SELECT COMMITTEE INTO PUBLIC OBSTETRIC SERVICES

Establishment - Amendment to Motion

Resumed from 10 May on the following motion moved by Hon Helen Morton -

(1) That a select committee of three members is appointed, any two of whom constitute a quorum, to inquire into and report on the adequacy of the decision-making process undertaken to determine that public obstetric services should be restricted in the metropolitan area to King Edward Memorial Hospital, the proposed Fiona Stanley hospital and four peripheral hospitals, as outlined in the "WA Health Clinical Services Framework 2005-2015" in September 2005.

(2) The committee is required to inquire into and report on the extent to which -

(a) the community was appropriately consulted;

(b) the community view was incorporated into the decision-making process;

(c) the community received feedback about how its views were treated;

(d) the proposed model is based on evidence applicable to Western Australia in respect of -

(i) service quality,

(ii) economics,

(iii) service sustainability,

(iv) risk management; and

(e) alternative models were appropriately considered and the reasons they were discarded.

(3) The committee, and the proceedings of the committee, are subject to chapter XXII of standing orders and it is to be regarded for all purposes as a committee appointed under that chapter.

(4) The committee may present interim reports without a requirement for leave and is to report finally not later than 30 June 2006.

to which the following amendment was moved by Hon Giz Watson -

Paragraph (1) - To delete all words after "committee of" and insert instead -

four members is appointed, any three of whom constitute a quorum to inquire into and report on -

(a) the adequacy of the decision-making process undertaken to determine that the provision of public obstetric services should be restricted in the metropolitan area to King Edward Memorial Hospital, the proposed Fiona Stanley hospital and four peripheral hospitals, as outlined in the "WA Health Clinical Services Framework 2005-2015" of September 2005, specifically the extent to which -

(i) the community was appropriately consulted;

(ii) the community views were incorporated into the decision-making process,

(iii) the community received feedback about how its views were treated,

(iv) this determination had regard to evidence applicable to Western Australia in respect of service quality, service sustainability, risk management, cost-benefit analysis and consumer satisfaction; and

Paragraph (2) - To delete the paragraph and insert instead -

(b) the models of obstetric service being considered by the government, including community-based midwifery, and the extent to which -

(i) the community will be appropriately consulted,

(ii) the community views will be incorporated into the decision-making process,

(iii) the community will receive feedback about how its views were treated,

(iv) this determination will have regard to evidence applicable to Western Australia in respect of service quality, service sustainability, risk management, cost-benefit analysis and consumer satisfaction.

Paragraph (4) - To delete "30 June 2006" and insert instead -

30 March 2007

HON SALLY TALBOT (South West) [2.03 pm]: I foreshadow a very minor amendment on the amendment moved by Hon Giz Watson last week, to correct a typographical error. The numbering of the third part of the amendment as it appears on the notice paper should have referred to paragraph (4), not paragraph (3).

When I concluded my comments last time this motion was being debated, I was just drawing to the attention of members the fundamental pull of the provision of health services. I was making the point that health planning must take account of two factors. These need not be in conflict, but often tension between the two manifests itself in the provision of maternity services. On the one hand, quality care must be provided close to where people live and on the other hand there is a need to provide specialist care in world-class facilities. There is no doubt that we have the opportunity in Western Australia to provide world-class facilities for women should they need them. The question then becomes: who accesses which services? How can they be spread appropriately through the community?

I touched last week on the importance of a woman having choice in the lead-up to giving birth; that is, having a sense of autonomy and agency in choosing what she thinks will be the best outcome for her and her family. I am reminded that some 20 years ago a big nationwide survey was carried out into people's experience of childbirth. I can remember reading the report of that survey with some interest at the time, having just gone through that experience myself. The interesting thing about the survey was that people's reported levels of satisfaction were related not to the actual experience they had, but rather to whether they felt they had retained a sense of control over the options available to them.

The many and varied reports into obstetric services in Western Australia identify at least a half a dozen different kinds of service provision. The first is the traditional hospital birth, which itself is subdivisible into tertiary and secondary care; tertiary being the provision of specialist services and secondary being more in line with the traditional hospital birth. There is also the general practitioner obstetrician option and GP shared care. Then there are the three options that were quite extensively canvassed in the report, to which I referred before, of the Standing Committee on Environment and Public Affairs' inquiry into a petition on primary midwifery care; that is, team midwifery care, birth centres and home birth.

In my electorate, around the Peel region, I have been fortunate enough to make the acquaintance of several members of a group called, appropriately enough, PRAMS, which stands for the Pregnancy Resources and Midwifery Support Group. A woman named Corinne Thorneycroft came to my office many months ago with her young son and put to me a very eloquent argument in favour of what she would say is not very appropriately named midwife-led care. She would rather refer to it as woman-led care, with trained birthing attendants providing the care. Depending on the outcome of this motion, I look forward to talking to Corinne and many of the other women who make up the PRAMS organisation in the Peel region about the input they would like to have to this inquiry.

I am sure that this is one of the things that has been on the mind of Hon Helen Morton as well as people on this side of the house who will be speaking on this motion. I want to make a particular point of this because it is true to say that we do not have an entirely level playing field when it comes to an evaluation of some of the arguments about appropriate types of obstetric care. The balance always tends to swing in favour of the medical profession's point of view. That is not always inappropriate, but organisations such as PRAMS and the other agencies that make up the Maternity Coalition have a very valid point of view that needs to be heard by people like us, who are legislating for the provision of these services, and taken very seriously. I will share with the house two comments that have been made by a woman called Justine Caines about the experience of the medicalisation of childbirth. I do this in the context of statistics provided by the Maternity Coalition. Research shows that only 15 to 20 per cent of women in developed countries need obstetric supervision during pregnancy or labour to achieve a good outcome for themselves and their babies. If people are interested in exploring that data in more detail, I refer them to the executive summary of the report into the petition on primary midwifery care by the Standing Committee on Environment and Public Affairs. Point 6 states -

> Intervention rates in childbirth in Western Australia are reported to be amongst the highest in Australia. In 2002, -

I dare say that some of my colleagues on this side of the house may have access to more recent figures than these -

> in Western Australia, 20 percent of women giving birth were induced; 51.1 percent of women had an epidural and 29.4 percent of women had a caesarean delivery.

In a sense, this redresses the balance of the argument from the medical profession about the need for specialist services and the capacity to intervene when intervention is necessary to save lives. The other side of the

argument is to adopt a path that will see the rate of intervention drop dramatically. It is in that spirit that I share these comments by Justine Caines, who states -

> . . . current obstetric practice in Australia is not about women, or even babies. It is about fear and control, the necessary ingredients in keeping maternity services dominated by the medical profession, and keeping the birthing of babies as big business.

Further into her article she gives us quite a neat metaphor for those experiences. She states -

> Unfortunately birth in Australia is dominated by medical practitioners. On the whole these practitioners only believe in the safety of birth after the event. To me this is most telling and explains our huge rates of intervention, and resultant morbidity.
>
> If the pilot responsible for flying the plane you travelled on was only convinced air travel was safe after he had safely landed the plane what would you think? Would you doubt his competence as a pilot? Think perhaps he should get another job? Would you doubt the safety of the actual aircraft?

That is a very telling metaphor for the sort of discussions that are relevant to this issue. On that note I will end my comments. I look forward to following the progress of this motion with some interest.

THE PRESIDENT: Before I give the call to Hon Robyn McSweeney, I understood that Hon Sally Talbot was proposing to move an amendment to deal with the numbering of a paragraph. As I read it, I do not think there is any need for such an amendment. If there were, it is something that we can come back to. Is the member proposing to change the time frame?

Hon SALLY TALBOT: I was acting only on the advice of the Clerks.

THE PRESIDENT: I am sure that the advice was very good but, as I read the motion, I do not see any need to change the wording because the wording on the notice paper does not conflict with what the member is proposing to do.

HON ROBYN McSWEENEY (South West) [2.14 pm]: I congratulate Hon Helen Morton on putting forward the establishment of a select committee into public obstetric services. Women comprise 51 per cent of the population. It is a sad indictment on this government that an issue as basic as access to choice for obstetric services has come into this Parliament in 2006. I am sure that women from all parties in this Parliament would agree with me that if men had to have babies, there would be an obstetrician on every street corner. That comment in no way means that having babies is just secret women's business, although there are probably some men in this chamber who wish that it was! Of course, having babies is very much a family affair. Men are very much needed before, during and after having a baby. The Standing Committee on Environment and Public Affairs, of which Hon Kate Doust and I are members, reported to the house on primary midwifery care in November 2004. Hon Louise Pratt was a member at the time of preparing the report. Dr Hilda Turnbull chaired a committee some years ago that looked into much the same issue. One of the issues in the report was the high number of births that were subject to intervention and caesarean delivery. From that we can conclude that instead of getting better, the situation seems to be going backwards in many ways. I refer especially to country areas. Many doctors will no longer deliver babies, partly because of high insurance premiums and partly because of the risk of being sued if something goes wrong. There are also difficulties in finding doctors who will work in regional areas as general practitioner obstetricians. In many regional areas doctors are not available even if the local hospital can accommodate patients. I will return to that point later. Hon Giz Watson asked the Standing Committee on Environment and Public Affairs, through a petition, to inquire into the preservation and expansion of primary midwifery programs in Western Australia and to ensure that measures are taken to make primary midwifery care a choice available to pregnant women in Western Australia. Hon Helen Morton quite rightly wants to know how adequate the decision-making process is and asks why obstetric services should be restricted to the metropolitan area, in particular King Edward Memorial Hospital, the proposed Fiona Stanley hospital and four peripheral hospitals.

I thought it was disgusting of the Minister for Health, Hon Jim McGinty, to say that he did not believe that members of the Legislative Council could contribute anything to the development of a maternity services plan. That is very high-handed. How can he pre-empt what the upper house will do? That goes for members on both sides of the house, especially the women members.

Birthing is a very personal event. It is up to a family to decide how and when its baby comes into the world and with what intervention. Having mentioned interventions, it is probably true to say that, concerning caesarean births, the wealthier a person is, the more likely she is to have a caesarean birth if she wants one. Caesarean births in the public system seem to occur only if there is a problem. If a problem occurs, the doctors will intervene and perform a caesarean. Otherwise, women wanting caesareans have to go private. It is their choice to do that.

It seems that this government is trying to depict an orderly structure in the metropolitan area for something that, for each woman, is a unique and different experience. If women from country Western Australia cannot have their babies in their home regions and must come to the city, that creates a flow-on effect. I had four children in five years some years ago. My youngest child is 22 years old. I feel quite qualified to comment on the reality of childbirth. I had my babies when I was very young, compared with the age of women who have babies now. I had finished having all my children by the time I was 26. These days, some women do not start having children until they are 35. The average age is probably 29 or 30. Hon Kate Doust advises me that the average age is 29. Women in this chamber who have had babies know that, with the first child, it does not matter how prepared a person is or how well read she is. Having a baby cannot be explained fully to an expectant mother. Women have to experience childbirth before they believe the reports on what it is like. I believe Hon Sally Talbot said that it is called "labour" for a reason. She is right; for some women it is extremely hard work.

Hon Simon O'Brien: What, you mean expensive?

Hon ROBYN McSWEENEY: I will let that one go through to the keeper.

I had my babies in a small country hospital, as did everyone else in the community at that time. I knew of only two women who had homebirths. One had a midwife in attendance but ended up having to go to the hospital, and a doctor came to the house of the other woman; therefore, homebirths certainly were not encouraged 26 years ago. Some women members of this place, such as Hon Giz Watson, had an advantage. She had a father who was a doctor and she was home delivered. Also for Hon Sally Talbot in England, homebirths were probably the norm. However, it was not the norm 26 years ago in small country towns in WA, and it still is not the norm in many parts of WA. I almost had my second child at home. The only reason I did not have my second child at home was that my husband said, "Oh, no you don't" and we sped into town from the farm. I think he had one eye on me and one on the road. When we arrived at the hospital I told him that he had to carry me in. He did not realise that the birth was as imminent as it was, and he turned around to get our other daughter out of the car. I ran up the hospital corridor and around the corner and said to my friend, who was a midwife, "Quick, I am going to have this baby." I still hold the record - I think it is about 40 seconds - for the shortest time in hospital before giving birth. I still do not know to this day how I ran up that corridor.

Hon Barbara Scott: You were very lucky.

Hon ROBYN McSWEENEY: Yes, I was very lucky. When I was about to give birth to my third child, my husband was stranded in Singapore due to an airline strike. I therefore waited a while and drove myself to the hospital about half an hour before I had Jason. I knew when I had my fourth child what other women had gone through, and I thought there would not be a fifth. However, I had to wait until I had the fourth one to find out what some women had been complaining about. I was, therefore, extremely fortunate in that regard. I remember a speech that Hon Peter Foss gave in this house, which was very vivid, about how women used to give birth in the old days. I recall reading a book on the subject that said that in those days women had their legs tied in stirrups. I find that totally offensive. It was not that long ago that women had no choice over what happened to their bodies or where they had their babies. I had a choice of doctor and hospital, I was near my family and friends, I knew all the staff and I had no complications. Those sorts of things make a big difference to women when they are giving birth. I believe that hard work should be rewarded and if a woman and her family want a homebirth with a midwife, they should have that choice. However, choice is taken away somewhat, given the low number of funded places available through the community midwifery program. That funding is for only 150 midwives who cater for approximately 25 000 births each year. Choice therefore is very limited. Denmark has a wonderful homebirth program that is funded by the Department of Health. It is probably the only one, and it is sad that that model cannot be used in other parts of regional Western Australia. It could be used in regional areas where a doctor can be reached in a short time frame. I think Denmark allows 25 minutes -

Hon Sue Ellery: Which model are you talking about? I coughed as you said that.

Hon ROBYN McSWEENEY: Denmark.

Hon Sue Ellery: No, are you talking about the midwifery program?

Hon ROBYN McSWEENEY: Yes, the midwifery program in Denmark. It is probably the only one in the region funded by the Department of Health. The reason Denmark has this service is that it found that women in the community wanting to have an alternative birth were not going to a hospital and not going near a doctor. Denmark started this program for that reason. I believe that choice probably kicks in when women are giving birth for a second time as they are better prepared, they know what to expect and they want it done differently. I recall years ago talking to a doctor who worked at King Edward Memorial Hospital. The mental image he presented of births in days gone by gave me the horrors. He said he walked into a corridor of the hospital that contained women in different stages of labour who had no privacy; it was just like a factory. They were not allowed to have their husbands with them. I thought that was no good for mothers or their babies. Obviously that should never happen again but directing women to only certain hospitals will mean no choice. I do not have

a problem with the concept of women giving birth in a hospital environment; however, giving birth in a big hospital can be very daunting to some women, especially women from the regions. What is wrong with providing smaller community-orientated, less clinical hospitals?

I did some research a few years back about midwives visiting homes in an English county. They visited many times before the birth of the babies, continued the visits after the birth and then handed over care of the mothers and babies to our equivalent of a child health nurse. Those children have been documented for 15 years and are still being documented. They have been shown to have a higher rate of achievement because of the early intervention strategies in place for the children and the parents and because problems were picked up early. I know that I have gone a little off track, but that illustrates that giving birth is the start of a long process. The way in which a child is delivered can have an effect on the mother and the baby for a lifetime. Postnatal depression after a long and difficult birth in unfamiliar surroundings, an unfamiliar environment and with unfamiliar people present in a clinical setting is just one issue. There are many more issues that I will not go into now. However, from my own experience and the way I thought when I was young, I know that I would have hated to come to the city to deliver my babies among strangers in a clinical environment. That is happening now to women who, through no fault of their own, cannot deliver in their own regional communities.

The federal government is trying to address the issue of the lack of doctors in the regions. I would like to know what the state government and local governments are doing to attract doctors to country areas. Funds of $60 million over four years have been secured from the federal budget for 400 extra first-year medical student places at Australian universities. That funding is aimed at encouraging students to study medicine at university and at initiatives to increase the number of doctors in rural areas. Many of those new university places will bond the students to rural areas, which makes a lot of sense. Some local governments in the regions are paying through the nose with incentive packages to attract doctors. It has reached ridiculous proportions in New South Wales where a local government is paying for the children of doctors to attend schools in Sydney to encourage the doctors to remain in the regions and to lure them into what is perceived to be the outback. I hope it never comes to that in Western Australia. Not so long ago the maternity section in Manjimup hospital closed down, forcing women to go to Bridgetown to have their babies. We are pretty fortunate in Bridgetown where there are four doctors who deliver babies. However, some women have to travel more than two to three hours to get to hospital. I consider that to be extremely dangerous. Of course, some women who live in the regions up north have much further to go. It is not uncommon, even in the wheatbelt region, for women to be sent to Perth to have babies for no other reason than that there is either no local doctor who delivers at the hospital or there is no local doctor at all. That is not good enough, considering that giving birth is a natural event and should be treated as such. Some of us who have given birth were not offered caesarean sections or spinal blocks. That was just not done years ago; we just had babies. Perhaps it would be a lot easier now and all of us could have these interventions; then giving birth would not be as hard! There is only one family birth centre in Western Australia, according to the committee's report, which is adjacent to King Edward Memorial Hospital. Only 3.6 per cent of the birthing population has used this facility up to 2004; that is, equivalent to 660 women. Paragraph 5.2 of the report states -

> The numerous state and federal government reports over the past fifteen years have repeatedly urged governments to shift to a shared care model of maternity services with an emphasis on increasing birthing choice for women and providing continuity of care.

This is just rhetoric - words on paper. Every report that comes out repeatedly urges governments to shift to a shared care model of maternity services. What do we get? We are herded like cows into four main hospitals and a couple of peripheral ones. The same reports have highlighted the disconcerting trend of ever-increasing levels of intervention, which I have already discussed. The predominant view put forward in these reports is that there are health benefits - both physical and emotional - and cost benefits in shifting to midwife-based models for maternity care. I do not have a problem with intervention if it is needed. However, as I said, I have a problem with women in the public system being herded like cows without having much choice. I look forward to the outcome of this select committee.

HON LOUISE PRATT (East Metropolitan) [2.30 pm]: I very much welcome this debate. However, these issues are a movable feast within the community. Although I do not support what could be purported to be the dismissive comments of the health minister about the role of such a proposed committee, I understand those comments in the context of the fact that there is a lot of work going on within this area of government, and should such an inquiry get up, we should be careful that it makes a useful contribution and does not muddy the waters of the important and successful processes that are already in place.

Hon Helen Morton: What are those processes?

Hon LOUISE PRATT: The Reid review recognised the need for a new framework for the complement of clinical services in this state, and identified a range of significant problems with maternity services. The Reid

review identified issues such as fragmentation of the health system between the primary care sector, general practitioners, pharmacists, health professionals, community nurses etc. Indeed, that dislocation could be seen to be the case in maternity services. The review also identified poor coordination and communication between primary care and acute care leading to avoidable admissions and adverse events and poor patient outcomes. In some instances, a lack of coordination across the maternity services could be seen to be a contributor to dislocation. The Reid review also identifies a lack of strategic policy focus on health promotion and early intervention and a concentration of hospital beds in large tertiary hospitals etc.

The Reid review identified those problems. A better coordination of services relating to the management of drug and alcohol addiction, incontinence and postnatal depression also provide important opportunities to improve maternity services and to put in place a better framework.

Hon Helen Morton: They are such a small minority in Perth.

Hon LOUISE PRATT: I understand that, but they are very important to the outcomes.

The dislocation of services and lack of consistency across them - which the government recognises - means that many women do not know what options are available to them. In that sense, I think there is a great deal of inconsistency, which means that in some cases, prevention and early intervention services are not as well equipped as they should be. The "WA Health Clinical Services Framework 2005-2015" proposes a Women's and Children's Health Service. That is but the first step in the further development of women and children's health services, including maternity services. A great deal of work is going on in government in this area.

The Women's and Children's Health Service will include, from the outset, Princess Margaret Hospital for Children, King Edward Memorial Hospital for Women, the Child and Youth Health Clinical Network and the Women's Health Clinical Network, which includes maternal health services. We are now seeing the emergence of a discrete framework for the management of maternity services, along with other clinical services. Part of the role of the Women's and Children's Health Service will be the articulation of a maternity services framework. This will build on the successful models of care that are already in place in Western Australia. It is the role of this new organisation to inform the planning of new, enhanced services within the metropolitan area and country areas. This will be done with the aim of supporting and promoting the practices of all members of the maternal care team, including obstetricians, general practitioner obstetricians and midwives. That is to ensure that the community has a choice of preferred model of care.

It is important to recognise that Western Australia faces a few challenges in the provision of obstetric services. That is largely due to our population density, our vast geographic environment and, indeed, our cultural diversity. Notwithstanding that, approximately 25 000 births occur in Western Australia each year and the majority of those involve healthy women and healthy babies; therefore, we should be able to have a framework that provides a reasonable level of choice and transparency of choice for women and the kinds of services they desire. That is well recognised by the government. We have heard the message, through the Cohen and Reid reviews and other forums, that women want access to a higher standard of maternity care that provides for their needs and desires and takes into account their individual circumstances. Women want healthy babies. They want to be safe. They want to be cared for by people with whom they have a relationship and whom they trust and with whom they can comfortably communicate. They also want to be close to their family and community when they deliver their babies. The government recognises those issues.

We aim to provide in Western Australia the highest standard of maternity care. The government has outlined that the Women's and Children's Health Service will work collaboratively within a network of metropolitan and country maternity services to provide support and direction in areas such as development of policy standards, clinical quality, safety activities, work force support and professional advice. The models of care to be provided within such a framework are also very much open to debate, and the government is actively considering those.

As a result of the Reid review and the Western Australian clinical health services framework, we have the beginnings of a universal framework to give transparency and consistency to our health services and - for the first time in a while - maternity services in this state. As part of the clinical services framework, we are taking a holistic look at the structuring of Western Australia's health services. We now have the opportunity to take these next steps, and I know it is the government's intention to drill down within each of those clinical service areas to further develop and coordinate policy within them. I know a great deal of work is going on in developing the Women's and Children's Health Service. I believe that the models of care to be provided by this service cannot be predetermined, as they are in Hon Helen Morton's original motion, but are very much under development. I am glad that this is reflected in the amendment that Hon Giz Watson has moved. That has been clearly put on the public record as part of the Western Australian clinical services framework. I am appalled at the lack of consistency of choice that is available to women and their families in this state. It has been highlighted during debate on the motion that, for example, only 150 women a year have access to community midwifery. There are limited locations in which women can give birth at a birthing centre. There is also a great deal of difference in

the types of services they can access at any of Western Australia's public hospitals. There is not a great deal of coordination and consistency in the management of the birthing process for women and their families. It varies from area to area. Within the work that is being done on the Women's and Children's Health Service, I note that consistent models to address those issues are being put together by the government.

Many issues have been raised with me. I understand that the majority of women give birth to healthy babies in normal circumstances. However, there is a very high rate of caesarean sections in Western Australia, and I hope that can be addressed by the Women's and Children's Health Service. I note that a larger proportion of caesarean sections occur within the private sector. It may be difficult to influence those rates to some extent, but I hope that in the long term, with changing community expectations, some influence can be applied to those issues.

Hon Helen Morton: However, more people are going to private hospitals because they cannot access their service of choice locally.

Hon LOUISE PRATT: I do not necessarily think that it should be an automatic choice for women to have a caesarean. If a healthy woman does not have any recognised health issues that make a caesarean likely, it should not be an automatic right. Women need to be better educated about their choices, and they need transparency in those choices. My view is that a woman should have a choice between a midwife, a general practitioner obstetrician and an obstetrician. I think that is the way it is done in New Zealand, and some interesting work has been done there. Some good work has also been done in the Netherlands, where it is pretty much expected that women will give birth at home. I think that is a good practice, because childbirth should not be over-medicalised, as our current health system and, to some extent, community values seek to do.

Drugs, alcohol, obesity, postnatal depression and incontinence issues etc - I know that only a small minority of women and babies are affected by these issues - need to be consistently managed and well coordinated.

Hon Robyn McSweeney interjected.

Hon LOUISE PRATT: As Hon Robyn McSweeney has pointed out, early intervention is important, and no less so than at the earliest stage of a child's life when parents form a relationship with and learn to care for their child.

It has been a great pleasure for me in the past few years to work with the maternity action coalition and community midwives. They provide a fabulous service, but it has been limited by funding opportunities that make it available only to about 150 women. It is clear from the outcomes of their work that women have a high satisfaction rate with the service and there is a much lower rate of caesarean sections. Indeed, it is a cost-effective service. My view is that access to that form of midwifery should become a more mainstream part of the maternity options in Western Australia. There could be team-led midwifery, case-load midwifery, GP obstetricians and obstetricians. There also needs to be transparency for women so that they know the options that are available to them. There will be some limitations on the number of options available to women who live in certain geographical areas, such as the remote north west of Western Australia.

Hon Helen Morton: But not in Kalamunda.

Hon LOUISE PRATT: Swan District Hospital is very accessible for the residents of Kalamunda. I thought the member said Kununurra, and I was thinking that the residents of Kununurra should have access to local birthing options. I have lost my place now. One should never respond to interjections on that basis!

Hon Matt Benson-Lidholm: They are unruly!

Hon Ljiljanna Ravlich: That one certainly was.

The PRESIDENT: Order, members! We will not have unruly interjections.

Hon LOUISE PRATT: As I was saying, it has been my great pleasure to work very closely with organisations such as the maternity action coalition and community midwives over a number of years. Only a year ago I hosted a function for community midwives at Parliament; in fact, I have hosted a number of such functions at Parliament to raise the profile of maternity services. I know that people such as Tracey Riebel and Melanie Gregory were very pleased that those functions took place. They are also very pleased that this debate is taking place in the Parliament.

I also took part in the inquiry by the Standing Committee on Environment and Public Affairs into a petition on maternity services in Western Australia. The findings of that inquiry supported the need for a holistic review of maternity services in Western Australia. The committee had some debate about whether that should be undertaken by the Parliament or whether it was a role of government. The government is undertaking that review, and it forms part of the Reid review, which drilled down into the clinical health services framework, and is now drilling down into the Women's and Children's Health Service. That has been a progressive step. Some

people may have said that the government has taken a step too far and is ignoring these issues, but we started at the top and are working our way down. I stand by the approach that the government has taken in this regard. Notwithstanding that, should this motion be successful, I look forward to participating in the select committee.

HON SUE ELLERY (South Metropolitan - Parliamentary Secretary) [2.48 pm]: The government's approach to the issue of maternity services is very much that women should have choice in childbirth. In fact, they should have a much broader choice than they have currently, and the minister has said that on the record in several forums. It does not automatically follow from that, though, that all the bricks and mortar associated with maternity services should continue to provide that role forever without any analysis of where services should be best placed in the context of the range of health services that the public health sector provides. Flowing from the reform agenda of the Health Reform Committee, and building on the work of the earlier Cohen report, as has been referred to by Hon Louise Pratt, the government is developing a maternity services framework for Western Australia, along the same lines as it has developed other clinical framework and clinical service plans; for example, the cancer plan. That is expected to go before the minister in the next couple of months and will be made available for public consultation and comment after that. There are real planning issues to be dealt with relating to the provision of maternity services in particular, not the least of which are work force issues and ensuring that a range of services and choices are available to people where they live. Dr Harry Cohen started the work on behalf of the government by looking at the big picture. He made recommendations, which I will touch on in a moment, about further work that needed to be done, which the government is indeed doing.

I think the first part of the motion assumes, to a certain extent, that the configuration of maternity services is static and will remain so. That has in fact never been the case; indeed, as the Minister for Health foreshadowed publicly back in March, the maternity services framework discussion paper will be out relatively soon and will canvass a whole range of options. Some of those I will touch on in my remarks now. I wanted in a sensitive manner to touch on one of the issues that have been raised in the debate, because I am not convinced it was raised in a sensitive manner, and that is consultation and community participation in the Cohen review. I do not have the corrected *Hansard* in front of me, but the remark was made by Hon Helen Morton about the Cohen review and consumers' representatives, both from metropolitan and country areas, who were part of the WA Obstetric Services Working Group. I will paraphrase the comment, which was that they may well have found themselves being intimidated in such a forum. We need to be careful when we comment on things like that. The conclusion we were being asked to draw is that it was not appropriate consultation, because those two women would not have been able to match, as it were, the other people sitting around the table. Both those women are professionals. They have both spoken publicly, subsequent to that participation in the Cohen review, about issues around maternity services and birthing. They may well have done so beforehand, but I do not know about that. Unless one has evidence of it and knows it is the case, I do not think that one should suggest they were not able to hold their own in that forum. I am advised that they certainly made a valuable contribution to that process. I would expect that, on the basis of their experience and qualifications that they brought to the table.

The draft final Cohen report was made available for comment on a Department of Health web site. A range of organisations listed in the report were consulted and interviewed. I do not have the list of those attached to my notes, but they are certainly available publicly. When the Reid review process examined obstetrics, it noted the work done by the Cohen review and that it had been accepted by the Department of Health. It reviewed the report itself and largely agreed with its principles and recommendations, some of which I will refer to in a moment. The final Reid report endorsed the Cohen report. It is not the case that obstetrics were excluded from the general consultation. People were able to raise whatever issues they wanted to in the range of consultative forums that were held around the work that was done for that report.

I want to touch on Kalamunda District Community Hospital and Woodside Maternity Hospital in particular. I think there is a difference between the two. It is not correct to say that the model of care at Woodside hospital has been changed. I will talk about that in a moment. As I indicated in my opening remarks, it should not be the case that we assume that our commitment to providing choice in maternity services for women is automatically reduced merely because we chose the nature of the services that are delivered out of a particular set of bricks and mortar. The decision on Kalamunda hospital, for example, was made in the context of the wide range of decisions that were being made about the full range of services that the community expected to receive and the decision to meet the community's expectations that services should be delivered close to where people live. For example, in Kalamunda hospital birth rates were dropping. Getting the balance right between the provision of safe facilities and the right number of staff able to maintain the right cohort of skills was an important part of the decision making on Kalamunda hospital. As Hon Louise Pratt has indicated, some 18 minutes down the hill, a suitable facility was made available at Swan District Hospital, in which there has been considerable investment and upgrading of facilities. It also needs to be said that Kalamunda hospital remains a critical component of health care delivery in Western Australia. Sometimes, I guess in the habit that we have of using shorthand, people in this debate are talking about Kalamunda hospital being closed; in fact, Kalamunda hospital remains a

vibrant and really important part of the delivery of health care services and has been in receipt of significant capital investment in recent months.

In the reconfiguration for the delivery of services, taking into account the needs of the different demographics in our community, the focus of Kalamunda hospital has shifted and will continue to shift towards providing a range of services related to primary care, aged care, subacute care, surgical services, rehabilitation and palliative care services. They will be enhanced at Kalamunda hospital, and are indeed being enhanced now. Stage 1 of the redevelopment at Kalamunda hospital involved a substantial capital investment.

Hon Helen Morton: We are talking about obstetrics.

Hon SUE ELLERY: If the member had listened to what I said, she would have heard that I was saying that sometimes in the shorthand language that people have used in the debate, they have talked about Kalamunda hospital closing. That is not the case, and I am demonstrating why it is not the case. Stage 1 of the redevelopment included significant upgrading of the medical and surgical wards.

Part of the motion addresses the future direction, which I think it is useful to concentrate on, of maternity services in Western Australia. Pregnancy and childbirth are not illnesses. I am saying that and the minister has said it on several occasions. The policy position should be, and is, that a hierarchy of services are offered, and that women should have, and will have, greater choice in how they give birth, knowing whichever choice they make will be backed up by the most advanced clinical support available. For high-risk patients and for those for whom problems emerge during the course of delivery, safe, quality clinical intervention will be available, if that is required. The work that has been done in the lead-up so far to the maternity services framework has reinforced much of what has been said in the debate already; that is, what do women want? They want to be healthy; they want to have a healthy birth; they want relationships with the people who are assisting them at the birth; they want to give birth in their community; they want backup if it is necessary; they want a sense of control and of being able to make decisions about what happens to them; and they want choice. For example, the current family birthing centre at King Edward Memorial Hospital is a great facility. The framework that is being worked on now will canvass building on that and trying to ensure that women, wherever they live in the metropolitan area, for example, are able to access facilities similar to the single facility that is currently at King Edward Memorial Hospital.

Mention has been made of community midwives, and the number that we have now in comparison with the number of births. The framework will certainly canvass building significantly on existing numbers of community midwives. The framework will address all the strategic issues, some of which have been mentioned in the debate so far; that is, the real questions about the work force. However, it certainly needs to be acknowledged that the state of Western Australia alone cannot deliver on education and training. There is a real role for the commonwealth government to play. Some people are arguing very strongly that the commonwealth government is not playing its role as it should in respect of university places for health professionals - I refer to not only doctors and nurses, but also a range of allied health professionals. The working party of general practitioner obstetricians that was convened in 2003, I think, made similar recommendations to the Department of Health.

We need to manage those staffing resources. We need to recognise the limitations that exist in the light of the numbers that are available to us, and factor that into the reconfiguration, so that when we have differing numbers of health professionals, the maintaining of their skills is able to be managed so that they continue to operate at the highest level possible. As Hon Louise Pratt also indicated, we need to make sure that services are coordinated. A range of other issues need to be canvassed, and the government is committed, and the minister has indicated already that he is committed, to providing women with a greater choice in birth, starting with the principle that women should be the focus.

I will touch briefly on some of the recommendations made by the Cohen report, because it will demonstrate that we are addressing this issue in an orderly and methodical fashion and are following the recommendations in the Cohen report. For example, recommendation 4 was that a statewide obstetric service be established. That has happened, and the statewide obstetric service is taking a lead role in the preparation of the discussion paper that I have referred to already. Recommendation 5 dealt with consumer education. Reflecting some of the remarks that have already been made by the contributors to the debate, women should be able to get the information that they need on the choices and risks associated with childbearing. They should be able to get that information in a way that is appropriate to their language and cultural needs, and it should be available in the community where they live. They should be able to get the information easily, not with difficulty.

Recommendation 6 referred to consumer linkage and ensuring that we make available and use the technology that people now use every day to get information. The report also recommended that the department and the statewide obstetric service analyse work force issues and recommend options for solutions. Therefore, it recommended further ongoing work. It also recommended an enhanced role for midwives and that that be

implemented as a priority. It also recommended that a review be done of the training support and methods of attracting and retaining midwives in the speciality, in conjunction with the relative colleges. That work is being done also.

In respect of general practitioner obstetricians, who have also been mentioned in the debate, the Cohen report recommended that a plan be developed and implemented to ensure that general practitioners are encouraged to pursue the speciality of obstetrics, and to support general practitioner obstetricians to maintain involvement, training and the acquiring of credentials. The state government can initiate some of those things, but other initiatives must be done with other levels of government, primarily the commonwealth government.

I will touch on some of the evidence that was put before the Cohen review, because some remarks were made about that review that perhaps suggested that the work was not as rigorous as it should have been. In addition to the interviews and discussions with the stakeholders that are listed in the review, and in addition to the expertise and the professionalism that was brought to the table by the people in the working group, I will refer to the references listed in the Cohen review, because it is not accurate to suggest that it was not a wide-ranging, proper analysis of the material that was available. According to the discussion paper, some of that material is -

- Report of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in Western Australia, January 1990.
- Royal College of Obstetricians and Gynaecologists, 2000. *A Blueprint for the Future. A Working Party Report on the Future Structure of the Medical Workforce and Service Delivery in Obstetrics and Gynaecology,*
- British Association of Perinatal Medicine, December 2001. *Standards for Hospitals Providing Neonatal and High Dependency Care . . .*
- Submission to the Health Department, February 1988. *Optimal Place of Delivery. Levels of Care.*
- Gee V and O'Neill (2001) *Perinatal Statistics in Western Australia, 1999. The Eighteenth Annual report of the Western Australian Midwives' Notification System. Health Department of Western Australia.*
- W.C.H.S. 2001 *State wide Rural and Remote Clinical Health Services for Women, Infants and Children Provided by King Edward Memorial Hospital for Women and Princess Margaret Hospital for Children.*
- Roex A, *Proposal for a Pilot Project to Establish Two Collaborative Centres for Maternity Care in Metropolitan Perth . . .*
- Royal Women's Hospital and Health Service District, March 2001. *The Women's Health Plan 2001-2005.*
- NSW Health Department, 2000, *Strategic Directions for Health 2000-2005.*
- Victorian Government Publishing Service, 2001. *Measuring Maternity Care. A Set of Performance Indicators*
- Health Department of WA, 2000. *Guidelines for Rural Obstetric and Midwifery Services in WA.*
- Cahill, A., Phythian, M., Neale, J. July 2001. *Benchmarking in Women's Hospitals and Women's Health Units, 1997-1999. Women's Hospitals. Australasia.*
- RCOG, April 1999. *Royal College of Obstetricians & Gynaecologists and Clinical Governance.*
- Maternal and Neonatal Services in South Australia January, 2000 *Operational Policy. Maternal and Neonatal Clinical Programs Group.*
- Western Australian Allied Health Taskforce on Workforce Issues. June 2002.
- The National Institute for Clinical Excellence, the Scottish Executive Health Department and the Department of Health, Social Services and Public Safety: Northern Ireland, 2000. *Why mothers die 1997-1999. The Confidential Enquiries into Maternal Deaths in the United Kingdom; 'Deaths from Psychiatric Causes'. Chapter 11.*
- *Nurses Act 1992 . . .*
- Royal College of Obstetricians and Gynaecologists, '1999, *Towards Safer Childbirth: minimum standards for the organisation of labour wards, report of a joint working party,* ROCG Press London.

- International Journal of Epidemioloy, 2002, *Are we regionalized enough? Early-neonatal deaths in low-risk births by the size of delivery units in Hesse, Germany 1990-1999.*
- Department of Health Western Australia 2001, *Enhanced Role of Midwife Project,*
- R. Collins et al. 2002 *Does Western Australia have the ability to meet future requirements for Midwives.* Discussion Paper . . .
- Douglas N, Robinson J, Fahy K (2001) *Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital.*
- Australian Council for Safety and Quality in Health Care, July 2002, *Lessons from the Inquiry into Obstetrics and Gynaecology Services at King Edward Memorial Hospital 1990 - 2000*
- *Birth Rites: Video produced by JAG Films Ltd (2002).*
- Australia and New Zealand College of Anaesthetists, 2001, *Professional Standards of Anaesthetists*

It is just not accurate to say that the Cohen report was not a rigorous examination of all the material that needed to be considered. It is also the case that questions were raised about whether King Edward Memorial Hospital for Women is indeed family friendly. It is a tertiary setting hospital. It is a big building with a lot of people working in it. Nevertheless, a crèche is available, visiting hours are extended on the wards, and partners are encouraged to attend births, birthing classes and parenting classes. The family birth centre offers a home-like environment, and partners and children are encouraged to attend the births.

During the debate a question was asked about whether the Minister for Health would seek to impose - that was the suggestion - the same configuration on private hospitals for the delivery of obstetric services that he has proposed for public hospitals. Of course, the Minister for Health is not able to do that. In fact, he has no jurisdiction over the number or quality of services in private hospitals. The Commissioner of Health, in that person's capacity as an independent statutory officer, is responsible for the licensing of private hospitals, based on government legislation; that is, the Hospitals and Health Services Act 1927. In March and subsequently the minister has referred to the development of the maternity services framework. The decisions made by the department on the most recent reconfigurations took into account both the clinical needs of each specialty area and the broader needs of the health system. The Health Reform Committee provided a comprehensive model for acute hospital-based health care services throughout the metropolitan area to meet the overall objectives of the health reform agenda: improving access to services; reduced inequality in health status; provision of safe, high-quality health care; promotion of a patient-centred continuum of care; value for money; optimisation of public and private services; an improved balance of preventive, primary and acute care - we will need to concentrate on that balance even more in the future as we struggle with the difficulties of managing chronic disease; financial sustainability as an integrated system; and support for a highly skilled and dedicated work force. All those reform strategies are related to the achievement of those overall objectives.

The Health Reform Committee endorsed the recommendations of the Cohen report and applied the obstetric model of care in line with the broader plan for hospital-based services. For example, as I have indicated already, the Health Reform Committee recommended a new role for Kalamunda District Community Hospital - to help address the significant growth in demand for health care services in other areas, such as mental health, aged care, rehabilitation and palliative care. This care needs to be provided in the community setting, closer to home, so that we can improve the quality of specialised care at a lower cost than secondary and tertiary hospital care. That is clearly set out in the Reid report. Obstetric services are to be relocated, in line with both the recommendations of the Cohen report and community requirements for Kalamunda hospital. The framework will be released for broad consultation within the next few months. After that consultation period, the final framework will be used to guide area health services in planning for current and future provision of maternity services in their areas.

Area health services embarked on more detailed clinical services planning as part of implementing the overarching "WA Health Clinical Services Framework 2005-2015". This will inform area-wide health service planning, leading to the detailed service planning required for specific hospitals and health services, such as the Fiona Stanley hospital. That planning will continue throughout 2006 and 2007. All area health services have either already established, or are in the process of establishing, consumer and community advisory committees as per one of the recommendations of the Reid report. These committees, along with consumer representatives on specific project groups, will participate in area health service planning and development processes. The Health Consumers Council of Western Australia meets regularly with the Director General of Health to provide feedback on a range of issues.

I will turn now to the context of the planning and the decisions that have been made already on obstetrics. As I have indicated, the government has in place a clinical services plan arising out of the Reid report and it intends to stick to it. It includes massive capital investment: the building of the new Fiona Stanley hospital, to which I

have already referred, to service the people south of the river; the building of a new hospital in Midland to replace the Swan District Hospital; significant upgrading of the Joondalup Health Campus, to ensure that the needs of the people in the northern suburbs are catered for; and the rebuilding of Princess Margaret Hospital for Children and, in the medium term, King Edward Memorial Hospital. It is a big plan. Kalamunda, Woodside and Osborne Park hospitals have served the people of Western Australia well in the delivery of maternity services. A decision about reconfiguration of those hospitals is not a statement about their failure to provide services to the best of their capabilities. However, we are now in a position in which decisions must be made about providing a whole range of services close to where people live. That means there needs to be some reconfiguration. It is no longer appropriate for the government to stick to a model that saw, for example, all our tertiary hospitals concentrated around the inner city and the western suburbs. We need to move services out to where people live. For example, as I have indicated already, the focus of Kalamunda hospital will shift to ensure that the community's urgent demand for a range of services, including mental health and rehabilitation, is satisfied where people live.

Hon Murray Criddle: Will all that be delivered into the country as well?

Hon SUE ELLERY: Some of it is about country services as well, but the Reid report was quite clearly a plan for metropolitan services.

The clinical services plan is not only about services to be provided at hospitals. We need to implement the recommendations that have been made over a number of years and that will be done consistently. The minister has said that he thinks women should be given a greater choice and be presented with a greater range of options. He wants there to be greater recognition of midwife-led maternity services, rather than all births being concentrated in institutions that are there for difficult cases. The maternity services plan will be one of about 40 plans focusing on different areas of health care. The issues raised in this debate are being taken into account. Nothing raised in this debate is new, and those matters are being considered by the people working on the discussion paper that will go out for public comment.

I have remarked already that some comments have been made that Kalamunda District Community Hospital will be closed and that the model of care provided by Woodside Maternity Hospital has been changed. I have already said that Kalamunda hospital will not be closed, but in fact will continue to play a really important role in the delivery of health services. I turn now to the issue of Woodside. The service provided at Woodside was predominantly midwife led. That service continues today at Kaleeya Hospital, and any suggestion that a move to a building one kilometre up the road has resulted in a different model of care is incorrect. It must be made clear that the model of service provided at Kaleeya is the same as that provided at Woodside.

Hon Barbara Scott: That will be difficult.

Hon SUE ELLERY: It is a different building, but it is still a midwife-led service. In fact the new building has improved state-of-the-art facilities which I will list right now. The new maternity unit will be supported by on-site services already established at Kaleeya, including a satellite pharmacy, a central sterilising supply department, radiology, ultrasound, infection control and physiotherapy services, as well as excellent catering facilities for patients. It will offer four large birthing rooms, bigger than the recommended Australian standard. Each of the delivery rooms has access to a private balcony and gives women the option of being active throughout their labour. Kaleeya offers the full services of a wider hospital complex, with 24-hour on-site medical cover for emergencies to enhance the on-call services for obstetrics. Medical staff will be available to respond to the medical emergency team and resuscitation calls under the direction of the visiting medical staff or other senior medical practitioners available on site at the time. All the post-natal bedrooms at Kaleeya will have ensuites, something that did not exist in the predominantly four-bed wards at the Woodside facility. The maternity unit comprises five single rooms, two two-bed rooms, and one four-bed room, all with ensuites. There are more operating theatres. That is a significant issue for the general practitioner obstetricians who were working at Woodside and who are now working at Kaleeya. Woodside had one operating theatre, and if it was being used, it presented difficulties if an emergency caesarean or other procedure needed to be carried out. Theatre 2 at Kaleeya Hospital has been allocated solely for the purpose of obstetrics and gynaecological surgery. There will be access to other theatres in the event of an obstetric emergency. That should allay some of the fears.

The government understands what the numbers will be on this motion. As such, the government will not vote against it. However, it is fair to summarise the government's position as being that the work has already been undertaken. The framework will be published within the next few months and available for wide consultation to members of the public. We need to get the balance right. We have a plan that was set out by the Reid report. It is a practical plan. It has been backed up with finances and major capital investment to ensure that services are delivered to Western Australians where they live. It does not automatically follow that because a service has changed from a particular bricks and mortar location, the service is downgraded. The government is committed

to women having a much wider choice in birth. All the issues that members have canvassed in the debate will be canvassed in the discussion paper. I look forward to the discussion paper, as I am sure do all members of the house.

Amendment put and passed.

Motion, as Amended

HON HELEN MORTON (East Metropolitan) [3.22 pm]: I thank members for their support of the motion. In particular, I thank Hon Giz Watson for the amount of work she put in to her amendment to improve the motion.

I mention briefly that there has been a lot of rhetoric about choice. I can assure members absolutely that choice within maternity services is slowly being reduced. In particular, people who live in Kalamunda do not have the choice of having their baby delivered by their GP obstetrician. If they want the baby delivered in a hospital, they have to hand over the care to an obstetrician at Swan District Hospital, whom they have probably never seen before, nor had anything to do with. The obstetrician will be working on a roster, and a woman might end up seeing two or three different obstetricians. She might not have any further contact with the obstetricians after the birth.

The other point that has been missed during the debate relates to the indication by the parliamentary secretary that a new maternity services plan is being developed and that families will get to look at the draft plan after it has been developed. Families are not being involved; they need to be consulted and involved in developing the discussion paper. How does the minister or the Department of Health know what families want?

Hon Sue Ellery: We need to start somewhere.

Hon HELEN MORTON: Go out and talk to people and find out what they want, instead of trying to prepare a plan before people get a say. There is still an amazing preoccupation with turning having a baby into a clinical service. I was surprised to hear the parliamentary secretary state that a clinical stream in obstetrics is the same as a clinical stream in cancer treatment.

Hon Sue Ellery interjected.

Hon HELEN MORTON: Look at *Hansard*; I wrote it down. It is amazing that the streaming of obstetric services is seen in a clinical context in the same way as there is a clinical stream for cancer services. That is an offensive approach to the clinical specialisation of obstetric services. It moves it away from being a family-type service.

The Minister for Health has demonstrated, non-stop, an amazingly high-handed, offensive, arrogant and patronising approach to listening to women and understanding what they want. His dismissive attitude to this house and the contribution it could make towards the establishment of a maternity services plan is just another example of why people have no confidence in him to come up with a maternity services plan that is responsive to what women across the state want. That is an important reason the select committee will make a strong contribution to this issue.

The thing that most demonstrates his unwillingness to accept that this house can contribute is - apart from his arrogance - his complete unwillingness to answer a question on notice as late as yesterday about what community consultation the maternity services plan will involve and the evidence or research that will be considered. The minister is not able to demonstrate what research or community consultation is taking place in a process the results of which are to be delivered to him in the next two months. That is despite that information being requested by this house. There is a need for a select committee to inquire into what has happened with the decision making to date. There is some hope because the parliamentary secretary said that nothing is fixed; it can be a movable feast. I do not know whether that means we can reinstate a GP obstetric and midwifery service at Kalamunda District Community Hospital. However, I guess that a movable feast is a movable feast. One needs to be hopeful about that. I cannot believe the amount of preoccupation with capital development and the broad range of services when we are talking specifically about obstetric services, and the family-friendly obstetric services that should and could be available locally to people living in a place like Kalamunda.

I again thank all members for their support and I look forward to the select committee being established.

Question put and passed.

Appointment of Members

On motion without notice by **Hon Helen Morton**, resolved -

> That this house appoints Hon Sally Talbot, Hon Louise Pratt, Hon Helen Morton and Hon Anthony Fels as members of the select committee into public obstetric services and appoints Hon Helen Morton as chair of the committee.