SELECT COMMITTEE
INTO PUBLIC OBSTETRIC SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
MONDAY, 20 NOVEMBER 2006

Members

Hon Helen Morton (Chairman)
Hon Anthony Fels
Hon Louise Pratt
Hon Sally Talbot

Hearing commenced at 11.02 am

REIBEL, DR TRACY
Private Citizen, examined:

The CHAIRMAN: On behalf of the committee, I would like to welcome you to the meeting. You will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

Dr Reibel: I have.

The CHAIRMAN: These proceedings are being recorded by Hansard. A transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record. Please be aware of the microphones and try to talk into them, and ensure that you do not cover them with paper or make a noise near them. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that premature publication or disclosure of public evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege. Would you like to make an opening statement to the committee?

Dr Reibel: Yes, I would. Thank you for the opportunity to appear before this committee and provide my views on the community consultation processes associated with the provision of public obstetrics services. My interest in this issue relates to my own experiences with public maternity care in Western Australia, in addition to my professional interest as a researcher and my role as an advocate for the rights of child-bearing women. As the former program manager for the community midwifery program, in addition to my involvement with the Maternity Coalition, I have encountered a large number of women in the Western Australian community, as well as midwives, obstetricians and other health professionals, who are concerned with the provision of maternity care. As such, I have had an opportunity to gather a wide range of stories and opinions regarding pregnancy and childbirth. I have also actively been involved with the efforts to reform women's access to maternity care best suited to their individual needs.

Child-bearing is a very significant and intimate experience for women. It involves many changes in their lives, not the least of which is coping with the changes occurring to their bodies during pregnancy, the enormous challenge that labour and birth presents, and the strong emotions associated with the birth of their babies. For the large majority of women, this event will be a relatively straightforward process, even though it is a unique experience for every woman. It is my experience, having spoken with women on this topic for more than two decades, that birth experiences have the capacity to reverberate throughout one's life. Dependent on the process and the outcome, this may be positive or negative, and the repercussions of this affect not only the mother's transition to parenting, but also the whole family. That is why it is imperative that women have access to care that best suits their individual circumstances during each child-bearing episode to ensure that their experience is as positive as possible. Therefore, although it is incumbent upon the state and federal governments to provide high-quality maternity services, it is also their role to ensure that the services provided are meeting the needs of the targeted group. This has not been the case in Western Australia. Instead, services have been provider-driven, little regard has been afforded to women's choices and the control of maternity care has been vested with the group most

likely to financially gain from the provision of care. This has been justified on the ground of safety, the premise being that intensive medical surveillance of, and intervention in, a usually straightforward physiological process will produce the best outcomes. Research evidence does not support this justification; nonetheless, it remains the prevailing view.

Consultation with child-bearing women on the provision of maternity care should be a fundamental part of planning services. The Western Australian government has undertaken a major reform process of health services in this state through the Reid review and the resulting Health Reform Implementation Taskforce. The Reid review was supposed to engage in community consultation, but when it came to maternity services, the decision was made to incorporate the findings of the Cohen report. The Cohen report did not involve community consultation, as it was a review undertaken with some degree of secrecy, in so much as it was not a public review and the findings of the resulting report were not publicly released. Most recently, the health policy and clinical reform branch of the Department of Health released a discussion paper, "Future Direction in Maternity Care", calling for submissions on the future provision of maternity care. Although this might be seen as a positive step by many people, I remain concerned that the discussion paper explicitly states that the location of services will not be engaged with as part of this process and that this aspect of maternity care has already been set out in the clinical services framework 2005-15. The location of services is a fundamental aspect of maternity care. Centralising services into large hospitals and removing services from, or not providing services in, rural and remote communities, is a huge burden on child-bearing women. To remove this aspect of community consultation disempowers women further. If the Western Australian government is truly committed to providing the best possible service, it must set aside its own agenda and promote a process that does not come with predetermined goals. Maternity care is a basic human right and should be available based on a woman's individual needs. Until women are appropriately consulted, their rights will not be reflected in the services that they have access to.

The CHAIRMAN: You referred to the government setting aside its own agenda. I cannot remember exactly what you said, but it was basically that until it looks at what women want, the reforms will not meet the needs of women. What do you think the government's agenda is?

[11.10 am]

Dr Reibel: Clearly I do not know what its agenda is, but I have read the discussion paper - I had an opportunity to read it on the weekend - and the mere fact that it refuses to engage with the issue of location of services indicates, or certainly implies to me, that some degree of planning for the future provision of maternity services has already occurred. The document talks about models of care and invites comment on models of care, and of course this is a very important aspect of the provision of maternity care, but it is coupled very significantly with where these services are located. My assumption at this point in time can only be that the government is prepared to consider different models of care but only within the service locations that it has already predetermined. I see that in itself as a restrictive approach and I wonder how that will affect the consultation process that may or may not come out of this recent discussion paper. I was also notified on the weekend that there would be a discussion forum but I do not know what the agenda is for that. For the moment I remain sceptical about the process that will be followed through with this discussion paper because we have had them before and they have resulted in no change.

Hon SALLY TALBOT: What do you think might be driving the agenda as far as location goes?

Dr Reibel: I think there is a general overarching view, certainly amongst the work force issues associated with the provision of care and within the general view associated with that provision, that a service can most effectively be provided if it is provided in fewer locations. We have a declining number of specialist obstetricians and certainly of GP obstetricians. Again, I feel that the move is more towards provider-focused convenience by locating services in larger hospitals in fewer locations to cope with the issue of obstetric work force, which is not the same issue associated with

a midwifery work force, which tends to be placed not just across the metropolitan area but also throughout the state. There are midwives living in most regional areas and many rural areas who are not working as midwives. I feel it is a work force driven issue as opposed to a service provision issue, more specifically.

The CHAIRMAN: Do you think that is a legitimate reason to -

Dr Reibel: No, I do not.

The CHAIRMAN: Why not?

Dr Reibel: It comes down to models of care. If services are configured towards incorporating the use of midwives as primary carers, one instantaneously reduces the need for specialist obstetric access. At the moment we have a situation in which, certainly even in our public obstetric services, there is still a heavy reliance on specialist obstetricians to provide care. We have a situation with that reliance where we need to think about those work force issues. If the change in thinking were to occur to a more midwifery-driven work force that provided primary care in a great number of circumstances, it would reduce reliance on the need for that access to specialist obstetricians and then they would rightfully take their role in dealing with those women who are encountering difficulties either in their pregnancy or during birth. Those women would have access to those specialists whom they require for a good outcome. Again, it is a work force related issue and it comes out of thinking about the need to provide this medical model of care as opposed to a more holistic - if you like, social - model of care related to pregnancy and childbirth.

Hon LOUISE PRATT: Is it possible to combine the two? We have certainly had evidence to this committee about the assessment of risk and travel times and the need in reviewing models of care to not create a system where people find emergency care inaccessible.

Dr Reibel: That is always going to be an issue to some degree, particularly when we deal with the situation we have in Western Australia where there are people in isolated circumstances. A well integrated system that effectively uses these components of its work force - for example, midwives, GP obstetricians and obstetricians as well as peripheral health professionals - will not encounter those difficulties because it will use the associated guidelines and protocols that have been developed not only here in Australia through, for example, the Australian College of Midwives, and their consultation and referral processes, but also though very well researched and evidence-based integrated service provision models that occur in places such as the United Kingdom and Canada. Issues of risk will never be entirely addressed in any model of care. It does not happen now. The system is far from perfect, and it is actually premised largely on a medical model of care that is a risk assessment model and it does not have perfect outcomes and does not meet all women's needs. If there were a well integrated system and it took good account of the available work force, and if models of care were premised on good evidence that allowed for good risk assessment to take place, the opportunity for an emergency situation to occur would be lessened when that care was not accessible. It can be done. Our distances here are not so great, particularly in the metropolitan and outer metropolitan regions. Our access to good secondary or tertiary care is reasonably available. There are slightly different issues in rural Western Australia, but not so much in regional Western Australia. Geraldton, Bunbury and Albany all have good obstetric care available on site. It needs to be looked at on a location by location basis, but it is not impossible. It can be done and it is being done in other places.

The CHAIRMAN: Do you think the WA system is overly focused on risk as the predominant issue to be considered? Would you comment on whether that risk relates to the mother and child or the liability risk for the government?

Dr Reibel: I think they are both significant issues. Yes, I do believe it is primarily premised on a risk assessment model, as all medical services these days are. It is a really fraught area because we are talking babies and mums, so we are talking about what is best. This is where we have a

fundamental fissure, if you like, between those of us who view childbirth as a relatively straightforward physiological process, which in the majority of cases will come to a normal end and outcome, and those who primarily view it as a medical event that needs to be assessed for the risk to the baby and the mother. I do not know where we get a meeting of minds on this philosophical issue because I have battled this out with many an obstetrician over many years. In answer to your question, I think it is premised on a risk assessment model and I do not know that that is particularly healthy for women and babies. I think that that risk assessment model has come about through the issue of liability of the practitioners involved, largely obstetricians, and I believe that in itself is driven by the requirements of an insurance industry that is selectively looking for evidence to justify the provision of indemnity insurance to practitioners. This was certainly evident in the withdrawal of midwives' professional indemnity in 2000, I think; they looked at obstetric risk as opposed to the midwifery model of care risk in their assessment of the indemnity premiums associated with midwives' insurance. So, yes, risk is a basic premise of the provision of care.

The CHAIRMAN: Going back to the consultation areas, in your submission you refer to your involvement with numerous consumer initiatives and you talk about having provided some detail about those matters to government. Was a response sought from the government or the Department of Health; and, if so, what was the response?

[11.20 am]

Dr Reibel: Certainly I sent a submission to the Reid review. I never received a response to that submission. On various occasions I have met with Sue Ellery, who is the parliamentary secretary to Jim McGinty in the health portfolio. My colleagues from the Maternity Coalition have met with Jim McGinty on two occasions and submitted Maternity Coalition documentation as well as evidence of the situation in Western Australia as it pertains to childbearing women. The response has been minimal. We have received the odd extracted promise to do something about the situation, which has been verbally provided, but it has never been followed up with any written confirmation or commitment towards change. My short answer is that the continual efforts on the part of me and my colleagues in the Maternity Coalition have turned up very little by way of formal responses or commitments to engage the issues we have raised.

The CHAIRMAN: What was the time frame of your meetings? What was the extracted promise you referred to?

Dr Reibel: Certainly the most recent was a meeting we had with Jim McGinty regarding the implementation of the NMAP document in Western Australia that we had prepared. I am wracking my brains while I am speaking.

The CHAIRMAN: Was it this year?

Dr Reibel: No, it was last year. It was when Melanie Gregory was president. She has been gone a year. The best I can say is within the past 18 months. I can get a more specific date.

The CHAIRMAN: I was just wanting to see whether it was within the time frame of the future maternity direction document that is being developed.

Dr Reibel: I have had no contact with either Jim McGinty or Sue Ellery in the past 10 to 11 months about this matter, so it would have to be prior to that time.

The CHAIRMAN: In your submission you state that significant documentation based on current evidence and best practice has been provided to the minister and the Department of Health. You state that it has become apparent that various vested interests involved in the obstetrics debate have pointed to a body of evidence that supports their views and disregards others. What evidence did you provide to the minister? Are there any particular issues that you believe have a strong evidence base and, conversely, which areas require more research?

Dr Reibel: Has a copy of implementing NMAP in WA been submitted to the committee?

The CHAIRMAN: Yes.

Dr Reibel: That document contains most of the most recent evidence. Research evidence is coming out all the time and to keep up with it is a job in itself. That document contains the most recent relevant research evidence, although there have been a couple of interesting pieces of research in the past six months. I cannot quote them off the top of my head, but I am prepared to provide that information to the committee. I have referred to the selective use of evidence and, of course, that assertion could be pointed in many directions, including the Maternity Coalition. My argument is that because there is a great deal of research evidence available it tends to fall into two streams. The first very much looks at obstetric outcomes. This is the effective outcome of interventions where medical surveillance or medical intervention has been a primary driving force. If we look at things like the caesarean surgery rate, for example, and we look at the outcomes of caesarean surgery overall in western developed nations, most of the evidence supports the fact that caesarean surgery is a straightforward and relatively safe surgical procedure in so much as it has very good outcomes and it is responsible for saving women's and babies' lives. By the same token, we also have a great deal of evidence around caesarean surgery that is coming out of Australia less so - most of it is coming from the United Kingdom - that shows that caesarean surgery rates are exponentially on the rise with every given year. Lots of questions are being asked in the obstetric community as to why this is so. We have the body of evidence that considers the safety of caesarean surgery and other medical interventions in childbirth and then we have the evidence that has been emerging in the past decade from the United Kingdom, Australia, New Zealand and Canada that looks at the outcomes of midwifery models of care. Part of the premise of this research has been to counter some of the obstetric and medically-related research that has been done over a very long period of time. Part of the process of that has been to promote the use of midwives as primary carers to demonstrate that midwifery-led care, particularly for low to medium-risk women, is very safe and equal to, if not better than - in terms of normal birth outcomes - obstetric-related care. Western Australia has always had a medically dominated maternity service, and when people have looked at evidence it has tended to be selective. It tends to be focused on research that has come out of the obstetric community. Very little regard has been paid to evidence that has come out of the midwifery community. Again, we have this dichotomy whereby it is very difficult to get the two parties to meet, and caught in the middle of all this are women and their babies. They are not interested in what the research is saying; most women are interested in having a live and healthy baby. If we start to look beyond what this research means, it is about politics, power and control. Again, the people caught in the middle are the women and their babies. We need to get a more objective view of the research evidence that is available. We must look at the models of care that are working well. My 2003 Churchill Fellowship to the United Kingdom demonstrated that there were very effective integrated maternity care services that took full account of the full work force available for maternity care, being midwives, obstetricians and GP obstetricians. Those models of care are available and they are based on research evidence, the same sort of evidence that is available to Western Australia if it chooses to use it.

The CHAIRMAN: Talking about community midwifery programs, do you think that that program can be replicated throughout the state? What problems may need to be tackled before that can occur?

Dr Reibel: The community midwifery program and the model of care that it has promoted are imminently replicable across metropolitan, rural and regional Australia. Possibly it would not work for remote Australia because we would start to encounter a completely different set of rules and issues that must be taken into account. In terms of its capacity to be utilised in metropolitan, rural and regional Australia, what needs to occur prior to that is a dialogue between the medical providers, both GP obstetricians and obstetricians, who are located in various places around the state. We have to be mindful of their concerns and certainly make every effort to address their concerns around community midwifery and the model of care that it provides. Ultimately, we must

have an integrated service whereby all health professionals are working together in a cooperative and collaborative manner to provide good care to women. With the right work force - it would take time to generate the right work force to underpin this service - it could be made readily available to women. It requires a degree of education in the public. We must remember that women have been imbued into the medical model of care in this state for a very long time. It is their first port of call. It requires a degree of education in the community itself. I do not think that that process would take terribly long. Certainly that has not been my experience in the work that I have done around the state. I have talked to women all over the state on this matter. Once you start talking about midwifery care and what it can offer, and the integration of that with good GP-obstetric and obstetric backup, women are very open to the possibility of having midwifery-led models of care.

[11.30 am]

The CHAIRMAN: So why is it not happening?

Dr Reibel: It has been financially restricted. We had a program that started as a result of a commonwealth initiative in 1996 to provide care for 75 women. Within two years we had matching state funding to provide care to 150 women. At that stage we had a commitment by the then Minister for Health, John Day, to roll out the program further. However, with the change of government, a new view was taken. We attempted persistently to get further funding for the community midwifery program. We attempted to get it replicated. We had a group of midwives in both Bunbury and Margaret River who were very keen to start a community midwifery program. We could not get any joy out of the area health service managers at that point in time. We attempted negotiations with the Department of Health and with the then Minister for Health, Jim McGinty, without any joy at all. We have to ask the same question as to why a family birth centre has been located only at King Edward. Why has a birth centre not been built in all the metropolitan units? Why is there not a birth centre in Bunbury or Geraldton? Why has there been this control on choice, with a limit of 200 women through the family birth centre, and 150 women through the community midwifery program? There have always been more inquiries than they can take. There have always been more applications for places than they can manage. This is because of the restriction on funding. However, on the other hand, the midwives have not had full case loads. They have not been allowed to have full case loads, because you need to maintain a certain ratio of women to midwives to provide the primary service. You also need to provide a backup service from your midwifery colleagues. Therefore, because you need to have a certain number of midwives to provide a service, they are all put on part-time case loads so that you have the number of midwives that you need. The midwives actually want to work full time, but they cannot, because the funding is not available. The applications for the program are there from the women, but you have to turn women away because there is not enough funding to provide for them. The outcomes of the program are good. The outcomes of the family birth centre are good.

Hon HELEN MORTON: We have heard quite a lot of evidence from GPs, and others, that they support the role of midwives either in an integrated way or in a shared-care model. The future document talks in an expansive way about midwifery being one of the options for women. When all those things are taken into account, and with all that rhetoric, what is preventing it from being rolled out?

Dr Reibel: Fear - fear from the bureaucracy that it might get it wrong, fear from the obstetricians that they might lose control, and fear from the overall work force inasmuch as you have a highly institutionalised model of care. There is also a degree of fear from the midwives themselves that they might be forced to provide primary care when they do not feel confident to do so. There is also a fear that childbirth is not really a straightforward event and it is always going to be complicated, and about the what-ifs. It is primarily fear based. I sincerely believe also that it is based on financial circumstances. The birth industry is extremely lucrative. You do not see too

many obstetricians driving 15-year-old Toyota Corollas. It is a hip-pocket issue. Fear is the main motivator, but financial gain or disincentive is another issue.

Hon LOUISE PRATT: The stakeholders clearly have a significant vested interest in transforming maternity services in Western Australia in the short and medium term. What process needs to be put in place to bring the stakeholders together?

Dr Reibel: I think there is a will on the part of some obstetricians to come to the table, because they see the writing on the wall. The evidence out of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists is clear. Obstetricians are a shrinking work force. They are also an ageing work force. There is not the degree of interest in obstetrics, because it is considered to be an area of high risk. It is also not very conducive to lifestyle. RANZCOG itself recognises that there is an issue. There are some very good obstetricians in the system. They recognise that it is an issue not just of work force, but also of change in the community. Women want something different. The problem is how to address that in the short term. Consultation processes are very important. However, they must be true consultation processes that bring people around the table to thrash out issues in such a way that you have a forum, and people can put across their views and voice their opinions and concerns. It is very important that people's concerns are addressed and put on the table, and that all the stakeholders are represented. Women tend to be left out of this picture. It is possible to arrive at a better understanding of what women want. I do not believe that a lot of the health professionals who are involved in the provision of maternity care actually understand what women want. I do not believe they have ever taken the time to ask. It is sometimes very difficult for women to know what they want if they do not know what alternatives are available. To give an example, a booklet was produced by the state government. It was a little blue booklet with daisies on the front. It was called "Choices in Childbirth", or something like that. It was part of an initiative to address the issue of choice. It laid out what was available in Western Australia at the time. It talked about the community midwifery program. It also demonstrated that women could have shared-care models with GPs and midwives within a hospital-based environment. Woodside was an excellent example of GPs who were running an antenatal clinic together with midwives. The booklet basically put across the range of choices that were available to women. The booklet was distributed through GPs' surgeries across the state. It was never evaluated. However, anecdotal evidence suggests that boxes of these booklets are still lurking in cupboards in GPs' surgeries and goodness know where else. I do not think I have ever come across one woman in all the hundreds, and possibly thousands, of women I have spoken to in the past few years who has ever been given one of those booklets. That is not creating a dialogue. That is not informing women of the potential choices. There has been a closed approach to this whole process. When women find out the alternatives for childbirth - that is, they do not necessarily need to go to a specialist obstetrician or to a hospital to have their baby - they will walk over broken glass to get the information. Probably the most significant role that we provided - and it is still being provided through the community midwifery program through the resource centres - is giving information to women. A large number of women use those services, but certainly nowhere near the 25 000-odd women who give birth every year.

Hon LOUISE PRATT: Do you have a view on how that information could best be provided to women?

Dr Reibel: There are a number of ways in which it could be provided. The booklet should be placed next to the pregnancy test kits in every pharmacy, because that is what women do first. Women know they are pregnant anyway, but they get a pregnancy test kit to confirm that they are pregnant. They then go to their GP to confirm again that they are pregnant. If next to the pregnancy test kits in every pharmacy there was a booklet that explained the choices and the available services, you would probably find that a lot more women would be informed. Information can be distributed in a range of ways. You start through the education programs in schools. The

Birthplace Support Group, which is a longstanding birth advocacy group in Western Australia, has been providing a school talks program for 15-odd years, and possibly longer.

[11.40 am]

You can provide it through GPs' surgeries. You should make sure that there is a requirement to display this material. It should be displayed in antenatal clinics and pharmacies and distributed through schools. It should be put it into child health centres and playgroups; the whole range of places where women are located. We are not trying to pick up only the first-baby women; women generally still have more than one baby. There is a range of public forums in which this sort of information can be distributed. It can also displayed on web sites. The WA health department has a web site with all sorts of consumer information on it. I do not think there is anything about the choices in maternity services.

The CHAIRMAN: Not yet?

Dr Reibel: No.

The CHAIRMAN: I want to ask you something about that. Are you aware that the health department is in the middle of a three-stage community consultation process? We are into the middle stage, which is a seven-week stage for community consultation to find out what people want. No community will be forums run. It is a process -

Hon SALLY TALBOT: I believe Dr Reibel referred to the half-day seminar.

The CHAIRMAN: That was for providers. I am talking about consumers. The seven-week process is essentially about community consultation. We are actually in the middle of that time frame right now. I think it takes us to the end of December.

Dr Reibel: The only consultation I am aware of at the moment is the document that has just been released; it was posted to me last week. It is a discussion paper. I received a notification by e-mail last night that there would be some type of forum held at the Burswood some time but there was no detail attached to that about whether it would involve consumers. I am not aware of any other processes.

Hon SALLY TALBOT: We also have a document called the consultation plan. Have you seen that?

Dr Reibel: No, I have not seen that.

The CHAIRMAN: The reason I asked was that you commented that the health department has never used an effective method to find out what women really want. I guess I am asking whether you think that the seven-week program for community consultation that we are in right now - which you are obviously not even aware of -

Dr Reibel: No. I think that speaks volumes, actually. The fact is that I have been a leading advocate in this state for the past 10 years but have not even been informed about it. As far as I am aware, the Maternity Coalition has not been informed.

Hon SALLY TALBOT: The timetables are set out.

Dr Reibel: Seven weeks is not a long enough process to consult with the community in a state in which there are people from Albany through to the highest point. If I do not know, how many of the other consumer advocacy groups associated with maternity care do not know and therefore cannot engage their stakeholders? It is very poor form.

The CHAIRMAN: I just wanted your comments about that.

Dr Reibel: I will follow it up, obviously.

Hon SALLY TALBOT: I wanted to ask you a bit more about the idea of consulting with a view to finding out what it is that women want. You referred several times this morning - we have evidence

at previous hearings of which you may have read the transcripts - to the fact that there is not an integrated view coming from the providers. Do you think that there is more of a unanimity of view coming from women themselves?

Dr Reibel: No.

Hon SALLY TALBOT: Can you talk about some of the voices you hear coming from women?

Dr Reibel: I have spoken to an incredibly diverse range of women on this issue. There is a range of views associated with childbirth. It appears to me that the experience people have had of childbirth greatly influences their views on the whole topic. One of the consistent things that I hear from women is that they certainly want to have a live and healthy baby; that is their primary goal. All women want that. Women are not particularly well educated on how to achieve that but, generally speaking, women are of the view that because they are healthy, they feel that their chances of having a healthy baby are pretty good. One of their concerns - this particularly relates to women I have spoken to in rural and regional Western Australia - is access to services. That is of real concern to them. They are concerned that they have to travel, that they have to leave their families and that they have to take what they have in the town they are in - if there is a service. They are very limited in their capacity to do anything other than basically see the local doctor. That drives a lot of women sometimes to seek care in other places. I have spoken with a great number of women who are involved with, for example, Birthrites: Healing After Caesarean, because they have encountered in a range of ways obstacles in their journey to have the birth experience that they actually want. I have spoken to Aboriginal women, particularly in the north of our state, who had to leave their communities - sometimes for weeks on end - to get any care at all, and who are very distressed by having to leave their families and their support networks. I have spoken to women across the metropolitan area who have been desperate to have a carer whom they can get to know and who understands them as a person. I have also spoken to a lot of women who said that they just want to go to hospital and have an epidural and a five-day stay; that is all they want. That is absolutely fine, too. I think what we have to understand is that there is an incredibly diverse range of women with an incredibly diverse range of needs and, somehow, we have to try to meet those individual needs. I believe we can do that by providing integrated services that use midwives and GPs and obstetricians more effectively. Women have been having babies for a long, long time. I think that if we can demonstrate to them now in this day and age, when the medical model of care is so predominant, that there are other ways that they can get really good care and have really good outcomes and have a really good birth experience, we will then have the same experience as has occurred in New Zealand. In New Zealand, women have flocked to midwives in droves. I think the outcomes in New Zealand speak very largely about how that can be done. Does that answer your question?

Hon SALLY TALBOT: Yes, it does. It is a very adequate answer. I suppose my follow-up question, which you might not be able to answer without some thought, is: of that range of expectations that women bring to the process of giving birth, how many of them do you think can be adequately taken into account by the services that are offered in a place such as Western Australia?

Dr Reibel: I think a vast number of them can be. You will never be able to suit all the people all the time. Like anything in life, childbirth does bring risk. You might be all out for a full-on natural birth but end up in hospital with a caesarean section. There are no givens in this process, but I think the evidence demonstrate that we can accommodate women in a variety of ways, even in the spread-out population as we have. I will not say “easily” because I do not think that any services are provided easily but I think that they very adequately provide for the expectations of women. You can do that by more effectively using the midwifery work force to provide basic maternity care within a range, whether it is community-based or clinic-based in a small regional hospital. It has to

be said that small hospitals in the state provide one of the best maternity services of all for those women who can actually access them.

[11.50 am]

Even though they come under the supervision of the local GP obstetrician, they are largely midwifery led. They do provide the expectations, but they are not available in all rural centres. There are so many of them that have closed. I do not think that is a really good use of the professionals that we have sitting in our rural and regional areas. There are a lot of midwives sitting in rural and regional areas who are not working because they cannot work within their own autonomous capacity as midwives, and they want to provide that care.

Hon SALLY TALBOT: What I understand you are suggesting, if I may paraphrase you, is that with the best use of the available work force, if we were looking at something like a pyramid, would be to flatten the top of that pyramid and spread some of those services out at, presumably, not much additional cost.

Dr Reibel: I suggest that over time it would actually show a reduction in cost.

Hon SALLY TALBOT: Is there evidence to that effect that you are aware of?

Dr Reibel: Certainly the Treasury figures out of New Zealand have shown a decline in maternity services spending. It did not initially; they had to make some adjustments. I cannot remember the reason, but a couple of years after they implemented the lead maternity carer system there was a problem because it shot up, but they addressed the issues. I cannot specifically remember what they were. Treasury figures now indicate over a very long period of time that there is a slow decline.

Hon SALLY TALBOT: The New Zealand model would be one to which you could refer us for that kind of evidence?

Dr Reibel: Absolutely, and the Treasury figures associated with that. I do have them. Again, I could forward those to you.

The CHAIRMAN: If we were to go down that track, what sorts of changes, mostly legislative but also policy and issues around things like indemnity, would have to take place to enable a system like that to occur in Western Australia?

Dr Reibel: We clearly need a maternity services framework. That is required at a national level, but it is certainly required at a state level. We need to have a framework that is modelled on the type of consultation process that the "Future Directions in Maternity Care" discussion paper is proposing - a little less rhetoric would be nice. We need a framework that was developed out of a consultation process; that underpinned an integrated approach to the provision of maternity care; that took account of all the stakeholders' needs, themselves emanated out of a full consultation process, and so met the expectations of women, within the boundaries that we have to acknowledge exist in some of our more remote locations; that took account of the indemnity issue, which is a huge issue for midwives, in particular, because they simply cannot access indemnity at the moment. We have these unusual arrangements where we have, for example, community midwives on the community midwifery program employed through the Women's and Children's Health Service, as they have been for the past five years because it was the only access they had to indemnity insurance. If we were going to roll out this type of program, those would be addressed to some degree, because they would be addressed through RiskCover itself, and the employment of those midwives through a state-based system. The provision of independent indemnity insurance becomes less of an issue. If you have a state-based maternity framework that enables community midwives to be employed across the state through the state government, then you do not have an indemnity problem. You certainly do need to address that problem with GP obstetricians, who are leaving obstetrics at a vast rate. One of the main reasons they quote is the cost of indemnity. If they are in a small town where there are not a huge number of births, they have to ask themselves,

"Is it worth my while to maintain this large premium for this small number of women?" There are issues around that that need to be addressed. I am not an expert in that area.

The CHAIRMAN: Does the government not pick up the indemnity costs for GPs in small towns?

Dr Reibel: Not if they are visiting; they have to be employed.

The CHAIRMAN: In towns with a population of a certain number?

Dr Reibel: Possibly they do; I really do not know the details.

The CHAIRMAN: I am almost certain they do, but I cannot tell you precisely what it is.

Dr Reibel: Certainly if we had a framework that provided an integrated service - and the way to effectively do that is to have a continual assessment process, because populations change in different areas. You might go through a boom of babies over a 10-year period and then you might have a really significant decline. It is not about saying, "This is how we are going to do it" and it being written in concrete for the rest of all time. It is about making assessments around the demographics. We can do that. We can project those things. We have all sorts of sophisticated analysis software available to do that. You need to have a basic framework that promotes integrated services; that makes good use of your available work force; that promotes good use of the variety of models of care that are available. You need to continually review it, so that you are providing the services where they are most needed. You do not shrink services into three or four hospitals in the metropolitan area and shift all the women in, because what happens then is that you get rising caesarean section rates, and that is to be avoided.

The CHAIRMAN: One of our previous witnesses, Dr Simon Tower, commented that Swan Health Service has a 17 per cent caesarean section rate. That is a rostered obstetrician service for all women. He made the comment about that being a statistic that is worth looking at because it is so low in comparison with other areas. That flies in the face of some of the things that you have been saying. I do not understand it and do not know why it is. You may want to comment on that.

Dr Reibel: I am not specifically aware of the Swan District's situation. I am aware that at one stage they were paying an inordinate amount of money to maintain that obstetric cover. I do not know if that is still the same case. I cannot comment on that. I am not aware of the situation.

The CHAIRMAN: I have never fully understood the issues around how the community midwives are paid for what they do. I had not, until today, fully understood the way their insurance is managed. I understand you to say that currently community midwives are employed by the Women's and Children's Health Service.

Dr Reibel: Community midwives on the community midwifery program are covered by Women's and Children's Health Service, yes.

The CHAIRMAN: When you are engaged for a woman and you are delivering in the home or wherever, do you get paid by the hour or on the basis of the go-to-whoa service that you provide for women's birthing? How do you get paid?

Dr Reibel: The community midwives are currently employed through the Women's and Children's Health Service. That is how the service will proceed from now on; and as has been the case for the past couple of years, they are on a salary. There was an agreed salary for the work that they did, which took into account all the components. Prior to that, they were actually paid on a fee-for-service basis; that was an episode-of-care fee for service. They are now employed on a salary. They are also now provided with all their equipment and the drugs that they are required to carry with them to keep a birth at home. Again, that has been a fundamental change, because previously they were paid a fee for service and they paid for and provided all their own equipment etc. Now you have independent midwives who are still practising as independent practitioners.

The CHAIRMAN: How do they get paid and by whom?

Dr Reibel: By the client.

The CHAIRMAN: What about their indemnity?

Dr Reibel: They do not have any indemnity. They work without indemnity. They choose as practitioners to do that, and they do that because they believe in what they do.

Hon SALLY TALBOT: How many people do we have in Western Australia providing that service?

Dr Reibel: As independent practitioners, at the moment four, maybe five; four that I am aware of.

Hon SALLY TALBOT: Are they all in the metropolitan area or in the regions?

Dr Reibel: There is one provider in the south west. I believe that provider has backup. That is a fairly new service. There are three in the metropolitan area who are active.

Hon LOUISE PRATT: In your Churchill paper you talk about midwifery leadership. From the discussion we have had this morning about evolving to different models of care, it is clearly not just the models of care at stake but the whole of the management principles that would be behind a new maternity services framework. How are the stakeholders - GP obstetricians, midwives, the health bureaucracy and obstetricians - able to put aside their vested interests to examine how these things should be best led in the future?

[12.00 pm]

Dr Reibel: That is an interesting question. The situation in the UK is driven by the fact that everyone is employed by the National Health Service. Therefore, it is much easier for the NHS to avoid some of the hierarchical issues that exist here because of the public-private divide, particularly because obstetricians tend to work across both sectors. How can those vested interests be put aside? That is where the maternity services framework becomes an important initiative. A strong framework must be underpinned by good evidence-based policy that takes account of the needs and concerns of all the stakeholders and enables them to see very clearly where they fit within the framework. The framework must be based on good consultation and referral guidelines that have been agreed to. People must agree to the framework and everyone must be able to have their say on it. That comes back to the issue of leadership. Good, strong leaders are needed who are committed to the process of change and who can see that maternity services can be provided in a far more effective way that will lessen the burden on all the work force involved. Lessening the burden on the work force is an important factor in the provision of maternity care because it is not a nine-to-five job; it is a lifestyle. If agreement can be reached, if there is strong leadership and a sound framework has been provided, a lot of issues can be resolved. It is not hard to resolve many of those issues because there is goodwill across all the professionals involved. Some midwives who have been sitting in a post-natal ward at King Edward for 20 years will resist it because they do not want to change their practice. Similarly, some obstetricians who have been working in a certain way for 30 years will not want to change. However, there is a will to change, which is partially driven by having had a reality check of what is happening to maternity services. People know that there are work force issues that must be addressed. We need to find more effective and cleverer ways of providing care. We also are more cognisant now than we ever have been of the need to involve consumers in the decision making processes. That cannot be done unless a system is in place that enables them to do that. We have past the rhetoric on that; there is a requirement that those types of processes must be put in place, and that cannot be done unless a good system of care is operating. The community midwifery program is a very good example of how to get to that point. It has taken a long time, but the community midwifery program is integrated with children and women's services, which is an indication that it can be done. There has not been a great deal of shift in the model of care provided by the community midwifery program; most of the movement has been in the other direction towards it, which is interesting.

The CHAIRMAN: Are the community midwives in that program able to assist with delivering the babies of the women who they have been working with if the women have to go to a hospital? Are the midwives able to go into the hospital and maintain that care in a hospital setting?

Dr Reibel: I am not sure whether that is the case. Women who have chosen to give birth at home use the community midwifery program. Traditionally, a midwife will transfer a woman to a hospital and hand over the care of the woman to the hospital, but the midwife will remain as an advocate and provide a supporting role. Often that suits the midwife because she may have been on call at that stage for a lengthy time and it is time for her to hand over the care of the woman anyway because it is an issue of occupational health and safety. Officially, I do not know. Unofficially, I think it depends on the hospital that the patient is transferred to. Most patients are transferred to King Edward. The midwives are employed by women and children's services, and I presume that the midwives would continue to provide care. It would largely come down to who was on the labour ward, the relationship between the midwife and the hospital, and what the midwife wanted to do in the circumstances, taking into consideration how long the midwife had been on call. The committee would need to check with the service about that because I am not entirely certain.

The CHAIRMAN: I am interested in the continuity of care for the mother and baby from the antenatal stage through to the delivery and postnatal stage. Must that care be with an individual person? Is that an important issue? Does continuity of care also involve being able to hand over the delivery of a baby to a rostered doctor at a hospital or to a midwife who works in a small hospital, or whatever? Is that a significant issue for mothers? What are the issues regarding continuity of care versus another model that would allow the transfer to take place as a matter of course?

Dr Reibel: The Australian College of Midwives recently published an article of a systematic review of women's responses to the continuity of care. It was a largely flawed study, I have to say, but from the literature it used, it indicated that women are not concerned about the continuity of care from antenatal care to labour and delivery. That study used papers from Australia and the UK. I say it is a flawed study because it used a variety of different models of care, which is like comparing apples with oranges, and I have some other concerns with it. I have done research on this matter that was based on the cohort we had with the community and midwifery program and on women I have spoken to. I was in Geraldton last week and spoke with a midwife who has been evaluating a service offered by the Geraldton Aboriginal Medical Service, which provides antenatal care out of the Geraldton Regional Aboriginal Medical Service. GRAMS has had an exponential increase in the number of Aboriginal women who have presented for antenatal care, which has been a real issue in Geraldton. The women tend to present at a hospital in labour, having had no antenatal care. The introduction of this service into GRAMS has meant that there has been a significant increase in the number of Aboriginal women presenting for antenatal care. One of the highlights of this research has noted that the women are saying that they are now going to the hospital because they do not have to attend structured appointments; they can drop in whenever they want to. Also, they do not have to tell their story to half a dozen people because they see the same midwife every time they visit. The midwife knows the patients, which encourages them to come back. That was interesting because it is exactly the same sort of response I have found from my own research. Women do not want to tell their stories to half a dozen different people during the course of their antenatal care and to then, when they are in labour, be presented with a completely different person who knows nothing about them and who does not know their background, their fears and has no relationship with them at all. Similar findings were found in an evaluation of the Albany practice, which is a community-based midwifery practice in a lower socioeconomic area in London. Not much has been done qualitatively in terms of women's experiences in the transition from what happens in antenatal care to what happens in labouring care. However, the information that is available indicates that women feel more comfortable if they know their practitioner. This may underpin why women choose a specialist obstetrician for their antenatal

care. Even though the obstetrician will be present only for the birth and not throughout the labour, it is an issue of continuity of care for the women - that is, that the obstetrician is someone they know. This is an undervalued and under-researched component of women's experiences of childbirth. If a woman must continually tell her story to someone, she will very quickly get bored with it and will not disclose information that might be important to her care. If she has already said it once or twice, she will not say it a third or fourth time. I can relate that to my experience as a patient at King Edward when I had my first child. I never saw the same practitioner twice in eight antenatal visits. During the labour and birth there were two shifts of midwives. I never saw the same person twice. I decided not to do that again. My second child was born at home. I knew the midwife from my twentieth week of pregnancy, and I still know her today.

The CHAIRMAN: How can the issue of the long hours be resolved? Midwives cannot be available for 24 hours a day, seven days a week.

Dr Reibel: Community midwives are on call 24 hours a day, seven days a week. That is part of the territory. It must be looked at in the context of midwives being on call 24 hours a day, seven days a week when women are due to birth, but it is all about planning and management. That is an attractive element of midwifery for some midwives. That is why we do not just want case load community midwifery care. We must have a variety of models of care and we must ensure that the work force is taken care of. That was a significant finding of my Churchill fellowship. I spoke to midwives who had done case load work and who loved doing it but who now have young families and therefore need more control over their working environment. They are working in share care models and a variety of other models, and they are determined to go back to case load work when it is more conducive for their family circumstances. However, for the time being, they are working in alternative models of care. They shifted in and out of different models of care because those models were provided that meant that they could do that. It is a matter of addressing the issues and the needs of the work force. A balance can be maintained because community midwifery can be provided. That service will be taken up where it is provided. Hospital-based services will also need to be provided because there will always be women who will want to go to a hospital to have their baby delivered, and they must be provided for. It is not possible to tell them that they must have their baby delivered elsewhere because that is where the services are provided. Midwives must be able to easily move between models of care, depending upon which arrangement is conducive to their current circumstances. Obstetricians are on call 24 hours a day, seven days a week. They must be provided with a service that allows them to take off an adequate amount of time. A whole range of matters must be taken into account. That can be done and it is being done. How can continuity of care be provided? It can be done by providing good, solid services rather than by providing services that are always running on the smell of an oily rag and which are always trying desperately to meet everyone's needs. It can be done by providing a good, well-supported and well-trained work force. That can be done. Sometimes we create obstacles that are not necessarily there. It can be done and it is being done in other locations.

The CHAIRMAN: Thank you very much for your time. Your evidence has been very informative.

Hearing concluded at 12.13 pm