out. They must be seen as part of the right and requirement that we have to provide care for reproducing families. What is happening is that hospitals who are having trouble meeting their budgets at the moment are cutting bed days because it makes it cheaper for them. But

there is not necessarily the capacity in the community or the outreach service from the hospital to cover that care provided for women.

At the moment it is part of this cost shifting, cost cutting exercise with no monitoring or regulation or standard about what is appropriate. There is no guarantee that women or babies are getting what they need. That is the other concern that we have. There is no evidence that what we are doing by reducing postnatal stay is safe. There is no evidence that it is not safe and some of us as practitioners would feel very comfortable about high quality domiciliary midwifery but, again, we are feeling comfortable about it on clinical or anecdotal grounds not because we have any evidence. This is one of these areas where there is a wholesale change of substantial magnitude occurring without any monitoring, without any standard and with no oversight about what is appropriate or not.

Senator TCHEN—Would you recommend that postnatal care should be part of hospital funding?

Prof. Barclay—It is part of a package. However that package is distributed, it must be part of some sort of package. I have done some work with one of the large medical benefits firms who were trying to bundle some of their obstetric services for private practice. In private obstetric work one of the things we cannot guarantee necessarily is follow-up or postnatal care. Private hospitals are generally covering that by having a longer bed stay in hospital, but again they are under pressure to reduce their bed stay. It is a vital area of development of standards and it is an extraordinarily important area to monitor.

One of the difficulties that you could postulate, which has come from the North American model of care, is that they have had no midwives and no early childhood nurses. People have gone home from hospital very rapidly following birth, within 24 to 28 hours. There has been no support for the establishment of breastfeeding or support of the mother after discharge. They have not built it into their system and they have not had the professionals involved who can maintain the quality of care. The outcomes of care have been consistently lower in that model that we have had in Australia. In Australia we have taken for granted these services that are, if you like, the poor sisters of the hospital based high profile obstetric led service, but they are a crucial element of the total pattern of care.

Senator TCHEN—Thank you.

CHAIR—Could you take me through the cost shifting that you spell out on page 2? It states:

Public hospitals are increasingly looking for ways to reduce costs . . . Currently, in many public hospital antenatal clinics, women are 'bulk billed' for their care if they have been referred by an obstetrician. This occurs in general clinics as well as specialised 'day only' clinics for high risk women. This system means costs are shifted from the state to the federal system. . . . Public hospital salaried midwives . . . are prevented from providing care, or else, provide care requiring the 'rubber stamp' of an obstetrician.

Please elaborate.

Ms Homer—As I said, state run hospitals, public hospitals, are increasingly looking for ways to get more money and one of the ways is to double-dip or cost shift on to Medicare.

What happens in lots of antenatal clinics is that if women have been referred by an obstetrician—they might have seen an obstetrician in the community or in the hospital, they might have been admitted early in their pregnancy for vomiting or for a number of other complications—they then have on their notes a note from the obstetrician saying, ‘see me in clinic next Tuesday’. When that woman then comes to the clinic, she can be bulk-billed. She was asked for her Medicare card, that is run through the machine and the hospital will then get that money from the federal system. That is an additional topping-up of their already funded antenatal clinics.

CHAIR—This only happens if the obstetrician is actually working in outpatients that day?

Ms Homer—No.

CHAIR—Tell me how that happens?

Ms Homer—Not necessarily that obstetrician. There will be an obstetrician or an obstetric registrar. It seems that it does not have to be the same obstetrician that has referred the woman.

CHAIR—Under what criteria are people then bulk-billed?

Ms Homer—I am not sure of the exact numbers that people use in terms of referral from a specialist obstetrician and I presume it is to another specialist obstetrician because it is under that caveat that bulk-billing occurs. Maternity care is not the only service in which this occurs. Medicare machines are readily seen in many outpatient clinics in hospitals so as to cost shift. GP shared care is another way of cost shifting. We suggest that women might like to see their GP. That means less visits in the antenatal clinic, less visits to the hospital based service and more visits in the community. The community costs are met by the federal government rather than the state government.

CHAIR—Our next terms of reference concern funding of hospitals, so we will have to read this report more closely.

Ms Homer—It is part of the difficulties with having state and federal relations; it becomes really complicated as to who pays for what health care. The woman is the one that gets stuck in the middle. She gets pushed from one side to the other, getting more and more fragmented care and not knowing when to put out her Medicare card and when to give her other card. If we are talking about women centred care, at the moment it is kind of system- and practitioner-centred care that is chaotic.

CHAIR—We are talking about obstetrics, outpatients or antenatal care, whatever we want to call it, if I from the Commonwealth wanted to know how my Medicare agreement funding to the state was being spent, would I have access to how many outpatient episodes were now being funded on the Commonwealth by a bulk-billing swipe?

Ms Homer—I would imagine so. I am not sure what the process is to get that information.

CHAIR—I have a fair idea. But it is not usually a patent. Your information is very interesting and that may be something we will pursue. I just wanted to check the cost shifting for this inquiry, not the next one. The interesting point you make is that it turns out to be a fragmentation of care and maybe a little increase in the anxiety level for the mother, whereas you were telling us earlier that, with the antenatal care provided by midwives out in the community, they smiled.

Ms Homer—Ironically, the former system ends up being more expensive in that women end up having more investigations because they are seeing a new care giver every time, who cannot find the results of the last investigations or who gets nervous because this is the first time they have met this woman and the baby seems a bit small so they say that they will do another ultrasound. Whereas if the same person had seen the woman all the way through, you just cut out all of that extra—

CHAIR—The women who turned up to your St George antenatal and midwife outreach service, how were they paying for that or was it all funded?

Ms Homer—It is all funded through the public hospital system.

CHAIR—So it was free to the patient?

Ms Homer—Yes.

CHAIR—No wonder they smiled.

Ms Homer—It was like attending their antenatal clinic, it was just the same. Hospital salaried midwives and a hospital salaried obstetrician provided the care. We just moved the location. We took it out of the big white hospital and out into the community.

CHAIR—That is interesting. It is a model that I have been arguing for about 15 years, so I am extremely pleased to hear that. We have had some very conflicting evidence—I think Senator Tchen picked up on this—in terms of the contradiction between early discharge versus home births where they are up and about within a few hours and do not regard themselves as pathological. Would you be able to give us any evidence on whether postnatal depression and breastfeeding is established in the home birthing mums any differently—better or worse—than early discharge or slow discharge from hospital. That seems to be one contradiction.

The other thing I would like you to comment on is the evidence we have been getting that one of the significant predictors of bad things is low birth weight. We find it quite contradictory having visited a lot of neonatal intensive care units—we have even got photographs to prove we were there—that we are now talking about routinely that at 24 weeks you can expect that the babes will survive, although at 23 or 24 weeks and under 500 grams I guess it is likely there will be some ongoing disability of some sort. But can you comment on the extreme contradiction of low birth weight babies—the evidence now suggests that a number of things are being attributed to low birth weight, including adult diabetes, blood pressure or obesity—versus we are falling over backwards at considerable cost to save the lives of very low birth weight babes. I do appreciate that it is not going to

be sexy to suggest that nobody under 28 weeks can come into the neonatal intensive care unit but I would love your comments.

Ms Homer—I will address the first question about the home births. It is really important to remember that home births represent an absolute tiny minority of births in this country. It is hard to then make comments about breastfeeding and levels of postnatal depression. They are probably different sorts of women at the moment who choose home birth because it is not the mainstream, they have to go and find it and they have to pay for it. Although there are some health funds that will rebate independent midwifery, it is not the norm. It is not what happens with most people. I think comparing rates in those groups with the general population is hard and problematic.

CHAIR—Could you comment on birthing in birth centres, if you do not want to put home births in there?

Ms Homer—In New South Wales two per cent of women birth in birth centres so, again, it is not a lot of women.

CHAIR—It is not big but it is a chunk.

Ms Homer—Sure. We have done some research at St George Hospital comparing the outcomes of women who birthed in the birth centre—this is women who arrived in labour in the birth centre, not the ones who moved out before that—with similar kinds of women who birthed in the labour ward. There were similar risks, similar age and similar types of women. We found that there was no difference in the caesarean section rate: it was four per cent in both groups for that population of women. About one-third of the women who presented in the birth centre ended up going to the delivery suite for epidural, instrumental delivery and a small amount for caesarean section. Almost all of them managed to take their midwife with them. They still got their continuity of care. It just happened to be around the corner because of the way the hospital is situated.

That study did not collect data on breastfeeding outcomes for that group of women but, from our other research, the initiation rates of breastfeeding are in the high 90 per cent band and they drop off over time after that. Birth centre women again are probably different from the general population. They are often more motivated. They seek what they want. They want a non-interventionist, natural birth in a home like environment. They are possibly not the same sorts of women. But we were interested that the intervention rates were the same in that study. I suspect it says something about the midwifery care and the medical care in the delivery suite—that basically the care in both settings was good so that the outcomes were pretty much the same.

Prof. Barclay—I might come back to the low birth weight issue, but one of the things that we have not covered is that the Midwifery Practice and Research Centre is a collaborative effort across our medical colleagues and midwives to bring about a culture of evidence based practice. As we talked about earlier with Professor Henderson-Smart, it is not dependent on single opinion leaders, it is dependent on a group of middle ranking clinical experts in midwifery and people like Caroline who work together with clinicians to use research as a tool for introducing culture change.

Part of the funding of the Midwifery Practice and Research Centre has been used to bring clinical fellows into our research unit so that they can work alongside us and undertake studies that are important to them as clinicians—to research things that they think need to be better understood and that need to be changed. One example of that is a clinical midwife consultant who was interested in routine urinalysis during pregnancy. We are working in a unit that working closely with a renal physician who does excellent work in pre-eclampsia in pregnancy. So this particular midwife has designed a study in consultation with our medical colleagues and with a lot of help from our research unit, particularly from Caroline, that is designed to establish whether routine urinalysis in pregnancy is a useful thing to do or not. It is a costly, intrusive process. We can now theorise it is probably not a useful thing to do. She is being paid for some time release, along with another antenatal midwife, to undertake this study over 12 months and to establish whether that is important.

CHAIR—I hate to cut you off but we are running into our lunchtimes. Can you make a quick comment about low birth weights associated with all sorts of nasties yet on the other hand we are keeping low birth weight babes?

Prof. Barclay—I would prefer to approach it from the end of looking at how we can reduce low birth weight rather than what we do at the consequence. We do have some good evidence that we can reduce low birth weight by again continuity of care by midwives with the women who are at most risk of low birth weight babies. There is a paper by Oakley and others—and we will give you the reference to that—where there was absolutely nothing done differently in the care of these women who were at risk of low birth weight babies except continuity of care by a midwife during pregnancy. It made a statistically significant difference in the weight, therefore the optimal outcomes of these infants.

CHAIR—We are talking about two things here. One is that low birth weight can refer to going through to term and weighing one kilogram or something—

Prof. Barclay—Undernourished.

CHAIR—Versus labour starts or something happens and you have to bring it on early, so you bring into the world an underweight one. My final two questions and maybe you can answer this one on notice: what is the relationship between the Midwifery Practice and Research Centre and the Australian Midwifery Action Project? Can I ask you to make a 30-second comment on this: we have been told quite often that one of the reasons we have a high caesarean section rate in this country is that women are demanding it.

We were told in South Australia about a meeting of 300 obstetricians. This is what we were told—we did not attend that meeting or see those people—when somebody asked, ‘If a woman asked for a caesarean section, would you do it?’ 300 obstetricians raised their hands. I am very interested that, on the one hand, if women ask for a caesarean section then on the evidence 300 obstetricians would do it for them; but, on the other hand, if women asked for a home birth or a birthing centre they are still regarded as slightly odd. You smiled: can you put that smile on the record in about three words?

Ms Homer—It is a sad indictment of society, if that is the way we go. I do not believe there are many, many women out there asking for caesarean sections. I think it is a myth

that we are starting to perpetrate ourselves. We need to look at the reasons why women are asking for elective caesarean section and I suspect a lot of it is to do with fear. There is a lot of research around that says if you give woman a supportive companion in labour—not necessarily their partner but an extra female companion who sits with them through the whole labour—you will reduce their fear, you will reduce the cascade that Professor Chamberlain spoke about and you will reduce intervention rates. It is a much more humane experience than just saying, ‘We can solve your problems. This is the 1990s, have an elective caesarean section.’ That is not the way to go.

CHAIR—Curiously enough to finish: one lady was in the paper the other day saying that she had a caesarean section to stop the pain. As Senator Gibbs said, I wonder what kind of counsel they gave her about what happens after the operation. On that note, we stand adjourned for lunch.

Proceedings suspended from 1.10 p.m. to 1.35 p.m.

WESTHORPE, Dr Rodney Neil, President, Australian Society of Anaesthetists

CHAIR—Welcome. The committee prefers all evidence to be heard in public but, should you wish to give your evidence, part of your evidence or answers to specific questions in camera, you may ask to do so and the committee will give consideration to your request. We have before us your submission, which is No. 162. Is there anything you would like to alter in that submission?

Dr Westhorpe—No.

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

Dr Westhorpe—I will make a very short opening statement and say that the society and, indeed, anaesthetists in general in Australia are extremely supportive of developments in obstetric anaesthesia. Anaesthetists in this country have been at the forefront internationally of new developments in all aspects of anaesthesia related to childbirth and delivery, as indeed we are with all aspects of anaesthesia. We do have regular educational meetings. We have a particular special interest group which addresses the issues of obstetric anaesthesia. We have published public information leaflets and, indeed, last year a video with the college on anaesthesia in labour, particularly related to epidurals.

CHAIR—‘It’s your labour and you’ll cry if you want to.’

Dr Westhorpe—I do not remember the second part of that title, but I do remember the first part and it was highly successful.

CHAIR—Elegantly batted back, thank you, Doctor.

Dr Westhorpe—I guess one of the biggest issues that comes back to us all the time is the problem that some hospitals have, particularly in the private sector, in obtaining anaesthesia services, and in particular after hours. That really relates to the fact that not many anaesthetists are really committed to providing that service on the basis of the poor remuneration that results from it and the impact that that service provision has on their subsequent day’s activities. That is related to the anaesthesia rebates which are available through CMBS which, for the level of service provided, the time commitment which is involved and the stress which is accompanied by anaesthesia for caesarean section, or indeed, just for epidurals, many anaesthetists choose not to be involved in.

Senator GIBBS—With the caesarean delivery rates, is there any evidence that caesarean deliveries increase with the procedure of the epidural?

Dr Westhorpe—There is some evidence that the rate of caesarean sections is slightly increased with epidurals. I cannot give you any figures on that. I am not an obstetric anaesthetist. I do not go anywhere near obstetric anaesthesia personally. As I understand it, there is a slightly increased rate.

Senator GIBBS—When you were talking about the rebates for anaesthetists, what levels would you like them to increase to for your remuneration purposes in the event of childbirth?

Dr Westhorpe—I think we would suggest that something approaching the AMA recommended fee would be appropriate. The AMA fee for anaesthesia services is a time related fee; so the longer the anaesthetist is involved directly with the care of the patient, the higher the fee. In essence—I would be hazarding a guess—I would suggest that it should be somewhere in the order of \$400 or so.

Senator GIBBS—At the moment you are not paid the AMA rate. Is that what you are saying?

Dr Westhorpe—The anaesthetist can charge the AMA rate, but the patient gets back 75 per cent of \$216.

CHAIR—So they are \$54 out of pocket?

Dr Westhorpe—That is if they charge the schedule. If they charged the AMA rate, they might be \$300 or \$400 out of pocket. But I would put it to you that for a specialist medical practitioner to get out of bed at 2 a.m. and spend a minimum of two hours attending a patient for a difficult and fairly stressful procedure which carries with it a fair degree of medico legal responsibility, a schedule fee of \$216 is really pretty laughable. It is no wonder that anaesthetists choose not to be involved in it, particularly when at 7 a.m. the next morning they will have some sort of scheduled list of patients to deal with.

Senator GIBBS—I might be wrong, but it is my understanding that anaesthetists are actually booked for certain operations at certain times.

Dr Westhorpe—Yes.

Senator GIBBS—So you have obvious advanced warning of operations at particular times.

Dr Westhorpe—Most anaesthetists have regular commitments. So they will know a week or more ahead that on Tuesday starting at 8.30 a.m. or 8.00 a.m. they have a list of seven patients. They will know the names and the operations and they would normally proceed to the hospital at about seven in order to see those patients who are coming in on the day for surgery, which is what happens mostly now. But they would know that well in advance. To place themselves in an on-call position the evening before that is a substantial impost into their work pattern and indeed has an effect on the outcome of those patients the following day because that lack of sleep certainly has a detrimental effect on the ability of the anaesthetist to provide the appropriate vigilance and care in the subsequent day's activities.

Senator GIBBS—Are we talking here of anaesthetists in the private or public sector?

Dr Westhorpe—We are talking about the private sector. The public sector always have trainee anaesthetists who are available to provide this work.

Senator GIBBS—That is what I thought. I thought they would have them working in the hospital like the registrars.

Dr Westhorpe—They can normally adjust rostering arrangements so that the trainees who are on during the evening are then free during the following day. That is the normal practice.

Senator GIBBS—Thank you very much.

Senator DENMAN—Just following up on that, I live in a remote area on the north-west coast of Tasmania. We have very few anaesthetists in public hospitals, which you are probably aware of, so that throws your theory out the window. In an area such as I live, are there GPs—and GPs do a lot of the work in hospitals—who have the skills to do an epidural procedure?

Dr Westhorpe—Yes. The society includes a number of non-specialist anaesthetists in its membership, and they are encouraged to be actively involved in educational programs. So we recognise that you cannot provide a specialist anaesthesia service in the geographical population distribution that we have in this country and that, in some places, appropriately skilled non-specialists need to provide that service and that it is our job to make sure that they get the necessary training, background and support to be able to do that.

Senator DENMAN—Would the lack of epidural specialists or anaesthetists perhaps explain why there are not as many caesarean births up in the area where I live? There are necessities, but—

Dr Westhorpe—You really need to ask the obstetricians that.

Senator DENMAN—Okay. There are not any.

Dr Westhorpe—Anaesthetists do not determine the need for caesarean section.

Senator DENMAN—No, I realise that.

Dr Westhorpe—And I really honestly could not answer that.

Senator DENMAN—No, I realise that anaesthetists do not; but what I am getting to next is that the obstetricians—and there are very few of those, too, I might add—do not have that skill to call on, so they usually send them to a large centre in Launceston. Is the lack of epidural anaesthetists a problem in rural and remote areas?

Dr Westhorpe—Perhaps at the outcome of this inquiry you will be able to tell us and be able to tell us what we need to do to address that. I suspect it probably is a problem in that it is less available, and it is quite likely that we need to look at means of addressing that.

Senator DENMAN—We need to look at means of addressing a lot of specialist issues in rural areas because we are not attracting people anyway.

Dr Westhorpe—Sure, I understand.

Senator DENMAN—Thank you.

CHAIR—Dr Westhorpe, the college must surely be aware of the challenges of rural and remote medical practice in this country?

Dr Westhorpe—Indeed.

CHAIR—Anaesthetists are different from anybody else? You are there on the ground in hundreds, just waiting for surgeons?

Dr Westhorpe—If only! Here I am representing the society, but I have to say that I also sit as an elected counsellor on the college, so I can wear both hats. The college and the society jointly have recently put in place a Rural Anaesthesia Recruitment Service, and the aim of that is to enhance the movement of anaesthetists into rural areas. We have appointed a full-time staff member to deal with that recruitment service. That recruitment service will address not just full-time positions but locum positions, enabling rural specialist practitioners to be able to get away from their practice so that they can take part in educational programs and also recreational leave.

CHAIR—But the answer to Senator Denman's question is yes, there is a dearth of anaesthetists out there, like there is a dearth of every other specialist.

Dr Westhorpe—Yes, but we are doing what we can. It is at an early stage, but we are conscious of the need to deal with that and we are dealing with it.

CHAIR—What is the difference between the society and the college?

Dr Westhorpe—The college is the educational body. The college accredits anaesthetists. It undertakes all the training; it is responsible for publication of standards of anaesthesia practice and accreditation of hospitals as training institutions. The society is involved in continuing education, but also in industrial and fee related matters. The society also is the publisher of the *Journal Anaesthesia and Intensive Care*, which is one of the prime anaesthesia journals internationally. Both organisations work together on many issues, and the example of the Rural Anaesthesia Recruitment Service is one of them.

Senator DENMAN—To be registered as an anaesthetist, you obviously have to do your postgraduate stuff and whatever, but does that then go before a registration board? Is there a cap on the number of anaesthetists registered each year?

Dr Westhorpe—There is absolutely no cap on numbers at all. In fact, the numbers passing through the training program have gradually been increasing, although the college is conscious of the reports of the committee that is looking at numbers of practitioners. The current anaesthesia training program is a minimum of seven years after graduation in medicine. It is clearly a fairly major commitment for anyone to undertake. It involves finally the successful completion of an extremely rigorous examination and then completion of another year in what is called a post-fellowship year. There is no restriction on the numbers who can enter the training program; there is no cap.

CHAIR—What are the virtues of epidurals and the risk with epidurals? I have your paper here and I have read it very closely.

Dr Westhorpe—What is the ‘risk’ with epidurals?

CHAIR—Is the epidural the ‘in’ pain relief for the birthing mum? We have passed the stage of ‘Lift up the mask, put the giggle gas on and take a deep breath when the contraction starts’? Do we use that at all any more?

Dr Westhorpe—That is still used. I think epidurals have to be seen as part of an armamentarium of a variety of pain relief methods.

CHAIR—It says here:

Doctors regard it as the most effective means of reducing the pain of childbirth.

With that kind of promo, tell us how we are going to resist.

Dr Westhorpe—I will say that the epidural is probably the most effective, complete method of pain relief during labour.

CHAIR—Why not a GA?

Dr Westhorpe—A general anaesthetic is inappropriate because you do not know how long the labour is going to last. The labour might last one hour or 17 hours. A general anaesthetic would be entirely inappropriate.

CHAIR—Does an epidural last two hours?

Dr Westhorpe—An epidural lasts, with the insertion of a continuous infusion catheter, as long as you need it to last. The important thing about an epidural is that it provides excellent pain relief but does not diminish the function of the mother from the waist up. In other words, they are perfectly normal, active, aware and able to enjoy all the good things about childbirth.

CHAIR—The evidence that we have been given is that epidurals actually contribute to slowing labour and may, indeed, lead to increased intervention, particularly caesarean section.

Dr Westhorpe—You would have to ask an expert in obstetric anaesthesia about that. As I said, I think the figures show that there is a slight increase in intervention with epidurals but I do not think it is a large increase.

CHAIR—I think you will find that there is some evidence to the contrary. Does the society or the college do research on questions like this?

Dr Westhorpe—Yes. It would be done by individuals and it may well be published through the society or the college.

CHAIR—Has the NHMRC done any on the impact of anaesthetics in childbirth?

Dr Westhorpe—Not that I am aware of.

CHAIR—Could I ask you to take that question on notice and let us know if there is any research?

Dr Westhorpe—Yes, I can feed that back to you.

CHAIR—We are concerned about evidence based changes in medical practice or hospital practice at the time of delivery. We are very concerned about the significantly higher caesarean rate in private hospitals and/or with privately insured patients and, of course, about the significantly higher epidural rate with those same patients. I find it extraordinary that, when you compare two populations of Australian women on either side of the same town, as I was observing the other day, in most every state in Australia, it is the western suburbs that are down on their uppers, and the eastern suburbs are doing it well with a higher caesarean rate. Why is it that the women in the eastern suburbs need a higher caesarean rate or a higher epidural intervention when compared to the women in the western suburbs or the women in the public hospitals? Overall, there is a comparable community of mothers.

Dr Westhorpe—That is a fair question, and I will come back to you with some answers, but I think you probably need to separate the inference that the higher caesarean section rate and the higher epidural rate are necessarily related.

CHAIR—Well, we have had evidence that they are. We have been told by professors and researchers that epidural anaesthetic leads not only to numbness below the waist but also slowing of contractions—

Dr Westhorpe—I said to you that I do not disagree that there is, as far as I am aware, an increased rate. I do not think it is a large number.

CHAIR—And then sometimes—you do not think it is large?

Dr Westhorpe—No.

CHAIR—Well, we have some suggestion that it is. Not only is the epidural used a lot but it may indeed be causal of a slowing of labour and tired, exhausted mums and therefore of a higher rate of intervention. That has been given to us as evidence, and it seems to be authoritative. It is not just anecdotal. What other things are doctors using for pain relief during childbirth?

Dr Westhorpe—Primarily inhalation of nitrous oxide and oxygen mixtures—and, as far as I am aware, they still use injections of pethidine narcotics.

CHAIR—Has the college done any research on the different pain relief in women having homebirth or birthing centre births, as apart from more traditional labour ward births?

Dr Westhorpe—The college will not have done. It may have been done by individual practitioners, but the college or the society will not have done that.

CHAIR—You tell me that the college is responsible for education?

Dr Westhorpe—Yes.

CHAIR—Where does it get to know what to put in the curriculum?

Dr Westhorpe—The college is very careful not to specify methods of management, because different methods of management may be appropriate in different settings.

CHAIR—Does the college have anything to do with best practice standards?

Dr Westhorpe—It is looking at evidence based medicine and whether to produce things in that line, but at this point in time it is being careful not to—because it has been seen as a means of directing the way that practitioners should practice and, in the practice of medicine, that is not always appropriate because there are so many different factors involved.

CHAIR—Do anaesthetists fight with obstetricians and say, ‘There is no need to do that’? Do you ever say, ‘Absolutely not, I am not persuaded’?

Dr Westhorpe—I do not fight with an obstetrician because I never see one.

CHAIR—What is the professional independence of an anaesthetist, and does that professional independence mean that the anaesthetist can stand up to another professional and say, ‘Absolutely not, I am not going to do that’?

Dr Westhorpe—That can happen, sure—recognising, though, that the anaesthetist is often placed in the position of a service provider after an initial decision is made by a treating surgeon.

CHAIR—That must do great things for your professional independence. Note for the *Hansard* record that Dr Westhorpe raised his eyebrows. Would you please illustrate with words what that look meant, Doctor.

Dr Westhorpe—For some anaesthetists, it puts them in a position of difficulty which depends very much on the personality of the anaesthetist as to how well they can deal with that situation.

CHAIR—Have you any papers or research that addresses just that question: that is, what happens when an anaesthetist is effectively brought in as—to use your words—a service provider for a specialist? In this case we are talking about an obstetrician who says, ‘We’ll have to do this,’ and the anaesthetist is rung—‘Come on in, doc, and we will have you do this.’ Has the college or the society done any research, or do you know of any research, about how the anaesthetist then negotiates with the specialist?

Dr Westhorpe—There is no research, as such, that I am aware of. The college is clear in its guidelines as far as the professional responsibilities of anaesthetists are to the patient rather than to another medical practitioner and that they need to make a judgment on the appropriateness or not of treatment on the basis of their knowledge and their assessment of

the patient. How the personalities of a treating surgeon, obstetrician or other proceduralist impact on the activities of an anaesthetist is a difficult one. We have been starting to address that issue through another joint organisation—nominally known as the Welfare of Anaesthetists Group, which makes you smile. That is an all-encompassing group which is looking at all aspects of anaesthesia practice, particularly impaired anaesthetists and anaesthetists with substance abuse problems—it happens to all practitioners—and also their personal and professional relationships. It is an area which has not been ignored, but it is not necessarily easy to deal with.

CHAIR—No, it is not, but if you have a college that is an educational body that is setting standards for what should be appropriately part of a curriculum, so that you could tick off on the younger emerging generation of anaesthetists and say ‘They are qualified under the following criteria . . .’, I am particularly interested in why you or the college would not be doing research. How does the college inform itself of what is the latest current practice? For example, if you knew that there was evidence somewhere that epidurals were slowing down childbirth, how does that research get into your anaesthetist curriculum? Does the college chase it down? Is it taught to the up-and-coming anaesthetists? Is it part of the continuing education?

Dr Westhorpe—In the training program for anaesthetists the prime source of their knowledge comes from two places. One is lectures at training courses. The lectures are always delivered by their senior peers—consultant anaesthetists—who are highly respected for their position in the practise of anaesthesia. In the curriculum of the course on obstetric anaesthesia, that would be delivered by someone who is prominent in obstetric anaesthesia from an academic department. It would be expected that that person would impart a fair and reasoned appraisal of current research and development in obstetric anaesthesia.

CHAIR—How would you know?

Dr Westhorpe—The college does not direct what people should be told. It is quite important that they are—

CHAIR—I appreciate that. We are talking about fine line stuff here, aren’t we?

Dr Westhorpe—Also, the trainees must spend a minimum amount of time in the various subspecialties, including obstetric anaesthesia. That will be done in a training institution which is accredited by the college on the basis of the facilities it has, the people it has, the case load it deals with, et cetera.

CHAIR—I appreciate all of that. We have also heard at length in this inquiry about the extreme difficulty of getting current research and that it is hard enough to even decent evidence based on hard research. A lot of practices have it—it is culture. As you say in your submission, we have been doing it here for 40 years for millions of women. You say:

Epidural anaesthesia has been used during the past 40 years for millions of women.

Then you turn the page and you see at length the contrary indications—and you will, of course, no doubt teach those. But the interesting thing is that we have been hearing that, in

lots of ways, it is very difficult to have current practice informed of the latest best research and a changing climate of practice. Maybe we are getting too theoretical here, but we are very concerned that, for example, in one group of hospitals the culture of practice for the birth process is extremely different from the hospital down the road. One of the best indicators of what is going to happen to you is whether or not you are privately insured, which does not seem to be a medical criteria to people this side of the table.

Dr Westhorpe—I agree.

CHAIR—Maybe I could ask if you could take on notice—further to those earlier questions—if there is any evidence or research on how the impact of epidurals is being informed into the course that teaches the up-and-coming anaesthetists. How do the expert anaesthetists—the whiz bang anaesthetists—who are doing the lectures keep on top of the current research? How do they introduce it into their lectures to see a change of practice?

Dr Westhorpe—As I said, we regularly have educational seminars, conferences, et cetera. Obstetric anaesthesia almost invariably forms a prominent part of all of those. The people who are involved in presenting their research material and their current opinion have to keep up to date. Quite regularly, those people are invited overseas, as we invite overseas obstetric anaesthetists here. I can give you a list of names of people involved in obstetric anaesthesia here who have, in the last three or four years, been to overseas meetings as speakers and have been involved in extensive research programs and I can give you the names of overseas experts who have come here.

CHAIR—We may, in fact, draw on them but possibly not.

Dr Westhorpe—We cannot make people come to those meetings. Although we do have a maintenance of professional standards program, it is voluntary. But we are adamant that all anaesthetists should be part of that. In the fullness of time I would expect that 100 per cent of anaesthetists would be part of that program. But you can lead a horse to water but you cannot make it drink.

CHAIR—You can, actually—just take away their accreditation number. Certainly, the health minister is quite interested in ways—and the previous government the same—of maintaining quality standards. I presume that is what you are here for: to say that you represent a college and a society that is interested in high standards of care, and that everybody in anaesthetics would want those.

Dr Westhorpe—Correct.

CHAIR—And I am not in any way wanting to undercut that. I do not want to stick with that question, but if there is something further you can tell me, please do. The reason I want to get on to the question of what happens when an anaesthetist has to negotiate with the obstetrician, is that we are dealing with the concern about best practice criteria. It is one of our terms of reference. In the past, best practice criteria have been seen to be things that are for the profession to describe ‘the profession’.

We are hearing more and more, though, that best practice has to take account of the mother's, if not the family's, wishes. How do you negotiate best practice criteria that include other people who are not part of defining best practice? How does the obstetrician's best practice intrude on the anaesthetist's best practice? If you have any guidelines on how you negotiate that, it might assist us in looking at how the community or the mother is incorporated into best practice guidelines, if you see what I am driving at.

Dr Westhorpe—I can see what you are driving at. Certainly from the point of view of involving the mother and families in this, we are, as you see there, at pains to try to provide more information and an opportunity for people to ask more questions and get more involved.

CHAIR—Do anaesthetists understand amongst themselves what we understand to be the perspective of obstetricians and others involved in childbirth: that is, if a mother asks to have a caesarean, we are told that obstetricians would all perform the caesarean section, but, if a woman asked to have no intervention, she is regarded as slightly nuts?

Dr Westhorpe—I would not—

CHAIR—Come on doctor, be bold.

Dr Westhorpe—I think that would be most unfortunate. I cannot countenance that.

CHAIR—Do anaesthetists have to argue? Do you find sometimes you have to argue with patients that it would be better to have an anaesthetic, or do you find yourself engaged in conversations with women who say 'no intervention'?

Dr Westhorpe—We would very carefully advise anaesthetists to put the options on the table and couch advice in terms of what the anaesthetist would advise as appropriate, but never would we countenance directing a patient that that is what they must do. It is never appropriate.

CHAIR—The problem is that the patient is now being held responsible for directing the obstetricians. If a woman says, 'I demand a caesarean section,' the obstetricians are now saying, 'All right, if you ask for one, we will give you one.' That is a surprise to many people in this society who are shocked at the sudden power women have assumed. We are also very concerned that, if the same women have forthrightly said, 'I demand no intervention,' they are regarded as nuts.

Dr Westhorpe—I do not know by whom they are regarded as nuts. I think that is a perfectly reasonable decision to make, providing that decision is made after consideration of all the factors involved. If that decision is made without that information, that may be inappropriate. But, if the appropriate information is given and that decision is still the same, then that is a perfectly reasonable thing for a human being to do.

CHAIR—We have been told on a number of occasions that one of the reasons obstetricians are doing more caesarean sections is the fear of being sued, the medico-legal

impact. Are anaesthetists under the same fear? Are you regularly sued, or are you in fear of being regularly sued?

Dr Westhorpe—There is an increased litigation risk in anaesthesia practice. The problem from our point of view is that the adverse outcomes from accidents in anaesthesia are pretty costly.

CHAIR—To whom?

Dr Westhorpe—To the community and to the insurer.

CHAIR—What has happened to insurance premiums for anaesthetists?

Dr Westhorpe—In this state I think they are around \$16,000 a year. In Victoria they are around \$13,000 a year.

CHAIR—What is that up from, and since when?

Dr Westhorpe—In 10 years it has gone up from less than \$1,000.

CHAIR—Based on what?

Dr Westhorpe—You would have to ask the insurance companies.

CHAIR—Does it interest the college or the society?

Dr Westhorpe—Of course it interests the college and the society. We believe it would have gone up substantially more if we had not instituted guidelines on minimum monitoring standards and other practice standards in the late eighties.

CHAIR—What difference has that made, Doctor?

Dr Westhorpe—It has meant that we have kept up to date with current developments in safety in anaesthesia.

CHAIR—Does that mean that you can use as a defence against litigation, ‘These were the best practice guidelines, we adhered to them, and it is documented during this episode’?

Dr Westhorpe—It is partly that but, more than that, it has resulted in an extremely safe practice of anaesthesia and standard of anaesthesia in this country. We can now document that it is actually safer to have an anaesthetic in Australia and New Zealand than anywhere else in the world.

CHAIR—So why have your premiums risen?

Dr Westhorpe—There is a bit of cross-subsidisation. Also, as I said before, a single bad outcome from anaesthesia is liable to be an expensive one. I am talking about death or serious brain injury.

CHAIR—Is the college and the society interested in an alternative resolution process so that patients or their relatives get the opportunity to present their complaints and/or have them resolved by conciliation as with the Victorian Health Commissioner?

Dr Westhorpe—These are complaints related to anaesthesia services?

CHAIR—Yes.

Dr Westhorpe—In both the college and the society we have the ability to have complaints addressed through the system, yes. There is no formal hearing or anything.

CHAIR—Did you know that the Victorian Health Commissioner—who is thinking of changing her name to ‘Ombudsperson’; she is probably going to change it to ‘Ombudsman’—has instituted a place where you can go for no cost to make your complaint, and it is judged to be frivolous or not. If it is not frivolous, the parties to the complaint are brought to a conciliation process, and very few of those cases then proceed to court. But there is a conciliation process, and sometimes there is even a settlement payment made as a resolution. Has the college fronted that group much?

Dr Westhorpe—No.

CHAIR—You have not found complaints being brought against you to that body?

Dr Westhorpe—No.

CHAIR—Would you support it on the grounds that it might reduce your premium payouts and it might be an alternative to litigation?

Dr Westhorpe—If it did, absolutely. Even without that, we would support that as an opportunity to resolve complaints. As far as the premium problem is concerned, that is more related to an insurance risk assessment problem.

CHAIR—Not quite. If what you say is true, which is that there is an element of cross-subsidy—and I suspect you are right there—that sounds as though insurance is not entirely working on risk assessment.

Dr Westhorpe—I am not privy to the details of how they work out the premiums.

CHAIR—If there is anything that you could add to that, that would be very useful. We have hit our time limit, and I think you have to catch a plane.

Dr Westhorpe—That is right, but I can put it off.

Senator TCHEN—I am sorry, Dr Westhorpe, but may I detain you a little bit. How current is this pamphlet?

Dr Westhorpe—It has just been drafted.

Senator TCHEN—Following from what Senator Crowley asked you earlier about the complications, on the back of your pamphlet you say:

Some earlier studies suggested that epidural anaesthesia may prolong labour and may increase the likelihood of forceps delivery . . . However, more recent studies have disputed this. Even if an epidural does affect a particular labour, there is no evidence that this will harm the mother or baby . . .

You mentioned ‘more recent studies’. Can I ask you on notice to find out some information about those studies?

Dr Westhorpe—I will find out some details for you. You will also notice that we are quite specific in highlighting any risks involved with obstetric anaesthesia. An important part of providing information is that you do not just tell them all the good things.

CHAIR—Doctor, you will be at risk of missing your plane if you do not leave.

Senator TCHEN—If you have evidence of those studies, I would appreciate it. In part of your summary you said:

The society believes that urgent review is required of the Medicare rebate.

What level of increase would you like to see?

CHAIR—You can take that question on notice, Doctor. We do not want you to miss your plane.

Dr Westhorpe—Thank you very much for the opportunity.

CHAIR—I am sorry we have kept you back a bit.

Senator TCHEN—If you are taking that question on notice, could you also expand on your submission about improved techniques that allow greater voluntary control by mothers?

Dr Westhorpe—Sure. I will give you some up-to-date material.

Senator TCHEN—Thank you.

[2.20 p.m.]

BLATCH, Ms Julie Christine, Director, Policy, Planning and Service Delivery, New South Wales Pregnancy and Newborn Services Network

FISCHER, Ms Wendy Elizabeth, Health Services Manager, Research, Planning and Policy, New South Wales Pregnancy and Newborn Services Network

CHAIR—Welcome. The committee prefers all evidence to be heard in public but, should you wish to give your evidence, part of your evidence or answers to specific questions in camera, you can ask to do so and the committee will give consideration to your request. We have before us your submission No. 109. Are there any alterations that you wish to make to that?

Ms Blatch—No, there are not.

CHAIR—Would you like to make a brief opening statement, and then we will ask questions.

Ms Blatch—I have a few issues that I would like to raise which are not necessarily covered in our submission. They come under the heading of ‘data issues’. We believe all perinatal care and services should be evidence based. There are very few clinical practices which are currently proven to be effective, and we refer you to the third edition of *Effective care in pregnancy and childbirth*, which is in press.

We believe that evidence based practice should be supported by accurate and reliable monitoring of perinatal outcomes using appropriate databases, and these databases need to be in place in all states. Ideally, databases should be using the same variables and the same data definitions. We believe the Commonwealth could adopt a leading role in promoting data collections over and above the existing core data sets collected by the National Perinatal Statistics Unit and the Australia and New Zealand Neonatal Network.

We also feel that maternity and early child health should be identified as a priority population public health issue within the Australian Institute of Health and Welfare National Health Information Development Plan. On data issues, again, one of the difficulties is that of cross-border flows of patients, and the lack of comparable and complete epidemiological information from all states impairs our ability as researchers to conduct quality clinical audit.

In order to be able to access better and more comprehensive data to inform, research and develop clinical practice guidelines, we feel the public needs to be educated. Protecting privacy needs to be balanced against the need for data to undertake clinical audit and to undertake quality assurance and long-term follow-up of recipients of clinical procedures and interventions. It is very important that good data is available to inform practice to develop safe and effective services. Most of these issues that I have just referred to are covered in the Australian Institute of Health and Welfare National Health Information Development Plan, which I am sure you would have a copy of.

CHAIR—If not, we will get it soon.

Ms Fischer—We are happy to table one.

CHAIR—We would welcome that. Thank you very much.

Ms Blatch—We feel there is a pressing need to audit and evaluate long-term morbidity of all interventions in childbirth. For example, there is an evolving school of thought amongst better educated, privately insured women, and possibly clinicians, that it is preferable to have a caesarean rather than risk postnatal complications and possible surgical repair later in life.

I turn to some clinical practice issues. Systematic reviews of clinical trials are undertaken by the Cochrane Collaboration, but clinicians are not trained in how to apply or interpret this information. We have discovered this only recently. There is a huge gap in knowledge in this area. We feel perhaps the Commonwealth could support the newly formulated Australian Effective Health Care Network, which is attempting to get effective care into clinical practice.

I am sure you are aware that current clinical practice lags well behind available evidence for best practice. It is possible that the Commonwealth could take an active leadership role in disseminating clinical guidelines and information to consumers and providers through partnerships with the Australasian Cochrane Collaboration, the National Institute for Clinical Studies, the NHMRC and the Commonwealth Department of Health and Aged Care.

We are concerned because a wonderful document for clinicians and consumers entitled *Care Around Preterm Birth* contained a wealth of clinical information, but there was no formal mechanism in place to disseminate those documents. For example, we took a bundle to the Australian Perinatal Conference in Alice Springs to disseminate it. It seems a shame that there was no mechanism in place to disseminate or to evaluate whether the information contained in those booklets was adopted in clinical practice or helped to inform consumers.

We also think the consumers should have ready access to information and booklets on the risks of potential negative sequelae associated with all sorts of interventions, such as caesarean, so that they are in a better place to be able to make decisions and to be aware of intervention cascades which can follow from one intervention or another—for example, the risk of babies going into an intensive care nursery post caesarean section.

One thing which we did not mention in our submission was that we do not feel a service payment system for midwives, the VMO midwife model, is necessarily going to be a solution. We feel salaried models may be preferable, as they are less likely to perpetuate the demarcation that exists between obstetricians and midwives. They are more likely to provide continuity of care and give backup to midwives as part of a regionalised system of providing care and clinical audit.

CHAIR—Thank you. Ms Fischer, did you wish to say anything at this time or would you like to take questions?

Ms Fischer—We are happy to take questions.

Senator GIBBS—Everywhere we have been we have heard evidence that women are significantly more likely to have their babies delivered by caesarean section in a private hospital as opposed to a public hospital. We have asked a lot of questions about this, but it seems that the main thing, apart from diabetes and hypertension, that a lot of obstetricians or people who have appeared as witnesses are saying is that women are giving birth at an older age these days. Because older women can afford private health insurance, that is why we just rip them out. How do you feel about that?

Ms Fischer—I am sorry; I was smiling because it reminds me of when I did my own midwifery training in the early seventies. In those days in Britain an elderly primipara was 21 years of age. It is just an example of how fashions change in medicine and obstetrics, in particular. I was not aware that age per se was an absolute medical indication for a surgical intervention that has four times the risk of a vaginal delivery.

I think older women are more likely to have private health insurance, but I think the picture is much more complex than that. There are two particular issues that are very important. Perhaps the prime issue in health care all around the world is how you pay the doctor. It is that which has a major impact on the sorts of services that are delivered. That is well documented all through the health policy literature. I am happy to provide some articles if you are interested.

The other important issue from the point of view of private insurance is what people are actually paying for when they go private in an obstetric encounter. It seems to me that one of the things people really want is continuity of care. That is what you get as a private patient. You do not get the same continuity as a public patient. The private patient pays twice: they pay for the cost of their health insurance and for the cost of their encounter in monetary terms, but they also pay in terms of more interventions that have possibly a much higher morbidity.

CHAIR—If you have got a couple of articles that you could provide to the committee, or even references about how the doctor is paid alters the outcome, we would be very pleased to receive that.

Senator GIBBS—So it really does come down to the continuity of care, doesn't it?

Ms Fischer—I think it is a major issue, yes.

Senator GIBBS—So if we implemented continuity of care within the public hospital system—which we have been hearing in all states—Victoria, South Australia, Western Australia, we are yet to go to Queensland, and now here—where the preferred model is the continuity of care, the midwives, the doctors there just in case anything goes wrong, that seems to be beneficial to the mother and the child, too, afterwards. But how do you account for the high proportion of caesareans in the private health scheme?

Ms Blatch—There are a number of factors. In a private facility compared with a public facility there is often not a process of clinical audit whereby everyone meets and they discuss cases and look at intervention rates. Other factors that affect rates are whether or not there is a staff specialist available or whether it is all VMO directed, whether there are best

practice models in place in the hospital or whether it is just left to each obstetrician to conduct their own practice and they do not do it by best practice guidelines, whether a clinical audit is done routinely—those sorts of things.

Ms Fischer—I think too there are the issues that the Tito report has raised in the inquiry into professional indemnity. They have a good chapter on defensive medicine and those sorts of issues as well—things like the size of a provider's practice. If a private provider has admitting rights at four different maternity hospitals and he or she has a theatre list, rooms, patients booked and three or four women in labour on different sides of the city at once, that is an enormous pressure to be under. If you have to actually deliver to collect the fee, then the very structure of a practice can influence patterns of behaviour in subtle ways. I am not suggesting that people go out of their way to surgically deliver every pregnancy, but one has to take account of the pressures that people are working under and which direction those pressures are pushing them in. One of the reasons we have some concerns about going to a Medicare item number for a midwifery service is that you can create the same sorts of pressures that exist in the VMO system that perhaps would not be as bad if you had a salaried model which is more of a regional service.

Senator GIBBS—So you would be against a Medicare rebate for midwives?

Ms Fischer—I would be very wary of something like that that had the potential to increase demarcation and split domiciliary midwifery services from other levels of maternity services.

Senator GIBBS—That is very interesting because we have spoken to midwives previous to today—representatives of the independent midwives—and they have actually been pushing for a Medicare rebate. What they are saying is that if there was a Medicare rebate then far more women would be able to use the midwife system.

Ms Blatch—It would only produce a midwife VMO obstetrician model with all its current flaws if the midwives were also paid a fee for service.

Senator GIBBS—That is very interesting.

Ms Blatch—It is not the only way you could pay a midwife to deliver a service.

Senator GIBBS—The government could pay the midwife—have them all salaried. I was very interested to read on page 6 about death certificates. It is the last paragraph:

However, maternal deaths are probably under-enumerated here, because not all State death certificates contain a question related to pregnancy and the puerperium.

CHAIR—What does that mean, 'she died in childbirth'?

Ms Blatch—It does not always say that they died in childbirth. They may have died of infection or haemorrhage or whatever. It does not necessarily say that death was associated with childbirth per se.

Ms Fischer—She may have died during the puerperium, for example, three or four weeks after delivery, after discharge from hospital.

CHAIR—For the record, can you give us a definition of ‘puerperium’?

Ms Fischer—I think it is within six weeks of giving birth. Women can be out in the community and death can be recorded as another cause, but there may have been pregnancy related factors. I think Dr James King has managed to have the Queensland death certificates changed. The epidemiology department of NSW Health has for a long time tried to get attorneys-general to look at this issue, but it has difficulty in getting the lawyers to understand why this might be an important question to go on death certificates. I understand that those discussions are once again under way. It seems to be a simple thing, but it is difficult to actually achieve. I do not know what the situation is in other states, but it is perhaps something that could be looked at at Commonwealth level.

Senator GIBBS—Could you estimate how many there would be per year?

Ms Fischer—I have no idea.

Ms Blatch—The NSW Maternal Perinatal Committee does audit maternal deaths—those that are notified to the committee.

CHAIR—How do they notify them—on a death certificate that does not mention pregnancy?

Ms Blatch—I am not sure. I would have to get back to you on that.

CHAIR—Could you do that?

Ms Blatch—Yes.

Ms Fischer—Most of those reported are those that occur in hospital.

Senator DENMAN—What about home births

Ms Fischer—Obviously, for any mortality at home where a woman was not transferred to hospital there is a requirement for recording the cause of death. It is those that are further out that are a problem—where pregnancy may have been a contributing factor, but not necessarily the absolute factor. We do not know whether we catch any there.

Senator GIBBS—Unless there was an actual death certificate saying ‘this poor unfortunate woman died during childbirth at home and then something happened later’, you would not know, would you, with home births?

Ms Blatch—No.

CHAIR—There is a way in which all those deaths have to be reported. The body is removed to the morgue because it is an accidental death—it is not a situation where the

doctor knows this person and signs off on it—and, in that case, they would be known. My understanding is that they would be known because there would have to be a coroner's investigation.

Senator GIBBS—You would probably have a better chance of statistics in the country areas than in the metropolitan areas, if that is the case.

CHAIR—No, home births in the suburbs would go to the coroner too.

Senator GIBBS—I see.

Ms Fischer—There is not a statutory requirement on midwives as midwives to record the data in the midwives's data collection, for example, if they are home births. The midwife can choose to do that and the patient can say, 'I do not want it recorded.' In hospitals that statutory requirement is devolved from the CEO of the medical staff to the midwife. That does not apply to the midwife outside of hospitals, which we also think is a data gap in terms of tracking morbidity in the community.

Senator GIBBS—The midwives have to fill out data forms so that, if there is some sort of death related to a birth, that data is actually there. Is that what you are saying? That it is more accessible because the midwife has to record everything?

Ms Blatch—Are you referring to births outside hospitals?

Senator GIBBS—Yes.

CHAIR—Just to clarify it, I think you said, Ms Fischer, that midwives in hospitals have to fill out a detailed form, but it is not necessary for midwives at a home birth to fill out the same form?

Ms Fischer—Some do—154 did in 1997.

CHAIR—But it is not a requirement that they do?

Ms Blatch—No.

CHAIR—That is the whole point. They may indeed be 100 per cent filling them out, but it is not a requirement that they do.

Ms Fischer—The statutory requirement falls on the hospital's CEO and on doctors and they devolve it to midwives in hospitals to complete this form on all births.

Ms Blatch—It is a statutory requirement that it be filled in.

Ms Fischer—But for an independently practising midwife, or for anyone else attending a birth outside of a hospital situation, it is not a statutory requirement.

CHAIR—Just to follow that question if I might, Senator Gibbs. If there is a homebirth death and this all happens while the midwife is still in charge of the process, is there a pattern where she would contact a hospital-referring obstetrician or that person's local GP? Do you know whom she would contact?

Ms Blatch—If there was a death, someone would have to sign the death certificate.

CHAIR—And it always has to be a doctor? You are saying that you do not know whom the midwife would contact, but it could be one of those three—the GP, hospital doctor or whatever?

Ms Fischer—It would depend on the mix of staff/professionals involved in the home birth.

CHAIR—Sorry, Brenda, I just find this fascinating.

Senator GIBBS—I might be a bit thick here, but I do not quite understand this statement:

However, maternal deaths are probably under-enumerated here.

Where exactly is that?

Ms Fischer—If you died three weeks after you gave birth and the person filling in your death certificate did not know that you had recently had a baby—or there was nothing that jogged their memory—and so did not record that as a recent condition, then there is no way of identifying whether it could be a pregnancy related death or whether there are any factors that related to the recent childbirth.

Senator GIBBS—I see. In this day and age, a lot of people do not go to the same doctor or a different doctor might be called and, because the question is not asked, that is how it slips through. Thank you very much.

Senator DENMAN—What do you consider the most effective means of reducing levels of intervention where there is no medical justification, particularly in light of ultrasound and those sorts of things?

Ms Fischer—Probably the most effective means would be to take the patient away from the people who do the most interventions and create a bit of distance.

Senator DENMAN—Private patients?

Ms Fischer—I think it is a sort of dynamic situation. One of the big problems in medicine is asymmetry of information between provider and consumer. As health professionals, I think we have to be very wary of falling back on the argument that the patient requested something and therefore we did it. That is not what the health encounter is supposed to be all about.

Senator DENMAN—So would you support the theory that if a private patient, for instance, wants an ultrasound then they should bear the cost themselves? Why should the government have to pay for that?

Ms Blatch—Not unless there are clinical indicators.

Senator DENMAN—Some people want a photo of the baby. Why should the government have to pay for that?

Ms Fischer—There is evidence from the States, for example, that the rate of ultrasound antenatally was reduced by removing a specific item number for antenatal ultrasounds so that you could not bill it every time you did it. From an evidence based perspective, there is also a concern that, while ultrasound is one of those procedures that has come into common practice, it has never really been effectively evaluated. So the issue of how much radiation you are subjecting the baby to and what happens if you do that on a repeated basis antenatally in an otherwise normal pregnancy are of concern from a quality and patient safety point of view. The boat was sort of missed in evaluating that technology before it became routine.

Senator DENMAN—If midwives were involved in consultation with the doctors on that sort of issue and were able to speak with and maybe counsel the patient, particularly a patient who is requesting an ultrasound that is not absolutely medically necessary, do you think that would help overcome the problem?

Ms Fischer—Not on its own, I don't. I think one of the problems that consumers face is conflicting information, and we have said in our submission that we see a need for the Commonwealth to take a role, as it has said it is going to do in other health areas, as the authoritative provider of information. I am not aware of any pamphlets in antenatal clinics, for example, that outline the risks of ultrasound and the fact that it has not been subjected to scientific evaluation as well as the benefits—the same with epidural and the paper that was presented earlier. That may be produced by the College of Anaesthetists, but I would like to see that sort of information in antenatal clinics and other places where women are being seen.

Senator DENMAN—Maybe again midwives could play a role in educating women in these areas.

Ms Blatch—Having little brochures readily available for women delineating the risks and benefits of all these sorts of interventions would be very helpful, I think, so that the consumers are more informed.

Senator DENMAN—Sometimes women need somebody to help them work their way through it, though.

Ms Fischer—But if you have a written guide, it is more likely that people will get consistent information than if they are relying on professionals talking off the cuff, because not everyone has the chance to evaluate the information in depth.

Senator DENMAN—But my point is that there are a lot of women who cannot evaluate without having somebody like a midwife or someone else sit down with them and say, ‘This is what this is about.’

CHAIR—That is actually an interesting point. On previous evidence we have had, just that point has been drawn out, and also, I think, the point that you are making, Ms Fischer, that as well as needing someone to explain it, it is a useful idea to have one person explain it and not six, because quite often you then get six variations and that can be then very confusing for a person, particularly a person who is in need of assistance to interpret.

Ms Fischer—And particularly where you are dealing with a lot of different ethnic groups, and relying on interpreters, and all sorts of things are happening. There is lots of information around in antenatal clinics and so on but, in terms of interventions and their relative harms and risks, I have yet to see anything published in that area that women have access to and that midwives can pick up and discuss with someone who is asking about the pros and cons of epidural or some other intervention.

Senator DENMAN—Just one more question. Various ethnic groups were mentioned. Do you have problems with, let us say, the Vietnamese women who have not got anyone to interpret for them, getting information through to them, or do you have someone you can access who can help them with this?

Ms Fischer—In New South Wales, there is the Health Care Interpreter Service.

Senator DENMAN—Yes, but it is not available everywhere.

Ms Fischer—There is a telephone interpreter service available as well and people can ring up a number and book a telephone interpreter. It is a problem, though, and a particular problem if you have to rely on family members sometimes to communicate complex information at a time of stress. Each area tends to have different concentrations of ethnic groups, and I would say the interpreter service, if it does not exist everywhere, it should exist and it should be expanded.

Senator GIBBS—Is that a state or a Commonwealth service, the interpreter service by phone?

Ms Fischer—It is state.

Senator GIBBS—So it would not be everywhere; it depends on your state.

Ms Blatch—Yes.

Senator TCHEN—In your recommendations, you said basically that the Commonwealth needs to identify maternal and infant health as a national health priority. Do you cover the whole range of the birth process from prenatal through to postnatal in your description here?

Ms Fischer—Yes.

Senator TCHEN—On 2.1, you said focus of maternal infant health from provider to consumers. What do you mean by consumers?

Ms Fischer—The woman giving birth, the baby or the babies that are born.

Ms Blatch—The family.

Senator TCHEN—How far down do you define the postnatal period?

Ms Blatch—If you are referring to follow-up, we believe there should be methods in place so that women can be followed up 20, 30 or 40 years post-interventions, for example. Really it is a continuum of evaluation of interventions and care, not just ending four weeks into the postnatal period, because it clearly goes on for some time.

Ms Fischer—You may not need to follow every single person throughout their entire lives, but certainly there should be mechanisms which allow follow-up of people who have been at particular risk for various things or have had more interventions. Some of the things that we have no information on are questions that we cannot answer. We cannot answer because we do not have that follow-up information.

Senator TCHEN—Following on from that, one of the issues of the terms of reference is to look at early discharge. By discharging the mother early, basically you remove the need for postnatal monitoring from the hospital. The question is: should we develop a more comprehensive monitoring and assistance program for the mother and infant after they have gone home for the postnatal period? If so, how should it be funded, in your view? Once they leave hospital they are out of the medical system.

Ms Blatch—Up to now, part of the Medicare funding that was made available for early discharge programs was built in that what should be evaluated is the effect and satisfaction of the mothers with the early discharge program. It is hard. You would really need to either do discrete studies looking at samples of women over periods of time, taking a sample from a representative group of hospitals providing those services, or it could be as part of a community health database.

Senator TCHEN—No, I am not talking about data collection but actually how to provide the service.

Ms Blatch—To provide it from a hospital or community based?

Senator TCHEN—Yes. How would you fund it?

Ms Blatch—Commonwealth funding through the states to hospitals to develop an early discharge program with visiting midwives based at the hospital so that there is that contact made before the woman is discharged home. There should be links back to the hospital should they require it.

Ms Fischer—Some hospitals already have formal early discharge programs in place where the hospital midwives are early discharge staff, if you like. They go out to visit people

and their babies at home in the first week after delivery. One of the problems with that is that it can be difficult for a woman who wants to be on the early discharge program to actually get a place. It depends how busy it is when you have your baby whether there is a place. There are also problems because there are some private hospitals, for example, that are now offering three-day packages for people who have no additional private insurance. With first babies, for example, people are going home after a three-day package and attempting to get on to a public hospital early discharge program for help with things like breastfeeding and so on but are unable to access those services because there are not enough.

In the UK, in the days when I did midwifery, the continuity was there in that we could take a domiciliary patient into hospital and deliver our own patient in hospital if there was an indication for doing that. We would accompany her home at 24 hours, visit twice a day for 10 days and then hand over to the health visitor, who followed that child until it went to school. This was not necessarily every day or every week; there were categories for how often people were followed. But there was a continuum through the system which meant that you identify problems and give assistance if needed. We do not have those sorts of mechanisms unless, perhaps, the community nursing service was expanded to incorporate a midwifery service. That might be one option. Certainly a regional set-up which allowed linking back through the system to other sources and plugged people into proper audit procedures and so on would be advisable.

Senator TCHEN—I do not know whether it is proper to ask you to look at it again to see whether, from your study of the services being provided, that exist, that gap can be filled in and how it should be filled in. It seems to me that a lot of medical and hospital practices are now cost driven so funding is an important thing. It is all very well to say we can provide a service for this sector. The next question is who is going to fund it. I do not know whether it is proper to ask you to actually have a look at this again and perhaps make a supplementary submission.

The other thing—and I probably need to ask the chairman whether it is proper—is that in your recommendation No. 3 you say that a number of previous recommendations should be adopted. Should I ask the witnesses here actually to submit those items or whether the secretariat can help.

CHAIR—That is an interesting point that you raise, Senator. It is an entirely proper point, so you may put it to the witnesses and/or you may put it to the secretary, whichever you wish.

Senator TCHEN—I might ask you to actually identify those recommendations and submit them again because, for one thing, it will save the secretariat trying to second guess which one you actually meant.

Ms Fischer—We meant most of them, if not all of them. But the reason we have listed them like that is that some of these publications had up to 30 recommendations of their own, some of which are perhaps too detailed for this inquiry.

Senator TCHEN—I was a bit concerned that your submission might just go in as it is and we will not have any further look at it. It might be appropriate really for us to have some of the earlier recommendations. Some of them go back four years.

CHAIR—That is a good point, Senator. I think what the witnesses are saying is that they want to adopt all the recommendations of the following reviews on the assumption that all of them have not been implemented.

I would like to ask you a question. On page 8, I think you may have a wrong word. Having read it three times, it is contradictory, so please help me. Paragraph 4:

In private hospitals, the overall rate of caesarean section is significantly greater than the rate in public hospitals.

Emergency caesars are 13 compared to four. The next paragraph goes on to say that emergency caesarean rates are the same but elective is the difference. So in that first paragraph it would seem to me, if you had written there, 'Elective caesarean rates vary in New South Wales from 12.9 to 13.2 down to four', then it would be consistent with the data. Is it possible that you have said 'emergency' in that paragraph when you meant 'elective'?

Ms Blatch—Possibly.

CHAIR—Could you just look at it? The next paragraph says:

The rates of emergency caesareans are similar in private and public hospitals,

So the first paragraph says there is a massive difference. I think you mean 'elective' in that first paragraph. Is that right?

Ms Blatch—Yes, that is correct.

CHAIR—If it is not, ring us up and we will change it again. But I think it is elective. It is called 'not fair' when I am sitting here reading this. Everything else is so exciting and I come to this and it is counter-intuitive. I had to go back on it three times. If you agree that that should say 'elective' then I will be comforted. It would also be consistent with the data over the page and with what other witnesses have said. It is easy enough to understand the point you are making but I just need to be clear. You are happy that that is the wrong word?

Ms Blatch—Yes.

CHAIR—The New South Wales Pregnancy and Newborn Services Network and Centre for Perinatal Health Services Research has sent us a copy of the New South Wales midwives' data collection. It is actually fantastic. You are advising us that the patient classification—hospital 1, private 2—has been removed. Can you tell the committee why and from when?

Ms Blatch—We were mortified because we use that variable a lot in terms of analysing trends and comparative analyses between hospitals. We are not quite sure, but a new form is only created every two or three years. So I am afraid we are going to have to live with it for

another two or three years, but we are going to make representations to the department of health that it be reinstated.

CHAIR—Can I just say if I was asking for a patient classification I would not call them ‘hospital’ and ‘private’. Have you understood hospital and private to mean public and private, because you do have private patients in public hospitals.

Ms Blatch—Yes. And Medicare and private.

CHAIR—The classification here actually does refer to the health insurance status.

Ms Blatch—Yes.

Ms Fischer—Yes.

CHAIR—You would write down this was a private patient at a public or a private hospital. This fascinating book, I might say, was quite interesting. We had the federal department along to give evidence, and the federal department was wringing its hands and saying, ‘We can’t tell which hospital because some of them are private and some are privately insured patients; that is not data we are entitled to.’ Then of course we could say to the Australian Institute of Health and Welfare, ‘But this data’—they told us—‘is available in annual reports from hospitals and in state reports.’ So I asked the federal health department what would happen if they inadvertently got to see what they are apparently not entitled to see when it is on the public record all over the country. I think they are still fanning themselves. They also told us that there were state laws of privacy that prevented the federal department being provided with this information. Do you know of any such privacy laws in South Australia that would prevent a hospital providing this kind of data to the state’s perinatal statistics unit or whatever it is called?

Ms Blatch—No, we do not at all.

Ms Fischer—We are not familiar with individual states’ privacy legislation but I think that it can sometimes be something to hide behind. This is really audit and quality assurance and epidemiology.

CHAIR—What we have to do is perhaps put a question to the department. I may have misunderstood what they were saying, but they do say to us sometimes that they would not know that, that they would have to go back and ask the state if they could provide the data. If I turn to this book, page 86 for example, ‘Confinement by onset and augmentation of labour and hospital—New South Wales 1997,’ it seems to list, as far as I can tell, every hospital where a baby is born. That does not necessarily give you the private or public status of the patient. Is it fair to say that if it is a private hospital that all the patients delivered there would be private?

Ms Blatch—We can analyse the data in two ways: we can analyse it by their insurance status, whether they are public or private, or we can analyse it by the facility that the birth occurred in. You will find that there it is reported like that. We certainly analyse it both ways.

CHAIR—You can be fairly sure that you can just talk about the number of private patients delivered in private or public hospitals across the country.

Ms Blatch—Yes, we can.

CHAIR—That would have to be layered over your hospitals because, while you can say all patients in private hospitals will be private patients, some patients in public hospitals will be private.

Ms Blatch—And some patients in private facilities are public insured too, patients that prefer to pay up-front rather than have private insurance.

Senator GIBBS—So they are electing for that admission.

Ms Blatch—They just pay for that episode of care.

CHAIR—They may not be privately insured but they are being treated as a private patient. It is the treatment rather than how they pay for it. I think we are little bit confounded by a contradiction in the amount of evidence. This certainly seems to provide just about the answer to every question, unless there are some that I do not know of.

Ms Blatch—We can also do analyses of things like caesarean section adjusting for risk, for whether the mother has hypertension or whether it is a breech presentation or there is gestational diabetes or a malpresentation. We have done that. We have done analyses adjusting for risk and comparing patients born in public facilities with those born in private.

CHAIR—This book is *New South Wales Mothers and Babies*, and I have not found the page that says ‘Home births’. Is there one?

Ms Blatch—It is there. It is towards the end. In 1997, 154 women were recorded as having a home birth and, of those, 36 per cent were actually transferred to a hospital for a higher level of care.

CHAIR—I interrupted Senator Gibbs before in her questions. I would just like to return to them briefly. The maternal deaths were, you suspect, under-enumerated because not all state certificates have to make a reference to a pregnancy or the puerperium. Can you tell us about the death certificate associated with home births or is our conversational guess right, that such a death would have to be referred to the coroner?

Ms Fischer—It is a standard death certificate no matter where a death occurs in New South Wales. There is not a separate death certificate for home births.

Ms Blatch—It is just a standard form filled in by the medical practitioner.

CHAIR—There are two sorts of deaths—those that go quietly to the grave and those that go to the coroner. Usually they go to the coroner if there is not a continuity of care or an assurance that this death is other than a normal one. If you have been treating somebody for

high blood pressure and a wobbly heart and they fall off the ladder and are dead, the local GP may say 'Heart at

tack,' and we are all happy. But for home births I do not think you would say that. I suppose you could easily find out for us what happens with a home birth death and what it would say in the death certificate. That would be helpful for the committee—as long as it is not a major search and destroy.

Ms Blatch—I will see whether they are also referred to the New South Wales Maternal Perinatal Committee which reviews all maternal deaths.

CHAIR—That would be very good, thank you. Does the death certificate problem also apply to deaths following home births or is that just back to your problem about pregnancy may not be mentioned?

Ms Fischer—The general problem in New South Wales is that there is no pregnancy related question on the death certificate, so we could be missing deaths out there at three to four weeks that may have a pregnancy component.

CHAIR—Does the state data collection system enable you to identify the number of births started at home and finishing in hospital?

Ms Blatch—Only if the independent midwives choose to fill in a form. A lot of them are completing forms, but we suspect that not all of them are.

CHAIR—But if they finish in hospital, wouldn't the hospital midwife have to complete a form?

Ms Blatch—Yes, if they finish in hospital, they would fill in one of those forms.

CHAIR—Where on this form would I find labour onset spontaneous at home? I see it is on the top right: place of birth—hospital, theatre, labour ward, birth centre, planned birth, planned home birth. So you would tick planned home birth and then you would fill in the form?

Ms Blatch—Yes.

CHAIR—Thank you. You need a PhD to fill it out. I like this category of record: 'baby, plurality'. It took me a while to realise, but I suppose that means whether there is twins, triplets or we are going for the big eight. Just remind me, what does APH under obstetric complications stand for?

Ms Blatch—Antepartum haemorrhage.

CHAIR—Thank you. Augmented with ARM—Republican Movement?

Ms Blatch—Artificial rupture of the membrane.

CHAIR—That one I did remember. PPH?

Ms Blatch—Postpartum haemorrhage.

CHAIR—You would need to be a bit au fait with the world in which you are filling in the form. If you could find out why the New South Wales data collection people have decided to remove the patient classification, that would be extremely useful—but only if that is not a major challenge for you. We thank you for that data.

Thank you very much indeed for this extremely useful submission. I like the way you tell us how you got started. I am now overloaded with specialist research data collection analysis groups in New South Wales. We have had witness after witness today. It is extremely useful. What is more, they have all been very good submissions because they are full of data and references to research papers and so on. So this is not anecdotal evidence. It has been extremely helpful to the committee. Thank you very much indeed.

Ms Fischer—If I table a couple of good articles that come from the *Guide to effective care in pregnancy and childbirth*. One of them talks about national strategies that the committee may be interested in.

Ms Blatch—Also, I do not know whether you have copies of the NHMRC *Care around preterm birth* booklet for parents.

CHAIR—We would welcome that too, thank you very much indeed.

Ms Blatch—That was the booklet I was referring to when I said there was no system in place, no mechanism, to disseminate it throughout Australia. It is a wonderful document, but it just sat in the NHMRC.

CHAIR—It certainly seems to me that there is now emerging a huge body of research work but it is not influencing the practice—or sufficiently so—and that you are recommending a national impetus to changing these processes. While it may be okay in New South Wales, if we are talking equity and better impact, it really ought to be available to all the families across Australia.

Ms Blatch—It is a real challenge to flow it on to the clinical practitioners.

Ms Fischer—And to the consumers, because the NHMRC is putting in enormous work and public funds to develop some terrific guidelines but the Commonwealth Department of Health and Aged Care seems to sit and wait for that to filter down through the profession. We wonder whether there could be some proactive mechanism at Commonwealth level whereby that information is picked up by the Commonwealth department of health and distributed down through the state departments of health so that the pregnant women actually get their hands on it. I am not suggesting necessarily a Sheila Kitzinger exercise of league tables of every maternity hospital, which was revolutionary in Britain. But that actually caused a lot of changes in practice because things were public for the first time and consumers could compare what was happening in different sites.

CHAIR—You may not be suggesting it, but it is worthy of consideration. The committee thanks you very much for appearing today.

Proceedings suspended from 3.13 p.m. to 3.26 p.m.

EVANS, Mrs Lynn, Clinical Midwifery Consultant, Royal North Shore Hospital

McCANN, Ms Yvonne, Divisional Nurse Manager, Royal North Shore Hospital

MAHER, Miss Catherine Ann, Midwifery Educator, Royal North Shore Hospital

CHAIR—The committee prefers all evidence to be given in public, but should you wish to give your evidence, part of your evidence, or answers to specific questions in camera, you may ask to do so and the committee will give consideration to your request. We have before us your submission which is No. 150. Is there anything you would like to add to that?

Ms McCann—We have a summary, if you would like to hear that for a start.

CHAIR—I was just going to say if you would like to make a brief opening statement and then we will have some questions.

Ms Maher—Yes. We would like to take this opportunity to thank the Senate Community Affairs References Committee for the invitation to address our submission to the inquiry into childbirth procedures. As a group of hospital based midwives, we saw this as an opportunity to address specific issues related to the terms of reference. These issues have been presented from the perspective of clinical midwives practising in a tertiary referral centre. As a result, you will note that our submission is more specific to our clinical environment but we believe that many of the issues raised can be extrapolated to the wider community.

Birth is a social event. For many women, pregnancy will be the first time that they connect with the hospital system. What happens to women during the course of their pregnancy and birth can have a profound effect on self-esteem, relationships and parenting ability. Interventions that have been addressed in our submission must be considered in light of their potential implications to women and their families.

This opening statement will address some salient points related to our submission. Term of reference A relates to antenatal services. We support and encourage any opportunity to validate antenatal screening tests to the Australian population. The use of ultrasound screening is worthy of particular scrutiny and should be considered in light of the social, ethical and financial implications of screening.

Currently, we offer all women the opportunity to have ultrasound screening for Down syndrome. In offering this service, the midwife is moving into the realm of the genetic counsellor. Midwives are finding the discussion of prenatal screening with all women at 10 weeks of pregnancy at times very confronting, and many midwives feel very ill prepared for these discussions. The results of this screening test are expressed as a risk factor—a high risk or a low risk for Down syndrome. Midwives are concerned that women may interpret the low risk result as no risk. We would like to be a part of research that examines women's perceptions of this type of screening. Equity of access to this screening must also be determined along with the financial implications of this service.

Terms of reference B and C refer to birth interventions and the variations in such procedures between public and private patients. The Royal North Shore Hospital has both a

tertiary referral and a community focus. Northern Sydney has the highest number of women over 30 years of age giving birth in New South Wales. The impact of a co-located private hospital has also been significant. Few women with private health insurance and a normally progressing pregnancy birth with us now, a reduction from 50 per cent to 15 per cent. We are attracting more women with a complex pregnancy due to the nature of our service. Our preterm birth rate has risen from 10 to 15 per cent in the last year. The reduction in the number of privately insured women has impacted on our labour ward staffing needs.

Most commonly, two midwives are required to attend a birth. Previously, with the high percentage of privately insured women, only one midwife was required for the birth due to the presence of the woman's obstetrician. As a result, the same number of midwives are providing care to more women with complex pregnancies who are most likely to be uninsured. Our epidural rate, though decreasing, is still significant. Many women we see have decided during their pregnancy to have an epidural for pain management during their labour. There is limited opportunity for labouring women to mobilise in our clinical environment. Decreased mobility in labour has been demonstrated to increase maternal needs for pain relief.

CHAIR—'Mobilised' meaning to walk around?

Miss Maher—Walk around, yes. In addressing term of reference D, we would like to reiterate our concerns related to choice for women. Target figures for caesarean section rates, for example, are difficult to meet when dealing with factors such as an older group of women, the case mix of a tertiary referral centre and the impact of numerous practitioners and their management of care. We are concerned that, when the concept of baby safety is indiscriminately introduced in relation to birth options, choice effectively is removed for women. Documentation is often inconsistent regarding discussion with women; for example, discussing vaginal birth after having had a caesarean section previously. Also, if a woman chooses to have her baby by caesarean section, we must ask ourselves whether this is an informed choice or a choice motivated by fear, misinformation or a perceived risk to baby or herself?

In response to term of reference E, we believe that the team midwifery programs can provide a sound alternative to birth centre care, particularly in an area health service such as our own that does not have a birth centre. Team midwifery and its foundation of continuity of care giver is also applicable to the woman with a more complex pregnancy. The team midwife is a valuable member of a multidisciplinary team and provides assessment, education and support throughout a woman's pregnancy. We support the continued development of this model of care. We are continuing to address the points under the term of reference E in the midwifery exchange program between the far west region of New South Wales and Northern Sydney Health. To date, eight midwives from the far west have exchanged to Royal North Shore and Ryde Hospitals and two more exchanges have been planned for this year. Royal North Shore and Manly Hospital midwives have had the opportunity to practise both midwifery and nursing in a remote setting as part of the exchange.

To conclude, in response to term of reference I, we would add to our submission the value of consumer input, particularly in written information that is given to parents.

Information given should be regularly re-evaluated and reflect the best available evidence. The midwives that have prepared this submission feel that we have raised a number of relevant issues related to childbirth practices that are worthy of consideration. Whilst we do not propose the answers to these issues, we believe that their recognition in a wider forum such as this will go some way to address our concerns and the concerns of others. The continued development of multidisciplinary groups to examine childbirth practices is relevant in an era of research based practice. We thank the committee for its consideration of our submission and look forward to any questions. Thank you.

CHAIR—Thank you very much.

Senator GIBBS—On page 12 you talk about Aboriginal and Torres Strait Islander women and women from a non-English speaking background. You have here that the perinatal mortality rate for the far west region of New South Wales is 18.2 per 1,000 births, the highest in the state. Why is that?

Miss Maher—It is very difficult to give an answer for these figures. Perhaps a lot of these women do not have access to antenatal care or perhaps they may present quite late in their pregnancy for antenatal care. Inherent problems with the Aboriginal community, such as those related to diabetes for example, may result in more problems for these women during their pregnancy and certainly with the birth of their babies. There are probably numerous reasons for that. These figures come from the midwives data collection. Unfortunately there is not a lot of background given into the reasons behind that, so one can really only surmise. From talking to the midwives who practise in this region, being able to provide the care for women in these areas is quite difficult.

Senator GIBBS—Are the midwives who are practising there Aboriginal?

Miss Maher—In this particular far-west region, no.

Senator GIBBS—Other witnesses have told us of the problems. This is a huge problem with Aboriginal women, and we really do have to look into it very seriously. In other states we have been told that the women do not go to hospital for antenatal care—they might go once—because they do not consider themselves to be sick.

Miss Maher—That is right.

Senator GIBBS—And they are not, of course. They see hospital as a place to go to if someone is sick. Also, they feel very uncomfortable going to these places because they will not be amongst their own people there. Then there is the problem of women who live in the communities having to come in and give birth. Mention has been made many times that some of these problems could be alleviated if more Aboriginal women were to be trained as midwives. Aboriginal women throughout pregnancy and giving birth then would feel more comfortable. How do you feel about that?

Miss Maher—A separate arm of the exchange program we are now looking at is the possibility of developing a maternity support workers program to work in conjunction with

these midwives in this particular region. You have probably heard of the James Cook University program which is run by Alison Bush.

Senator GIBBS—Yes, we have.

Miss Maher—Looking at the role of the Aboriginal support worker and the Aboriginal health worker in caring for women in their own communities is certainly something that those communities are very much aware of and will be working towards. There is a push from Broken Hill, in particular, to look at this project that we have implemented and somehow articulate with that.

Senator GIBBS—South Australia is introducing a university course where midwives, women or anybody can go to be trained; you do not have to be a nurse. Apparently, at the moment, nurses do a year of midwifery. South Australia is introducing a four-year university course where anybody can be accredited. It is thought that this will enhance the status and professionalism of midwives. Do you have any feelings about that?

Mrs Evans—Direct entry is very common in other countries. We have heard of the direct entry programs in New Zealand and how well they are going. I think Australia is moving towards being ready for direct entry. I certainly think that a certain number of women and midwives out there are interested in direct entry midwifery, breaking away from the traditional role of nurse and looking more specifically at midwifery practice and the ‘wellness’ model of midwifery care. That certainly seems to be the main theme and ethos in direct entry midwifery training. There will probably be increasing support for that in Australia. We have very little information about it here; we have little exposure to it. But it is going very well in New Zealand and other countries, so I think we will look forward to that.

Senator GIBBS—You say that the North Shore Hospital does not have a birthing centre.

Mrs Evans—That is right.

Miss Maher—There is no birthing centre within the Northern Sydney Area Health Service.

Senator GIBBS—None at all?

Miss Maher—No.

CHAIR—Is there any intention to get one?

Miss Maher—Yes.

Ms McCann—Yes, in mid-2001. We are well into the planning process of a new building which will have a birthing centre as part of its make-up.

CHAIR—Why?

Ms McCann—There was a great deal of support for having dedicated space for a birthing centre in the early planning stages of the site. Because it is well and truly in place, we are at the moment developing plans. The architects are in and there are two arguments. One is that, philosophically, one does not need to have a birthing centre to be able to practise active birth and the philosophical delivery of that type of care. But also a number of people at North Shore believe that having a dedicated space as a birthing centre would be advantageous. The girls have been at North Shore much longer than I have; I have only been there for nine months because I came in late. Perhaps Lynn might like to comment on that.

Mrs Evans—It is quite clear to us that a number of women from our area health service travel across the bridge to access birth centre care. This is a fact and has been a fact for many years—as long as there has been birth centre care at the Royal Hospital for Women and also at King George. So we know that women will travel to a centre that delivers the kind of care that they want and that currently we are not delivering.

Miss Maher—There is a significant number of home births in the Northern Sydney area as well. That perhaps provides another option of care for women who may want a home birth or a further choice to the ones currently available to them in Northern Sydney. This is another option that hopefully will be available to them.

CHAIR—Senator Gibbs and I have seen a huge number of birthing centres now, and we recommend strongly that you case the joint at the Queen Elizabeth Public Hospital.

Senator GIBBS—It is wonderful, the best.

CHAIR—Our view is that they have got the best birthing centre anywhere.

Senator GIBBS—I found it absolutely fantastic. If a woman is giving birth in your hospital, what is the process? She lies there on her back?

Miss Maher—Preferably not on her back. We are restricted by the fact that our labour ward rooms, delivery suite rooms—whatever you would like to call them—are very, very small and are dominated by the presence of a bed. So active birth is particularly difficult in our environment. There is also a large amount of through traffic outside the delivery room.

So, essentially, the woman is confined to a very small space. We believe that that significantly impacts on our use of pharmacological methods of pain relief because we do not have a private place where women can mobilise, move about and do what they want to manage their pain of labour. They are very much restricted to a very small area.

Senator GIBBS—So it is a very clinical process.

Miss Maher—Yes.

Senator GIBBS—If a woman wants to squat down and give birth on the floor, do you allow that?

Miss Maher—She can do that. Anything is allowed. Unfortunately, the only restriction is the space.

CHAIR—Do you pick the bed up to allow her to do that?

Miss Maher—We remove the bed from the room and put it out in the corridor for people to trip over.

Mrs Evans—Most of the furniture seems to sit outside in the corridor to make room. Also, women cannot access water in labour. We have one bathroom for eight delivery suites.

Miss Maher—That also contains the only toilet in the labour ward.

Senator GIBBS—It is very antiquated.

Miss Maher—It is. If you want to use the bath for a long period in labour, you cannot because there maybe three or four other women who have had their babies who would like to have a shower before going to the postnatal ward.

Senator GIBBS—I can understand that.

Miss Maher—It is all contained in the one room, so we are very restricted.

Ms McCann—In the planning of the new building, obviously rooms are much bigger.

CHAIR—When was the Royal North Shore Hospital built?

Miss Maher—In 1936, and it has not changed a lot since then.

Ms McCann—The King Edward was built in 1820.

CHAIR—Wasn't it in the 19th century?

Ms McCann—There have been no improvements to the building since 1936, with the exception of some wallpaper and paint.

CHAIR—Is that right?

Senator GIBBS—We should have inspected it.

CHAIR—I am sorry, King Edward was probably 1917. I must not take you into the 19th century.

Senator GIBBS—We would advise you to go South Australia's Queen Elizabeth Public Hospital. It is wonderful.

Ms McCann—It just so happens that next month we will be in Adelaide. We will make a point of doing that.

Senator GIBBS—Look up Dr Pridmore. He is a wonderful man.

CHAIR—You might also be very interested to know that the Queen Elizabeth Public Hospital maternity ward is the one most under threat. It has the best birthing centre and the lowest caesarean section rate. The committee is interested to note these facts.

Senator GIBBS—The team is one of midwives, and Dr Pridmore is there just in case. I notice that you say that ‘historically, the caesarean section rate at the Royal North Shore has always been higher amongst privately insured women’. We are finding this everywhere we go. What is your reasoning or what are your ideas for this? We have heard many and varied reasons and ideas throughout our travels.

Mrs Evans—We have mentioned here in our summary that the target that seems to get the finger pointed at it most in our area seems to be that of the older women.

CHAIR—Old at 30?

Mrs Evans—Yes, the age group of greater than 30-35. Of course we have a higher rate because the women are older and they have more caesareans. I am not quite sure why that is, but that is most often the reason quoted. Yes, we are tertiary and, yes, we have a complicated case mix—but so do other hospitals—but our women are older. That is the reason that is frequently given.

Senator GIBBS—So older women cannot give birth vaginally?

Mrs Evans—I think they can but apparently not where we work.

Miss Maher—Another rationale that is used relates to the number of assisted reproduction pregnancies; that is, women who have undergone an IVF procedure in order to become pregnant with what is termed the ‘precious baby’ quite often choose the option of birthing their baby by caesarean section because of the perception that birthing by caesarean section is somehow safer. We often hear, and perhaps you often read in the Sunday papers, for example, of women in our particular area health service who are very articulate and highly educated making the decision that that is the way they would like to birth their baby. These are the rationales that we are often given when a woman is admitted to have her baby on the next day by caesarean section. Talking to her as to why she is having her baby by caesarean section, the response will be ‘because that is what I have chosen to do’.

Senator GIBBS—We have heard quite a lot also about women who are demanding to have a caesarean section. These are older, wealthier, well-educated women who, as Senator Crowley has been saying constantly, have suddenly found this power—after our not having had it for centuries and centuries—in the delivery room. Do you believe that women are given all of the details? We have seen articles in the paper where a woman has stated, ‘I had a caesarean because I didn’t want to have any pain; it was painless.’

Miss Maher—Yes, we hear that.

Senator GIBBS—Do you believe that these articulate and well-educated women are well informed when it comes to caesarean section? Are they told, ‘These are the things that can go wrong with your body’? Are they informed, ‘These are the things that can go wrong with your baby; if he or she comes out normally, he or she wakes up to the world, but otherwise we have to wake the baby up’? Are they well informed about what can happen to them? Are they told, ‘This is major abdominal surgery you’ll be going through and you’ll probably be laid up with excruciating pain for the next six weeks,’ as opposed to, ‘Yes, this will be really tough and it is painful, but most women get through it. A few hours afterwards, when you have showered and got your baby, you will be returning to near normal because nature has this wonderful way of making you forget these sorts of things’? Are these women informed totally?

Miss Maher—To be brutally honest, we would have to say no. There is very much a perception in women, certainly with the women I meet through clinical practice, that a caesarean section is an easier option—‘I can plan when I’ll have the baby; I can organise my husband to have leave from work at that particular time; my mother-in-law is coming from the country, et cetera.’ You hear it all.

We certainly hear from our obstetricians that they feel that, if a woman comes to their rooms and says, ‘I’d like to birth my baby by caesarean section,’ their perception is that she is exercising her right to choice. We are concerned that the discussion seems to end there and that issues related to morbidity for the mother and for the baby and perhaps discovering the real reasons for her choosing this method of birth—as we have identified before, it may be related to a previous birth experience, fear or misinformation—may not always be dealt with.

It is very difficult for us as midwives in caring for these women in that, if they are privately insured, you do not meet them until the day they come in to have their baby. We sit there in front of the database thinking, ‘Well, what is the reason for this caesarean section? What is it that we can enter for the computer records?’ That can be quite challenging.

Senator GIBBS—It must be very difficult for you if you suddenly have this woman who is very healthy, nothing seems to be going wrong, and there is an elective caesarean section. Professionally, it must be a little difficult to come to terms with.

Miss Maher—It is. You can find that you have been in a situation where on one day you have been working in the clinic, spending a lot of time talking with a woman who has fears about childbirth—which is very natural—and she may have the perception that a caesarean section may be an easier option. You have spent a lot of time with her going through the whys and wherefores and trying to uncover and deal with those fears that she has only to be working in another area the following day and having women admitted who are just coming in for elective caesars for whatever reason. It can be quite professionally challenging and, as I say, the difficulty is that you have not had time to develop any real relationship with these women because you have not met them before.

Senator GIBBS—Do you believe there should be national best practice guidelines—guidelines whereby doctors have to be audited and everything has to be accounted for—and if there were, would this reduce a lot of caesareans?

Mrs Evans—I certainly think it has to be a good thing to look at our practice, whether we are medical or midwifery staff. If there were guidelines or indicators to guide us in that way, that can only be a good thing. I guess that formulating those would be extremely difficult because of the geography, the variation in individual practice—a whole host of reasons. I guess it would be a tricky task to try to develop that, but I think it can only be a good thing. We all have to be accountable for what we do and why we do it, and if such indicators or guidelines could be available to the consumer, they have got to be better informed as well. I think it can only have a positive effect.

CHAIR—When you get your *Hansard*, you will not have the submission of the previous witnesses, the New South Wales Pregnancy and Newborn Services Network for Perinatal Health Services Research—maybe we should provide it to you. On page 12 they have commented:

Increasing maternal age is not an absolute medical indication for caesarean section, yet in Australia a woman having her first baby between 35 and 39 years of age has a 39.9% chance of being delivered in this way if she is privately-insured and a 31.1% chance if she is Medicare-insured.

That is a reference from Day, P. et al (1999) *Australia's mothers and babies*. I think it is just really to remind you that at least some people are prepared to write down what you were saying as being the case. I want to thank you for your honesty. Has the Royal North Shore Hospital vetted what you have said, or have you just come here?

Ms McCann—As the divisional nurse manager I certainly have. The divisional medical head is very familiar with the fact that the submission has been written although, due to illness and various things, he has not actually read the full submission. He has, however, read the summary paper, which you heard in the first opening remarks, and thought that was excellent. The executives of the hospital were fully informed, but they also have not read the actual submission.

CHAIR—I think the three of you, in your comments, in the submission or in answer to questions, are, one could almost say, brutally honest. It is extremely refreshing for people on this side of the table to have you assisting our inquiry in this way. This is a public record document, so I cannot say that everything you said will be treated confidentially because it is now on the public record. I do think it is a great help to have the honest appraisal. It may not be the only appraisal, but it is a great help to us to have your comments. I want to ask whether you have any views about what would be the most effective means of reducing the level of intervention when you know there is no medical justification for it.

Ms McCann—I guess I would like to start on that one. Last year we employed a perinatologist for the first time at Royal North Shore, and we are certainly very keen to set up a perinatal unit with appropriate antenatal ambulatory care so that we actually reduce the length of stay and can monitor people appropriately. It is a refreshing change. Many of the obstetricians at Royal North Shore have been there for a very long time. They were trained

by their predecessors and have not necessarily always learnt to do things a different way. In that sense, in relation to some of the answers we have given today, if you were to ask the obstetricians the same questions, they would argue that there are some good reasons for doing this.

I recently asked a question on why a primigravida having a breech birth was not able to be delivered vaginally, and the brutal honesty was that many of the obstetricians have never actually learnt to do that. It was deemed 20 or 30 years ago by the people who were in the position of teaching that that was not a safe practice. Perhaps there was an adverse outcome for one, two or maybe 10 women; I have no idea. As a result of that, that practice has not become part of their repertoire. I think that, by bringing in new, more contemporary members of the obstetric staff, we will have a much better chance of changing some of those practices. Certainly there is a commitment by a number of the obstetricians to change practices. There is certainly a commitment by the divisional head to continue to challenge and to look at why we do things and what the outcomes are. There is also a fairly solid belief that a caesarean section is not necessarily a bad thing. So the only approach is probably our continual chipping away and educating and moving with the doctors, and particularly supporting the contemporary practitioners.

CHAIR—Your evidence is really interesting. You actually suggest to the committee that there is a new breed of young obstetricians coming into the profession who are more open to non-caesarean section intervention.

Ms McCann—That is true.

CHAIR—Where are they learning this?

Ms McCann—Not all of them, of course, trained at Royal North Shore.

Mrs Evans—I think there is also a really strong commitment from the midwifery staff to see a better way of doing things. We certainly have midwives who get out and about and who go to conferences and seminars and find out how the rest of the world practices—as we shrink into the corner, sometimes, wishing to go into obscurity. We bring back information and we try and share it with our colleagues. We are very motivated. We are looking forward to a new physical structure that is going to make such a difference in the minds of midwives.

I know that people will argue, ‘Can’t you apply birth centre philosophy no matter what room you are in?’ But there is a lot of anecdotal evidence to suggest that, no, you cannot. You cannot actually apply a birth centre philosophy in the kinds of spaces we have when you do not even have the physical environment that meets a basic birth centre kind of criteria. So I think we will see a bit of a shift in thinking, along with our midwifery colleagues. It is very hard to be a change agent in an environment where there has been in the past such a heavy medical dominance as far as caesareans, inductions and so forth go. It has been very difficult for midwives to effect a change in their own practice. I think a change in the environment will see a change in our midwives as well. They are ready for it; they are looking for it.

CHAIR—It certainly sounds as though there are a number of ways in which this might be pushed, as in a new building and a possible new culture. I would like to also say, just for your interest and for our further confusion, that when we visited the Mercy Hospital we were told—not on the record, but Senator Gibbs has put it on the record any number of times since, bless her—that the doctors there were saying, ‘There are a couple of us who are old enough to remember how to do breech deliveries. When we leave the system, there will be no younger obstetricians confident to do breech deliveries vaginally. It will all be done by caesarean section.’ We can say to them now, ‘Don’t fret. All of you young chaps at the Mercy who don’t feel confident, go to the North Shore. There is a new breed of young obstetricians going through there.’

Mrs Evans—There is one.

Miss Maher—The only other comment in relation to that question would be that the motivation to change comes from the women we care for. We introduced a team midwifery program 18 months ago, which was a very bold step at Royal North Shore. We are finding now that women are coming back for subsequent babies and demanding to be on this program. We are filling up this program very quickly. I think we have already taken all the bookings for most of April; there are very few vacancies for women booking in now who are having a baby in April. It is a very popular program. I think the more women who join that program and participate in that continuity of care will realise that that is the way to go and they will vote with their feet. They will say, ‘We won’t come here unless we can have that type of continuity of care.’ I think that will spill over to the midwives providing the care, and we will be looking towards starting a second team.

CHAIR—That is amazingly encouraging. Is this submission endorsed by the Royal North Shore or is it endorsed by you? I am not suggesting that you are going to get into trouble, but do let the committee know if you are. Is it endorsed or is this what you and the midwives have written?

Ms McCann—It is a submission that has been written by the midwives. It has not been formally submitted through Royal North Shore for endorsement, partly because the time frame was very limited, and there was no opportunity to get it through the formal processes. Certainly the divisional medical head is well aware of it, and I am the divisional nursing head, but it has not been through a formal process.

CHAIR—I want to ask you about this interesting outreach program that you alluded to earlier:

R.N.S.H. has been the major participating hospital in a midwifery exchange initiative with remote areas of N.S.W. This midwifery exchange program continues at the time of this report. The project leader is Professor Marie Chamberlain .. This exchange program was funded by the N.S.W. Alternative Birthing Services Program, Department of Health, in October 1998. This one off allocation of funds was for \$33,800.00

What do you buy for that out west?

Miss Maher—What we have bought is the cost of the midwives. It has involved the travel costs for the Far West midwives coming to us and the travel costs of the northern

Sydney midwives going to the Far West. They are paid while they are here—they are costed at working a five-day week and it is their salary.

CHAIR—Do you have any sense that this funding will continue?

Miss Maher—We would hope so. We hope that the evaluation of the project will be so favourable that the project will continue. We do have a fairly limited number of midwives who practise in these regions—for example, Walgett Hospital has a total of four midwives on staff, and all four have rotated to us for experience in the exchange program—but a finite number of midwives can access the program within that particular region. I do not know whether there is a possibility of extending it to other regions. We have had a fairly strong relationship with this region since about 1994. We have been sending the student midwives out as community midwifery replacements for the Far West. This grew from that and Professor Chamberlain's previous experience in working in the Arctic with indigenous communities.

CHAIR—I am really very interested. Is the alternative birthing services program state funded?

Ms McCann—It is funded by the Department of Health in New South Wales. Certainly that is where the funding came from.

CHAIR—Is it federally funded? I understood that the alternative birthing service program was a Commonwealth funded program.

Miss Maher—Yes, I think it is a Commonwealth initiative.

Ms McCann—It may well be. It is probably administered by the New South Wales Department of Health, but we submitted to the Department of Health in New South Wales.

CHAIR—It is a little difficult. Western Australia also have an alternative birthing services program, which they said was going to be effectively doubled by the state government putting in its money. It is difficult to know what dollar is which, particularly as alternative birthing is one of those public health services that is now rolled into the one program. They have broadbanded the whole of women's health in obstetrics care, breast cancer, cervical cancer and family planning, and they have passed the money to the state. What is that broadbanding called?

Ms Brodie—I cannot remember the name of it. My understanding is that those areas have been banded together. The alternative birthing services program is a national program that gets devolved down to states for dissemination at a local level.

CHAIR—I understand it is part of the broadbanding—I think we will have some great fun at estimates yet again. A year or so ago all of this funding was rolled in together. It was broadbanded and it was cut by 10 per cent, not your usual three per cent for efficiencies, so I am interested to know why it still carries this name—whether it suits the state government to call it that or whether it is still a designated Commonwealth dollar that is coming through

the system. That is something we will pursue, unless you can provide some information for us.

Ms McCann—We could certainly provide that information for you.

CHAIR—We have run out of time and we have got to catch planes at the end of the day, so I do not want to go over too much. As I have said, I do want to thank you very much. It is an extremely useful submission. It is refreshingly open. You are not the only people who have been refreshingly open—it is called one of the reasons why we have kept women down for so long: they are all coming along before this committee and saying all sorts of marvellous things. They are to be followed by a good young obstetrician, a male, who is about to come before us and be equally as honest and open. But I think it has been very interesting to have such a lot of input from midwives with the research and collaborative and cooperative data. I can only wish Royal North Shore Hospital well. Do you think we should come and get photos, before and after?

Ms McCann—You are most welcome.

CHAIR—We probably will not be able to, but we would be very appreciative if you would do so—

Ms McCann—We could send you some.

CHAIR—Actually it might be very useful to do that, because it is kind of heartening. If you are actually really struggling in a confined space and about to get a whole new lovely refreshing thing, it would be wonderful to see.

Ms McCann—We are very excited about having a new building—for all the reasons we have discussed today.

CHAIR—Exactly. Thank you very much for your contribution today.

[4.08 p.m.]

PESCE, Dr Andrew Francesco, Staff Specialist, Division of Women's Health and Newborn Care, Westmead Hospital

CHAIR—Welcome, Dr Pesce. In what capacity do you appear today?

Dr Pesce—I am a Staff Specialist in the Department of Obstetrics and Gynaecology within the Division of Women's Health and Newborn Care, and I am appearing as their representative.

CHAIR—The committee prefers all evidence to be given in public but, should you wish to give your evidence, part of your evidence or answers to specific questions in camera, you may ask to do so and the committee will consider your request. The committee has before it your submission, which is No. 34. Would you like to make any alterations to that submission?

Dr Pesce—No.

CHAIR—Could you make some opening comments and then field questions.

Dr Pesce—Yes. I would like to raise the salient, central point of the inquiry, which I interpret from the terms of reference as being variations in childbirth practices, intervention rates especially. I believe I would be speaking for my colleagues when we say that the differences in intervention rates need to be interpreted with caution. Certainly, as a part-time staff specialist and part-time private practitioner, I think I get a good feel for both sectors, and it is easy for me to see lots of reasons why in different scenarios you get what might appear to be quite significant and interesting differences in intervention rates, but often have fairly unexpected explanations—such as the sort of confidence in the facilities that one is working with, whether that is in a public or private sector.

So we would be always cautious when interpreting intervention rates and that is why, in medical studies which are published in the literature, a great deal of effort goes into trying to eliminate variables which might not be obvious—which is why we do randomised controlled trials. Interpreting intervention rates from disparate groups from different studies, and often even from different countries in the world, needs to be done with caution. That is not to say that there are not significant differences which this committee is obviously interested in.

As a division, we would express the view that, if there were ever to be any recommendations on changing of resource allocation, we as obstetricians believe that the funding for maybe more complicated and higher risk obstetrics is not compromised and increasing funding be diverted to normal obstetrics—in other words, taking resources away from higher risk and, therefore, maybe medically more important work in terms of disease and morbidity prevention, and allocating resources to programs which, although increasing satisfaction rates with normal obstetric and antenatal intrapartum practices, did not necessarily improve outcomes to the same extent that concentrating on the more abnormal things might. That probably sums up what my division would like me to say.

CHAIR—You are a brave man, Doctor—particularly brave to put the allocation of resources as you just have. I would like to ask you if you can talk about that a bit more. We have had some evidence to the committee that the allocation of resources can directly affect the practice of, in this case, obstetrics, and that the biggest factor to reduce caesarean section and other intervention in America was when the funding for a vaginal birth was changed so it became a higher amount than for a caesarean section and, for the first time in some years, the caesarean rate plunged. So the committee is aware that how things are funded may indeed have an effect.

I said ‘brave’ with a little bit of irony, but not entirely, because you are suggesting that you would not like to see too much transfer of funding from the medical intervention to what might be associated with a lower intervention rate and a high satisfaction. I wonder if you could comment on that. Before you do, though, what evidence can you give the committee that says that there is, in terms of the research, a justification for the differences between private and public patients in terms of caesarean section? We know it is a complex matter. We know there are a number of factors that get in. We know of no research—in fact we have been given evidence to the contrary—that says that, if you did adjust for all the variables, you would still find privately insured patients way out of the arena. If you know of research, the committee would welcome reference to that. Can you please expand on why you would not like to see resources taken from medical intervention and put to midwives?

Dr Pesce—I did not say ‘medical intervention’. I said care for higher risk and probably abnormal pregnancy. That does not necessarily mean caesarean section—

CHAIR—I beg your pardon. You are right to make me have the words right. Thank you.

Dr Pesce—So I am not saying that I promote funding for intervention. I am saying that I can see a scenario where, with the limited health dollars which we have been faced with for many years, whenever you increase funding for something you have to take it away from something else and presumably, if there is a soft or hard cap on funding for obstetric or childbirth services, that increasing funding for, say, community based domiciliary care has got to come from somewhere. We may be able to take it from a state budget here and a federal budget there, but at the end of the day it is going to come from somewhere else.

In answer to your question, for example, we have a very good domiciliary midwife program, which a lot of other hospitals have, as well. Research was done on the domiciliary midwife program when it was introduced at Westmead and it showed very high satisfaction rates, with women being discharged appropriately after being screened for risk factors; being visited at home by midwives and thinking it was a fantastic service—and it was. It just so happened that it cost more than conventional in-hospital postnatal care.

CHAIR—Can you give us the data for that?

Dr Pesce—I do not have it here, but it was published in the evaluation of the project. It was something which stuck in my mind. I said, ‘That’s good.’ It was not twice the cost but it was a higher cost.

CHAIR—Can you give us some indicators as to why it would be higher to have midwives out in the community than to have obstetricians?

Dr Pesce—I do not know. I presume it might have something to do with that fact that, when you set up a new service, you set it up ideally to make sure that you meet all the patient's needs. I would say to you that probably in the public hospital setting at the moment, in the postnatal wards, it is not set up to meet the patients' needs. Possibly, if you had the same midwife to patient ratio and you were able to spend the same amount of time with a patient, the patient satisfaction would be higher—and the costs would be higher as well.

It was quite a coincidence today that I saw about five postnatal patients who were delivered at the public hospital where I work. I am a great advocate of the public system. I was proud to be an intern at Westmead and I have done all my training there and I want to see it as a great unit. They said that the labour ward staff were fine, the midwives looked after them fine, they were happy with the delivery and all that sort of stuff, but they were really disappointed in the postnatal care that they achieved. That is probably not necessarily fundamental to this inquiry's objectives but, in a roundabout way, the point I am making is that sometimes the things which are much more important to the women having babies have not necessarily always been addressed in the hurly-burly of the midwife versus obstetrician turf war.

CHAIR—Did they say what was unsatisfactory about their postnatal care?

Dr Pesce—They anticipated that they would be given more assistance in coping with a newborn baby—especially the first time mothers. That is very difficult to deliver in the current public hospital environment: help with their breast feeding and help with mothercraft—the old-fashioned term, I suppose.

CHAIR—Not a bad term. If you could give us the reference or even send us that report, that would be fantastic.

Dr Pesce—I will have to send it to you. It was not a huge increase: it was probably a 10 per cent to 15 per cent increase. For the number of patients cared for, it is slightly more expensive.

CHAIR—It would be interesting to know what was counted towards the cost in both of those equations.

Dr Pesce—That is always very interesting.

CHAIR—Yes, it is indeed. One of the things that has fascinated this committee has been the evidence that says the money spent on ultrasound is about 50 per cent of the total antenatal birthing and postnatal care bill in this country—not a bad place to go for some dollars perhaps, Doctor.

Dr Pesce—It is increasingly a popular option for our trainees.

CHAIR—Meaning what?

Dr Pesce—A higher proportion of our trainees are finishing their training and going into ultrasound and imaging rather than into getting up at night and delivering babies.

CHAIR—I thought with your actually agreeing that we can find the money for all those midwives and alternative practices by reducing the number of ultrasounds.

Dr Pesce—It has to come from somewhere. If you make a decision that you want to provide new services and you need new funding for them, you have to get the money from somewhere.

CHAIR—And if you had research that showed that ultrasound makes not the slightest difference to the outcome in the majority of births?

Dr Pesce—That would be a very obvious choice.

CHAIR—We have been given that evidence. We have been told, fairly reliably, although it may be plus or minus \$10 million, within the ballpark of accounting, that 50 per cent of the total costs for antenatal, birthing and postnatal—hospital care, specialist care, the lot—is for ultrasound testing, in the face of evidence that it makes no difference to the outcome, in the majority of cases.

Dr Pesce—Yes. I think you have to look carefully at why that situation has arisen. I actually do have some knowledge of this, in terms of my position with the National Association of Specialist Obstetricians and Gynaecologists. I have been involved in the negotiations which they have been having to try to change the funding for obstetrics and gynae ultrasound. We would make a very strong case that a lot of the problem is in a failure of appropriate ordering of the investigation. There are a lot of women who turn up to my antenatal clinic or private rooms who have already had two ultrasounds before they have even come for their first visit, where it is likely that those ultrasounds were a waste of money.

CHAIR—Where did they get them, doctor?

Dr Pesce—They were ordered by their GPs. Women do not mind having ultrasounds, I can tell you. I have women asking me to see the baby. Their husbands come and they want to see the baby. I do not charge for it. I have a scanner in my rooms and I will give them a very quick look. I guess you could call it part of the bonding process. But, certainly, there is probably a problem in the fact that—especially at general practitioner level—there may be quite a large degree of inappropriate ordering of ultrasounds, not only in pregnancy but also in gynaecology. I am sure that we could decrease the funding for ultrasounds by keeping it more for well accepted and probably sensible indications, have very little difference in clinical outcomes and yet save a lot of money.

CHAIR—That is right. I appreciate that kind of contribution.

Senator GIBBS—Just as a matter of interest, can you deliver a breech vaginal birth?

Dr Pesce—I thought I would get asked that question, so I looked up my statistics. The vaginal breech delivery rate is 65 per cent in my private practice.

Senator GIBBS—Well done!

Dr Pesce—In Westmead Hospital, it is 55 per cent.

Senator GIBBS—It is a pleasure to meet you, actually, because we have heard so much about how obstetricians do not do breech birth and would rather do the caesarean. When we met this wonderful doctor at Mercy, he was actually talking about the deskilling of obstetricians, and it is quite a worry.

Dr Pesce—There is no doubt that that is a factor which a lot of people are concerned about and it has been the subject of a letter to the college publication recently. We have a proud history at our hospital. We actually get women coming to our hospital from the place that was represented just before me, when women have not been given the option of a vaginal breech birth, because they can get that option.

It is very easy to take a jaundiced and cynical view of this. But I must say that, as an obstetrician who delivers babies, you need to be comfortable with what you do. I would not want anyone to see an obstetrician and get a vaginal breech delivery from an obstetrician who was not confident in a vaginal breech delivery—in the same way as you would not want to press your gynaecologist to do a laparoscopic hysterectomy rather than an old-fashioned abdominal hysterectomy. Each practitioner has to practise in the way that they practise best, and I think they are the best judge of that.

There are obviously lots of variables in a decision as to why you might do a vaginal breech delivery or why you may choose to avoid it but, at the end of the day, the practitioner has to be comfortable with that type of delivery. I suppose this is a big problem when there is no choice available. So, if you are in a situation in a city where there are no people that do vaginal breech deliveries, it is a big problem. I suppose, as long as there is choice and people know that there are obstetricians who do vaginally delivered breeches, it is not as crucial an issue.

Senator GIBBS—No. I take your point. But also it has been put to us that, because it is so easy to do the caesarean rather than do the vaginal breech delivery, doctors are not receiving any sort of training or practice in this area. They would rather do the caesarean because they are not comfortable.

Dr Pesce—When you say ‘easy’, it is not easy: if the vaginal breech goes well, it is easy. There are two types of vaginal breech deliveries: there are the easy ones and the difficult ones.

Senator GIBBS—We are told of obstetricians who just cannot do them at all. Older obstetricians are quite worried about this, because it is the deskilling of the profession.

Dr Pesce—As someone who does vaginal breech delivery, I guess I am speaking on behalf of the people who do not. When I have a woman who has a vaginal breech

presentation, I will not say I have to work really hard at it but I have to spend more time convincing women that they should try for a vaginal breech delivery than I spend convincing the ones that I do not think should to have a caesarean. It is not uncommon, especially in the antenatal clinic—where presumably the patient may have less confidence in me or know that I am not going to be the one delivering the baby and that they could get anyone—that, when you have seen them at 36 weeks and they have a breech presentation and you have talked to them about vaginal breech delivery and how we encourage women to choose vaginal delivery options as long as they do not break any of the safety rules that we have established, they go away saying, ‘That sounds like a good idea.’

You offer to turn the baby and try external cephalic version, because that will increase your vaginal delivery rates when you do get them around. That is all fine. But then they come back two days later and say, ‘No. I have been talking to all these people out in the community and I really am very worried about this and I would rather just have a caesarean section. I want what is best for my baby. I know that caesarean might be worse for me but I have heard all these terrible disaster stories about stuck heads and things like that. I am really, really worried. I am not comfortable about it and I would rather have a caesarean section.’ In the same way that it is important for the obstetrician to be comfortable with what they are doing, it is obviously very important for the woman to be comfortable with the type of delivery she is having.

I promote vaginal breech delivery. If they want to go for that option, we go for it. If they say that they want a caesarean, I have no difficulty in performing a caesarean. Given enough information, the mothers always make really good choices. On two occasions in 12 years I have had mothers who I think have made very foolish choices, but that is two occasions I can think of out of the thousands of patients I have cared for. It is like decisions about a termination of pregnancy. The only person who can make the decision that is right for that person and her child is the woman in front of you. We should maintain the skills to offer all options, and we should tell people of the risks and benefits, because that is what it comes down to. There is no operation which is so great that everyone should have one, and there is no operation that is so bad that nobody should have one. So, given the options, the patients make the right choices.

Senator GIBBS—You obviously give your patients the proper information, but we have been told on many occasions that the high rate of caesarean sections in Australia is because women are older and all sorts of other excuses—some of them would turn your hair. But they also say that women demand caesareans. They say, ‘This is the best way to go. We live in a perfect society and want to have a perfect child.’ It is painless. There are all these sorts of reasons why women demand to have caesarean sections. This is in the early time, but do you find that women demand to have caesareans?

Dr Pesce—I would like to think I have a relationship with my patients which means they do not have to demand anything. But there are patients who say to me that they want to have a caesarean section. I ask them why. I tell them what my view is, given the situation. It would usually be that it does not seem medically necessary and that it is increasing the risks of their having complications compared with a successful vaginal delivery. They still say, ‘No, I still want a caesarean,’ and I do a caesarean. My caesarean rate in my private practice is 14 per cent. I have never refused a patient request for a caesarean section, although it is

easier to accede to some requests than others. I go back to what I said earlier: you follow a policy of giving patients information, and if they still want a caesarean after all that information, there must be a reason for that.

Senator GIBBS—Yes, you cannot force them. Is the fear of litigation always behind your reasoning?

Dr Pesce—No. I give them what they want. I cannot believe that, as an obstetrician, I know so much better than a woman what is best for her that I can tell her when she wants a caesarean that she must not have one.

CHAIR—But wouldn't you know better? If you have a very healthy woman, the pregnancy is going fine, the bub is normal and healthy and she is saying, 'Well, I want a caesarean because I am scared of pain, because I do not want to lose my figure and because I think it is going to be painless,' wouldn't you consider that you do know better?

Dr Pesce—I tell them it is not going to be painless. They are deferring the pain until after the operation. If you are worried about pain, the answer is an epidural, not a caesarean. That is what I tell them. But that is what some women want. I am not going to refuse it to them, although my private caesarean rate is not high.

CHAIR—No, it is not.

Dr Pesce—Quite a proportion of that would be women with whom I tried for a vaginal delivery. Probably about a third of them were women who did not have significant indications for a caesarean. About a third of that 14 per cent would be women who I thought should go into labour and see what happens but who have said, 'No, I don't want to.' The main single group that contributes to that would be women who have had a previous bad experience during childbirth. It might be a difficult forceps delivery which may or may not have been done for good reasons. It may have been shoulder dystocia where the shoulder gets stuck—and that is a terrible disaster. It may just be that they had a really long labour, ended up with a caesarean section and do not want to go through that again. We know statistically that 30 per cent of women undergoing a trial of scar will end up with a caesarean section. You give them that statistic, and they say, 'Gosh, that's not good enough for me. Let's just go ahead and do the elective caesar.' For all of these women, I see very rational reasons why they have made their decision. You can quote medical statistics at them but, emotionally, they feel more comfortable and happy with the choice to have an elective caesarean.

Senator GIBBS—Do you believe we should have a national form of best practice guidelines?

Dr Pesce—I referred to this in my submission. Probably, in an ideal world that would be great. However, it is going to be difficult to arrive at best practice guidelines which are not a result of a predetermined ambition to achieve a certain end—and I say that scientifically speaking. If you look at the available evidence in the literature, it is very difficult to be scientifically honest and say that this is a guideline which we would recommend based on good scientific fact. For example, you yourself have talked about caesarean section, and there

is no doubt that some problems occur after caesarean section that do not occur after a vaginal delivery. Having said that, you should be wary of comparing successful vaginal deliveries with caesarean section because what you should be comparing is attempted vaginal deliveries, some of which will be caesarean section and whatever the outcome is, versus elective caesarean section. If you look at the few studies which address that, it is very difficult to be so confident of the stark differences in outcomes as to actively promote best practice guidelines in terms of caesarean section and who should have elective caesarean sections and who should not.

You have to be very careful about extrapolating what seem to be raw data which demonstrate very impressive differences, because there is no doubt that successful vaginal deliveries that do not have complications do fantastically well. Elective caesarean sections do not do too badly either. The worst group of all is women who have gone into labour and tried for vaginal delivery and who have had an emergency caesarean section. They have the highest complication rates of all. You have to balance those potential outcomes with all the variables that contribute to them.

Senator GIBBS—We heard today from the NH&MRC, and they were talking about the best practice guidelines. They were saying that you had to be very careful and that you had to have a set of guidelines that they could implement in consultation with other people which would look at all of these things.

Dr Pesce—They are in the business of making best practice guidelines. What do you expect them to say?

CHAIR—What does that mean?

Dr Pesce—They are the people who would be involved in drawing them up and doing the research to show whether they are working or not. Without being too cynical, they are the group of people who say, ‘You’ve got a problem? We can fix it for you.’ As obstetricians in current practice, we are proud of what we do, and we think that any quick fix solutions should be taken with a grain of salt.

Senator TCHEN—We have heard a lot of anecdotal evidence about the practice of caesarean sections, and I was interested to see that you unearthed an empirical study by Turnbull and others.

CHAIR—What page is that on?

Senator TCHEN—It is on page 6. Could you enlarge on what you have there?

Dr Pesce—That is *Women’s role and satisfaction in the decision to have a caesarean section*, which was published not long before this inquiry was announced. Are there any specific questions you would like me to address?

Senator TCHEN—Yes. Was it basically an attitudinal survey?

Dr Pesce—Yes.

Senator TCHEN—You have some quite interesting comparative statistics here. This is the paragraph on the bottom of page 6. Should I ask Dr Pesce to read into the *Hansard*?

CHAIR—Do you want it on the record that 91 per cent agreed or strongly agreed that they were satisfied?

Senator TCHEN—No, just to give us a different slant on the evidence we had before.

CHAIR—Sure.

Dr Pesce—Do want me to read it?

Senator TCHEN—No. You can talk to it if you like.

Dr Pesce—If you look at the consumer opinion, it does not look too bad. We can talk about caesarean section in terms of complications, outcomes for mothers and babies and cost for the medical system compared with vaginal delivery. This was a study which looked at women who underwent caesarean section in a teaching hospital in South Australia. When asked about factors which would indicate whether they seemed to be happy with the decision, my interpretation of the study is that it was strongly favourable—that the women who underwent caesarean section, in general terms, were fairly happy with the fact that they had a caesarean section and with the outcome.

It was interesting that a lot of the publicity given to this study had exactly the opposite point of view. The only way that I can explain that is that they had what I would think would be a very unusual interpretation of what meant the woman was happy or satisfied. They took the definition that unless a woman said she strongly agreed that the caesarean was necessary or that she had been given enough information, et cetera, there was an element of dissatisfaction. I think the worst statistic was that possibly 30 per cent of women thought they should have more say in the decision making process. But that meant that a woman who, in this survey, answered that she agreed she had had enough input into the decision making process was put down as someone who was dissatisfied. It might be cheeky of me to suggest that if politicians polling before elections used the same criteria, they would get very depressing results about the support for their respective parties—that only people who strongly agreed with their party's policies would be found to be satisfied.

Senator TCHEN—There is a very strong preference for a politician to get dissatisfaction at the moment, before elections. That is very important for us.

CHAIR—Would you care to comment about any steps to make a survey of this sort internally valid?

Dr Pesce—It was internally valid. It was just that the spin, if you like, reflected a predetermined wish to paint the current practice in a poor light.

Senator TCHEN—Would you be able to supply us a copy of this publication?

Dr Pesce—It is in the *Medical Journal of Australia*.

CHAIR—I think we have it, or we can get it.

Dr Pesce—I am sure you can get it.

Senator TCHEN—At the end of your paper, in your section ‘other comments’, you make reference—I am interpreting here—to the fact that the committee should treat with caution this body of academic midwives and the opinions of the midwifery movement. If I read you correctly, you have not talked to any of the independent midwives.

Dr Pesce—Not as part of the submission. We do not have any independent midwives in that.

Senator TCHEN—If I can come back to the paragraph that is before the caesarean section and that is about homebirths, is that another empirical study?

Dr Pesce—That was published in the British journal. Could you clarify exactly what you mean by ‘empirical’?.

Senator TCHEN—That means evidence based rather than anecdotal.

Dr Pesce—It was as evidence based as the data that was available allowed it to be. It was a review of all of the reported homebirths. Not all homebirth outcomes were reported so, in that way, it was not a complete study. But it was based on all of the reported homebirths.

Senator TCHEN—And that result meant that homebirths were regarded with certain reservations.

Dr Pesce—As an obstetrician reading that article, it would seem to me that it showed that homebirths were being performed in situations which are not appropriate—for example, twin pregnancies and breech presentations. The message of that, probably if anything, was that there was a higher morbidity than should be expected for home births, which are meant to be for low risk confinements. If you compared it to the overall national statistics for morbidity for low risk confinements, there was a significant increase in morbidity and perinatal mortality. But if you actually look at it, it was probably because of an inappropriate use of home birth in clinical situations which were not low risk. I think that is a fair summary.

Senator TCHEN—Basically, you require prior screening then to identify which are suitable for home births?

Dr Pesce—I think almost all home birth practitioners would say that that was necessary, yes.

Senator TCHEN—So an obstetrician’s early involvement, before the choice is made, is important?

Dr Pesce—It does not necessarily have to be an obstetrician. Once again, I think it is a matter of giving open and honest information. It does not have to be an obstetrician giving that information. I am sure a midwife could give that. The homebirth option is chosen by an extremely small group of women in our society.

I have had discussions with a very prominent homebirth midwife—I do not see any reason not to name her—Maggie Lecky-Thompson. I enjoyed my discussion with her and she herself volunteered that the impact of the homebirth movement was not going to be to move birth to the home, but to civilise hospital births. I think she is absolutely right. I think that in the last 10 to 15 years, since it has become very apparent to any obstetrician that obstetrics was being practised in a way which was not necessarily either beneficial to mothers or making them happy, obstetricians have been changing their practice. I think it is obviously easier for young people coming through the training scheme and starting out in private practice to practice a different type of obstetrics than that practised by 60-year old obstetricians.

I would like to place on the record the statistic that the average age of obstetricians practising in this country is 55 and that 25 per cent of them are over the age of 60. I guess that shows—if they are that old—that it is harder to anticipate that there could be any change in the way that obstetricians practice. It is unlikely that they are going to make major changes to the way they practice. You also have to ask why it is only the older people who are practising. Younger people are not coming through and practising obstetrics. I guess that is not the point of this inquiry.

Senator TCHEN—Thank you.

CHAIR—That could be extremely interesting. By all means, tell us.

Dr Pesce—I do not know the answer. I can just give you my opinion.

Senator GIBBS—I thought you were going to enlighten us.

Dr Pesce—I will let my wife tell you why.

CHAIR—Could you comment on the threat of legal action contributing to young doctors deciding not to go into obstetrics?

Dr Pesce—My honest opinion is that I do not think people do not go into obstetrics because of the threat of being sued—you never worry about being sued until you get sued. As a younger obstetrician, I have never been sued yet and the threat of being sued really does not worry me that much. But I can tell you that the day it happens, it will really worry me and may well influence the way I practice after that. I believe the reason that people are not going into obstetrics is because of the impact on lifestyle. The rewards are there if you like obstetrics. You do not do obstetrics for the money, you do obstetrics if you enjoy doing obstetrics.

Increasingly now, the culture of working really hard and devoting your life to your practice and being on call all of the time for your patients is something which does not sit

comfortably with modern attitudes to life. My wife does not expect to be the suffering obstetrician's wife and be alone and bring up the children on her own, as my senior colleagues' wives have done for generations. She gives me hell, and it is making me change the way I practice. We are getting into group practices, and that is very slow. I think the reason that people do not want to go into obstetrics is because in the current way that it is practised it does not satisfy people's expectations of where they want to be in their life in 10 or 20 years time.

CHAIR—And where is that?

Dr Pesce—Probably going to the movies, going to the art gallery occasionally—

CHAIR—So it is lifestyle.

Dr Pesce—being able to go down to the South Coast for a weekend without having to—

Senator GIBBS—Actually seeing your kids occasionally.

Dr Pesce—Yes.

CHAIR—So it is lifestyle, rather than wealth.

Dr Pesce—Lifestyle has a lot to do with it. I think also there has been a culture of denigration of our speciality, which has a real impact on morale. I speak of this as a serious minded sort of young practitioner. Everyone wants to have professional pride in what they do, and that is why I do vaginal breech delivery. Anyone can do a caesar. Elective caesar is the easiest operation there is. Anyone can do that. I take pride in the fact that I can lend my skills, which not everyone has, and that is where I can say, 'I made a difference today,' whereas any GP down the road could have done an elective caesarean. So I see it as a source of professional pride.

I suppose that when we look at responding to the criticisms about obstetric interventions and all of those sorts of things, it is part of this distressing culture of denigration which we perceive as being directed at us by not only midwives or health administrators but even our colleagues. They do not get up in the middle of the night to deliver babies, but they will often snigger and devalue what we do. I think that has had a huge impact on potential trainees' decisions to enter into the work force.

CHAIR—That was a very interesting contribution, and I thank you very much for that. Last year or the year before I wrote a report on the status of teachers and the denigration of that profession leading to low morale and, therefore, to lesser good outcomes in terms of teaching. I think the points that you raise are very nicely connected. Maybe that is something that we will have to pursue further.

I want to ask you, Dr Pesce, about the curious language of the last part of this report 'Large body of critical comment of current obstetric practice'. I know you have to go, but I just want to ask one or two questions before the bell rings. The academic midwifery movement—a bunch of ferals?

Dr Pesce—No, not at all.

CHAIR—Please explain.

Dr Pesce—For a long time our profession has been critical of academic obstetricians—people who do not actually involve themselves in practice, who do not deliver patients anymore. They sit in university departments and they tend to be called in by lawyers who want an expert witness for the plaintiff in medico-legal situations. They sit up there and say, ‘This was obviously a terrible thing to do, and the patient has suffered and the baby has suffered because of this.’ The further they are from everyday clinical practice, the less they can understand why the practitioner chose the path that he or she chose in that particular case. So that is how I preface my remark.

CHAIR—It is an interesting comment but, given that you would argue that obstetricians can feel that their practice is affected by low morale, would you allow that the same could happen to midwives?

Dr Pesce—It does happen.

CHAIR—Can you say why it happens?

Dr Pesce—Because, whenever there is implied or overt criticism, it affects you. If someone says, ‘You are a terrible politician. You do not represent your constituency very well,’ you would probably be offended and defensive about it.

CHAIR—We will not go into what we might do, but I do think it is interesting to note, though. I think your comments about obstetrics, or any other part of the medical profession, are interesting. But at least you can feel attacked from a position of being well-recognised and favoured in the community. Would you agree that midwives are still struggling for fair recognition in this country?

Dr Pesce—It depends. If you mean in terms of how much they get paid, probably yes. If you mean in terms of what my patients think of midwives, no.

CHAIR—No, not what the patients think. It is interesting. We have just heard from witnesses from the Royal North Shore Hospital, who said that once the midwifery team was known to patients they have actually sought it out when they have returned to the hospital for their next pregnancy. Would you allow that there is any truth to the claim that midwives are still battling for fair recognition? Let me put it to you this way: if a woman asks a doctor for a caesarean section, then the doctor in the end—even you, Doctor—would say, ‘Yes. In the end I’ll do what the patient wants.’ If a woman asks to have an alternative birth, a home birth or a birthing centre birth she is still regarded as a bit odd.

Dr Pesce—I think your comments about home birth would be accepted by obstetricians, because—though you will never be able to prove it statistically—there are going to be certain situations which are fully retrievable in a hospital setting which may not be retrievable in a home setting. But hospitals in Sydney have birth centres. If women want to go to birth centres, they can go to them. I do not think anyone considers that odd.

CHAIR—Women witnesses have told us that they have a much harder task if they are trying to have a birth with no intervention than they have if they want intervention. The obstetricians are much more likely to intervene than to not intervene.

Dr Pesce—Sure. But I would say to those women that they should have the information made available of those obstetricians who are happy to have minimal levels of intervention.

CHAIR—I think that is fantastic. Would you do that? Do you reckon that we could have a list of all obstetricians and what they are prepared to do published in the *Sydney Morning Herald* each week?

Dr Pesce—I think that it would be fair to publish hospitals' intervention rates.

CHAIR—All hospitals?

Dr Pesce—I think so. You have to be very careful that you make sure that, if there are real reasons why there might be higher intervention rates in certain settings—because, for example, they have a higher risk population—that is made clear to patients and that all of a sudden patients do not make assumptions which are not valid. I suppose that is the problem with league tables. Teachers do not like them. IVF units do not like them, and I can see that there might be problems in that.

The way that I would address that would be to say that, in the same way as independent midwives seek out the obstetricians that they know will support them in their problem deliveries and not pour scorn on them for attempting a home birth or whatever, there is more of a network out there so that women who are interested in lower intervention vaginal breech deliveries can probably seek that out. The problem with breech delivery is you do not know you are going to have one until the end of the pregnancy. So you are booked in to see somebody, then all of a sudden it is a breech presentation. Are you going to change your obstetrician at 37 weeks? That is obviously very different.

CHAIR—That is true. But I think your comment about people having more information about the general practice of their practitioner is very interesting. I am sure that many of your colleagues would have a fit at this time and would be saying, 'No way. I need to have the right to decide in private, without having my figures up in lights.' I think what you are saying is very interesting.

Dr Pesce—We are talking about a group of older people who were educated and brought up in the era where expertise was given authority. I see myself with expertise, but not necessarily as an authority when it comes to dealing with my patients. And that is why, if they want a caesarean, I will give them a caesarean. I will do it the best way I can.

CHAIR—We are nearly out of time, but I must say that I find it very interesting and would like to know your thoughts on the contradiction—if any, but I think there is curious contradiction—between best practice that the obstetricians might arrive at and, if she asks for it, doing an intervention anyhow.

Dr Pesce—I think that an obstetrician has to stop short of doing something which harms a person who has no input into it. Therefore, I would never do anything which I thought would harm the baby. I have had a woman who asked me to do a caesarean section at 32 weeks for no reason at all, and I refused—she had twins—because those babies would have suffered, and they did not make the decision. It is like people saying, ‘I am not going to have a blood transfusion.’ With full consent—if I have satisfied myself that I have given her, and she understands, the information—I have no difficulty with her making a decision which affects her health and wellbeing.

It brings me to something interesting which I heard on a radio interview between Robyn Williams and Professor Watson, who is the co-discoverer of DNA. Robyn Williams, like myself at the time, was obviously a person who thought that—this was about genetic cloning, DNA research and so on—the government was going to have to be very strict and make really important rules about who can clone, in what situations you can clone and about genetic engineering. Professor Watson said, ‘Are you stupid? How much suffering in this century has been caused by governments who—well meaning or not—decided that they were going to make decisions on behalf of their population, and how much suffering has been caused by people who thought they were making the best decision for their children, unborn or born?’ That brought the point home. Women very rarely make a bad decision.

It is unfashionable to have a caesarean section. It has its disadvantages, but it has its advantages. Just because it is unfashionable does not mean we should ignore the advantages of caesarean section, and we should not overplay the disadvantages. If a woman is told and understands that she has a 50 per cent higher chance of getting a pulmonary embolus and possibly dying and still says she wants to have a caesarean section, then she is taking the risk for herself. I cannot see—

CHAIR—And if she is told that the caesarean section will prevent the baby having the benefits of its breathing being assisted by vaginal delivery.

Dr Pesce—There are statistical data which show higher admission rates to special care nurseries, et cetera, for respiratory distress. It is difficult to point to an increase in long-term morbidity or mortality in babies who undergo elective caesarean section. If you talk to a woman who has had an intrapartum stillbirth for no apparent cause at 41 weeks, you will have a very hard time explaining to her that the disadvantages of elective caesarean section outweigh the potential disasters that might affect her in a vaginal delivery.

CHAIR—The trouble is that you are dealing with the desire of parents to be safely delivered a well baby.

Dr Pesce—Yes.

CHAIR—I understand that. You cannot talk to anyone who has had a stillborn at 41 weeks. That is a matter of grieving with those people. I do not think you could predict after the event that you might have decided at 39 weeks to intervene—on what criteria? Presumably, a stillbirth at 41 weeks is, by and large, an unpredicted event.

Dr Pesce—Almost always, short of some sort of negligent action.

CHAIR—Quite. My last question is about horizontal violence. I am fascinated. This expression is nothing if not pejorative.

Dr Pesce—It is a term which is used by midwives. I actually do read a lot of midwifery journals, and I am very interested to follow them.

CHAIR—So it is a midwives term about how they fight amongst themselves?

Dr Pesce—Yes.

CHAIR—Does it apply to obstetricians disagreeing with anaesthetists?

Dr Pesce—Yes. We do not talk about it, but there is lots of horizontal violence within the medical profession.

CHAIR—Yes, there is. I am very interested. I like to take away a new expression. That is an amazing one. I have never heard of horizontal violence.

Dr Pesce—It is not my term.

CHAIR—It does not conjure up disagreements between two midwives. I am very glad the humorists are not here to get hold of it, because I am sure they would do something quite vulgar with it. It does suggest that there is a difference between midwives, like any other group of professional people.

Dr Pesce—The way I would interpret why it occurs would be that there are lots of midwives who have been working and doing the job the best they can for years and years and, presumably, providing what they see as a valuable service, and there is an implication that they have somehow been letting down the women that they care for.

I have no difficulty with the team midwifery projects which have been started up—and I do refer to it in my submission—but there is no doubt that, at this stage at least, there is a bias towards good care for women who are cared for by team midwives, because team midwives do not tend to have to look after two or three patients at a time in labour wards and conventional midwives do. It is really hard for the conventional midwives to accept that the conventional model of care which they have been providing is, in itself, somehow compromised, when they know that, if they could sit and be with their patient on a one-to-one basis throughout the whole labour, they might be able to provide some of the better outcomes, including patient satisfaction and lower intervention rates, because they are the ones sitting with the patient, they have their confidence, they are getting them pushing, they are not running out to see who is—

CHAIR—If you knew what you have just said to be true—that is, that having the one supporting carer, a midwife or an obstetrician, but let us say usually a midwife, through pregnancy and delivery gives a happier patient with less intervention—why aren't we doing it?

Dr Pesce—That is my opinion, yes.

CHAIR—Why aren't we doing it?

Dr Pesce—Because we do not have enough money to employ the number of midwives we would need.

CHAIR—That is a very interesting and excellent point on which to finish. Thank you again. You may not appreciate it, but I mean it extremely genuinely. We have not had too many people who have come along and been so very forthright. I said to earlier witnesses that I appreciated their honesty. I very much appreciate your contribution, and I think I speak for the committee. It is extremely helpful. If we are going to have to argue these cases out, we are much better assisted by people who are up-front and strong about the evidence. We thank you very much.

Committee adjourned at 5.01 p.m.

