SELECT COMMITTEE
INTO PUBLIC OBSTETRIC SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
ON MONDAY, 14 MAY 2007

Members

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

Hearing commenced at 1.43 pm

TOWLER, DR SIMON
Chief Medical Officer, Western Australia,
Executive Director, Health Policy and Clinical Reform, examined:

MAGGS, MS ALISON
Senior Development Officer, Health Policy and Clinical Reform,
Department of Health, examined:

The CHAIRMAN: On behalf of the committee, welcome to the hearing. Thank you very much for coming in again. You will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

Dr Towler: Yes, I have.

Ms Maggs: Yes, 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 the hearings for the record. Be aware of the microphones and try to talk into them. Please do not cover them with papers or make noise near them, and please try to speak in turn. 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, 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 evidence is finalised, it should not be made public. I advise you that premature publication or disclosure of your 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 Towler: Only a very brief one, and that is to say that we appreciate the opportunity to come back and speak with you. As you are aware, we have just released a draft policy document titled, "Improving Maternity Choices: Working Together Across WA". In its accompanying materials, there is a brief pamphlet. We have brought with us today some posters as well, which we are more than happy to provide you with. This is a very important point for us in the development of this particular framework. We have outlined to you previously our program in terms of consultation with the profession and the community. We have progressed down that pathway as best we can, with occasionally some slippage here and there. As you will aware from the document you have been given today, the consultation process extends for a number of weeks and will result in a review, subject to consultation across the state, of the details of the framework. This is a draft document. It is our intention to consult widely before it is finalised.

The CHAIRMAN: We did not get this document until one o'clock today, so I have not had a good chance to pick up some of the issues that you have just raised about the consultation process and the process that will take place from now on. Would you like to expand on that a bit?

Dr Towler: I will ask Alison to give you an outline of the consultation program.

Ms Maggs: The consultation will occur over the next 12 weeks. We are scheduling events across the state. We have involved each of the area health services and relevant groups, such as the ethnic communities, which are supporting us in undertaking consultation within their groups. The Aboriginal community is also supporting us in consultation with Aboriginal communities, together with the Office of Aboriginal Health. The consultation involves a variety of meetings, workshops

and events throughout the state. We are working with the relevant area health services in that process.

The CHAIRMAN: How will the community be informed about, and invited to participate in, that consultation process at the local level?

Ms Maggs: There is a variety of ways in which the community will be invited to participate. The public events will be advertised and promoted locally. In addition, posters will be provided at local points, such as shopping centres, local libraries, local governments and child health centres, along with a consumer leaflet, or summary leaflet, that will also be made available prior to any event. We will also be promoting it through the local media, and of course by invitation to people who have already expressed an interest in either the process that we are going through, or the process that you are going through, and also to groups that are known to be involved, or interested, in maternity care issues.

The CHAIRMAN: What areas will you be going to?

Ms Maggs: Every area of the state. We are going to the Kimberly, the Pilbara -

The CHAIRMAN: Whereabouts in the Kimberley will you be going?

Ms Maggs: How we are tackling the consultation is that the WA Country Health Service has nominated a local facilitator. In the case of the Kimberley, Dr Anne Mahoney is our local facilitator. She will be organising and conducting the consultation, along with staff from our office. We have actually said to Dr Mahoney, "What is the best way of talking to your public and your health professionals? Can you provide us with advice and ideas on how each of those events should be organised?" They are being organised at a local level, using local knowledge, information and networks.

The CHAIRMAN: In the Kimberly, for example, will it be in one location only, or in a variety of locations?

***Ms Maggs**: At this stage the program is still being refined, but the initial view is that there will be several events at a variety of locations, including visits to remote Aboriginal communities.

Dr Towler: We have taken advantage of the area health services having district advisory councils, which engage a number of consumers and local people. We have tried to build on their strengths in terms of setting up the local consultation framework, particularly in the rural sector. The metropolitan area is a little more straightforward, but we are working with the area heath service administrations and their clinical service planning units, which have been working increasingly with consumer groups over the past 12 months. The program in each case is designed to create an opportunity for the area health service administrations to develop a relationship with the consumer groups of interest in obstetric and maternity services so that when we later come to the implementation framework they will be well informed and they can identify appropriate consumer members for those processes at a later date.

The CHAIRMAN: Taking into account that we have not had a long time to review this document, can you give the committee an understanding of what has changed between the previous document - I cannot remember what it was called now - and this document? In what areas has there been change in direction in the concept and the plans for maternity services in this state?

Dr Towler: As you will know, the previous discussion document introduced to people a change in focus that emphasised particularly team-based maternity care. It looked to opportunities for people to provide input on what models of maternity care they might wish to have us consider. From that process, we also engaged an external research group, as you will remember from our last meeting, which reviewed the available evidence around different models of maternity care. That has been built into this framework in the beginning to promote options around the regional hub model that I discussed last time. We have become very aware during the development of this framework of the

challenges that are faced in maintaining and developing a maternity services workforce. That is an issue that has been identified across Australia. We have, therefore, in this model sought to take into account strongly workforce development as a theme. That is, we have been defining the options for care, which now includes team care, a strong emphasis around general practice engagement, particularly in the rural sector, and coming to an understanding of what other options for particularly peri-natal care are available. The document invites people to consider the evidence and the improved range of services, which includes homebirthing, birth centres, and traditional mainstream obstetric care, but very much in the context of a continuum from preconception right through to postnatal care. We are very conscious that this is a broad document at the moment. You will not find lists of sites. We are here looking at what is called a model of care; in other words, how do we deliver the service, and what is the range of services that the community would seek to have provided. We have also gone to check on the evidence that those services would be safe, which is consistent with our emphasis. I have been particularly grateful to the clinical reference group, which has been working with us. Following the discussion paper, we sought an evidence review. We then developed a clinical reference that is fairly broadly based, and that has assisted us in putting this document together.

The CHAIRMAN: Would you say that there is a change of mindset within the Department of Health?

Dr Towler: This document has been developed through the health networks group. We have worked strongly in partnership with obstetric service providers. The extent to which attitudes have changed I think is too early for us to assess. We have put the document out for discussion. We have certainly embraced obstetric practitioners. We have met with general practice. We have looked at the workforce issue behind that. I believe there is a greater interest in looking at the challenges before us in providing a safe and appropriate maternity care model for Western Australia. I think people have been very cooperative. There is an interest and an understanding that the situation has changed from the very traditional, very medically led model of the past. I think people have understood that the workforce does not exist to support that model. People have begun to recognise that there is a genuine interest from the community for changes in the model of care. We believe this document is a reasonable statement of the feedback that we have been given. The extent to which there is a broad change in attitude I think is too early for us to say. The reason we have put this out as a draft framework is specifically to seek input from all clinical groups on their view of what is being proposed. It will need to be balanced by a very strong consumer input -

The CHAIRMAN: And community input.

Dr Towler: Yes, very much so. Therefore, when you asked me about the Department of Health, I suppose in that context I am thinking that you mean the clinicians who work for us. From the department's point of view, I am speaking on behalf of the health policy and clinical reform division. We have developed greatly in terms of our understanding of what the options are. This document aligns strongly with the New South Wales maternity model of care, and we think it is appropriate for the Western Australian community.

The CHAIRMAN: One of the things that I did pick up in the very short time I have had to look at this document is that a significant amount of discretion is being given to the area health services to decide whether they want to go down this track, whether they want to consider having community clinics, or whether they want to consider having this, that or the other. I cannot find the exact wording, but if you want me to -

Dr Towler: I fully appreciate the direction in which you are going, and I would like to make some comments on that. All the work being done through health policy and clinical reform is based around the concept of what I call models of care. They are largely overarching, agreed frameworks for service development. It has been very clear during the feedback to us from the discussion document, particularly from the rural sector, that the opportunity for providing a range of services is

very dependent on who is available. We are very conscious of that. In terms of taking a document that is designed to discuss service models in their broader sense, the individual application of those models across the extraordinary range of environments that exist in Western Australia will need to be done in partnership with the area health services. That is no different from the work that we are doing on stroke care, or the work we are doing on the management of congestive heart failure. We see this document as an overarching, strong policy framework to then develop what are in fact location, site and regional specific implementation programs that are consistent with that. For example, I think we discussed last time that it will not be possible to offer birthing centres at every location across the state. In many cases, you will be dealing with fairly small communities -

The CHAIRMAN: What would make it not possible - the workforce?

Dr Towler: Simply the workforce, and the numbers of people being dealt with. If we have a very limited workforce - say, just a few general practitioners, supported by a few midwives - in a small regional centre, then we believe we need to take the principles of the model of care and have a strong discussion with the provider on how we can best make that model work in that locality.

The CHAIRMAN: Does the opposite apply also; namely, if the workforce is there, and the capability is there, and the community is seeking that -

Dr Towler: That is my view of what should happen. We will take the feedback that we get from the community and clinicians over the next few months on this draft document. The document will then be put to the state health executive forum, which includes the chief executive officers. At that point, it will become policy in terms of implementation. Consistent with the conversations we have had previously, it would be my expectation that at the implementation level in those areas - this was the metropolitan model that we talked about - there would be an improvement in the range of services that are available at each site.

[2.00 pm]

Ms Maggs: If I could perhaps give an example. In the document we talk about community clinics, but we also talk about GP practice clinics. Essentially they are very similar models but we have included those particularly because in some regional areas it would be possible to provide one or the other, but not both. There would not be the demand or the sustainability to have both models available. So, it is about looking at what best suits the needs of that community.

The CHAIRMAN: I am still following that line. One of the reasons that this committee got under way was sparked by the closure of obstetric services at Kalamunda hospital. That hospitals had sufficient midwives, had GP obstetricians who were willing to provide a service, and there were 300 or 400 births. Going by the comments you have just made, it sounds to me that had that service not closed, it could possibly have stayed open under this sort of approach. Is it a possibility that a centre such as that could be reopened, or is it the case that once it has closed, it is finished and there is no chance whatsoever?

Dr Towler: I am not going to be evasive but I am not going to answer the question specifically around Kalamunda because I do not believe I have the authority to do so. I am in a position to say that I think it is very clear that compared to the framework under which some of the original decisions were made about services and where they would be provided, we have seen a substantial increase in the number of deliveries that are occurring in Western Australia. We have seen some changes to the service modelling for hospital sites in south metro following the clinical services review, and it is my opinion that in every case we would be looking to opportunities to change and realign the services to be consistent with demand and consistent with appropriate safe practice. It will be up to the North Metropolitan Area Health Service, confronted with its responses to the final framework and the demand for services within that area, to consider what might be appropriate in terms of the service model. One of the great things about having an overarching models of care document like this maternity framework is that we believe for the future the approach being taken through health policy clinical reform means the decisions made on service modelling, how they are

set up and how they operate will need to be within a consistent policy framework. I look forward to that being the case when this is in place, as we are already beginning to see in stroke care, and the document we have before us at the moment on dialysis planning for the state will see some similar changes compared to some of the original decisions that were made following Reid.

Hon SALLY TALBOT: On a slight change of tack, you will remember a couple of weeks ago the minister made some comments about ways to reduce the level of intervention, particularly the lowering of caesarean rates. One of the things that struck me about the commentary following his remarks was the emphasis that everybody across the board put on the need for community education programs. I guess that in a sense I see this as the other side of the coin to the consultation. We consult about what people see as an ideal situation or how they reflect on their own experiences or expectations, but the quality of the consultation improves if there is some sort of education process in place as well. I notice on a very quick flick through the draft policy that you have a recommendation at strategy 10 that says health professionals will be supported to provide balanced information to enable better personal decision making in birth planning. I take it that strategy 10 is the sort of thing we would be talking about in relation to changing models of obstetric care delivery and, let us be blunt about it, encouraging women to make decisions that take them away from the medical model where they do not need it.

Dr Towler: I think there is no doubt that in the work that has been done to date we have been conscious of the need for there to be better education of women and the choices they make. What has proven to be very challenging is the interface that exists between public health service planning for any service and our relationship to general practice and primary care, where women often have their first encounter with whatever provider. That is taking primary care in its broadest sense, which means not just medical general practice but whatever community-based primary care services are available. It has therefore been an important element of what we have been doing to develop a strong liaison with the GP networks in Western Australia in looking at the general practice model. We have been talking to a number of leading practitioners from general practice who have been involved in team-based maternity care. We have been reflecting on - how can I put this politely - the inadequacies of the federal government's payment system for maternity services to support nurse practice models in general practice, which is somewhat disappointing given the role of practice clinical psychologists has now been endorsed. The federal government just walked away from endorsing chronic disease nurse practitioners as well. We see a lot of similarities. If we want to introduce a team-care model in general practice, some financial instruments are needed to make that happen. Regardless, in the rural sector we clearly have a leading role, and in that framework and within the metropolitan area we would expect to take on responsibilities for ensuring information provided to women is made available. The health networks themselves are seeking to create a very strong information source and a resource for people to access. We will be making our materials available in a number of community settings. We see this as one of the important elements of what this consultation process will give strength to, which is to improve access to information and make clear what the options are for care throughout pregnancy. The extent to which we can achieve that in a short time will be challenging. I am encouraged by the change in the service model in WA Health to a much stronger population and community base through area health services. You may well be aware that consumer councils are being developed within the area health services as well as with the regional service providers. I think that gives us opportunities to understand how best to communicate with people. The shorter answer is yes, I think we are committed to better education. One of the challenges is how we integrate that across primary care, particularly in general practice. I think the development of a maternity team model in general practice is a very important outcome for changing the overall landscape of maternity services.

The CHAIRMAN: Just following up on that point a little, you talked about improving access and I think I heard you talking about improving education. I wonder whether the area that needs a huge boost is out-and-out marketing, especially when there are significant voices in opposition to the

changes that people want to make, particularly from the AMA, saying that it is not necessarily in the interests of women to follow some of the options you have mentioned here. What will you do to balance that voice?

Dr Towler: One of the reasons the work has gone into this document and the process of stepping through this very extensive process we have set up is that the eventual maternity framework document that will be completed, we hope in August, will be the basis for making comments to the community on the services the WA public health system will offer. We will be endorsing in the implementation stage that those services be developed and offered. One of the challenges to date has been that in the absence of an overarching endorsed policy, opinions of all sorts often get pre-eminence in any conversation. I think there is clearly substantial influence from the medical model, and I perhaps should declare that I am still the state treasurer of the AMA, if you are not aware of that. There have also been very strong presentations made on other models of care. We have sought in this review to ensure there is a strong evidence base that the overarching maternity framework that is endorsed is appropriate and that those options will be made available. We have already had some interesting feedback from the events of the weekend.

The CHAIRMAN: From what?

Dr Towler: There was some media coverage on the weekend from the release of the document, and I think the upcoming consultation period will be interesting.

Hon LOUISE PRATT: I wanted to ask about the scope of practice envisaged within a community clinic. To my mind a range of different models could be accommodated in a community clinic from not much changing at all through to a scope of practice where midwives act as lead maternity carers. A team of midwives could be a small number of midwives setting their own rosters and handling work between them so that a woman has continuity of care, hypothetically from conception right through to post-birth, in a similar way to the community midwifery program. Alternatively, it could continue to be quite restrictive. I appreciate that some of that needs to be set according to local conditions and the capacity of the workforce. There would need to be a fair bit of leadership within each local area health service to transform the models of care that are provided if we really are serious about setting up different and new directions, such as the ones that have recently been developed in New South Wales where midwives have come from the public health system and hospital-based care and have built up the level of practice to which they are now the lead maternity carers. Could you comment on where to from here in relation to community clinics and what kind of leadership can be put behind developing the potential of the models of care that should be available?

Dr Towler: The first step for us is unquestionably to ensure that there is strong community endorsement for the models that are proposed. I think your expression about the need for appropriate leadership is very important. Once we have clear endorsement for the proposals, we will be making use of our clinical reference group to revisit the scope of practice, which is what you are talking about –

Hon LOUISE PRATT: Could I just interrupt you there? You talked about endorsement of the proposals. From what is written in here I cannot see a proposal that looks like that. That is an example of what could be produced within a community clinic framework. From what I can see, it is not there in detail in terms of the range of different things that could be done.

Dr Towler: You have just given us some very useful first feedback on our draft document. I am quite serious in saying that. I think if your impression is that the community clinics information is not giving us the broadest possible scope, we will certainly pick that issue up.

Hon LOUISE PRATT: Okay. I think it would be good to give some more examples. The word "team" that is sometimes used in relation to community clinics can be misleading. From a quick

reading, I think you need to be very clear about the diversity of models that are available. Please go on with what you were going to say.

Dr Towler: We are hampered by the issue that this document is trying to describe what is a change, but also it is looking at its potential application across a range of locations. My personal view, and that is all it could be at the moment, is that in the metropolitan setting we would see that as an important development, and there would be a wide range of opportunities available through the community clinic model.

Hon LOUISE PRATT: Great.

Dr Towler: It is that kind of next step conversation: once this model is endorsed, we will then have the robust conversation with area health services about what this means in its application in the different settings that are available. There will be greater scope in some locations than there will be in others and that is an important theme.

Hon LOUISE PRATT: I am pleased by that reassurance and the scope of what you are saying. I think I will have a better appreciation of that once I have read the whole document.

Ms Maggs: The variety of things we have mentioned that could be included under community clinics is not all-encompassing and will vary from area to area and according to the needs of the community.

The CHAIRMAN: In that section on the community clinics you are saying it will offer about 55 per cent of women who do not need medical intervention at all the ability to have their entire pregnancy, delivery and postnatal care, managed by a midwifery-led service.

Ms Maggs: What the community has told us, which is what this is based on, is that it would like continuity of care. Irrespective of who looks after them, they would like a team of people to work with them throughout the whole of their maternity care. One of the options they could have access to is a community clinic led by midwives, but involving other health professionals.

The CHAIRMAN: Do they have to involve other health professionals or could it be purely a midwifery-led team of midwives?

Ms Maggs: It could be, but the research and anecdotal evidence that is being provided to us states that even where there is a midwifery-led clinic totally run by midwives and containing midwives, they still have clinics with, for example, a GP coming in to provide other services to that community and to the people using that clinic. That has actually been proved to be the best model. It is a case of talking to the community and to the professions to work out what is the best model for each area.

[2.15 pm]

Dr Towler: The information at the top of page 30 talks about the fact that the labour and birthing facilities would not be located at the community clinics. The community clinic is the community footprint for the delivery of maternity services. It encompasses preconception advice and antenatal visits and it develops a relationship between the woman and the caring team. That caring team will vary; my view is that it would vary depending on that person's particular request. It would be built into a structure that would then allow the woman to make a choice around what environment she wishes to have the child in and what kind of support, but it underpins the theme of a consistent relationship between the woman and her maternity team. As you know, our theme from the outset has been about choice, and women will vary in the extent to which they do or do not want medical engagement in the whole episode of care. Certainly, in some of the conversations we have had, people are very keen on services that have a very strong midwife component, but want the reassurance of knowing that the general practitioner or obstetrician is engaged in the overall care program. We see this as an environment in which essentially a woman can make some choices about the extent to which other professionals are involved. At the moment we are not promoting in

this community clinic concept an entirely midwifery-led separate service, but if that is the feedback we get, and there are environments in which that is appropriate, that will be considered. That is exactly why the draft framework was produced.

The CHAIRMAN: If that were the choice of a woman, if that were the option she wanted, it is an available option.

Dr Towler: If we get strong feedback and support for that, that is the sort of thing we would be looking to endorse.

The CHAIRMAN: I gathered from your earlier discussions on the workforce that you were looking to re-engage GPs in GP obstetric services.

Dr Towler: I think I said last time how concerned we were about long-term options for maternity services in the rural sector in Western Australia. It is no news to this group the challenges that WA faces, having a very small number of people - around half a million - spread over two and a half million square kilometres and trying to provide appropriate services. The figures I quoted last time indicated that 12 per cent of mothers who are engaged in the community midwifery program end up having a caesarean section. In the rural sector we need appropriate credentialed and capable, competent clinicians to provide the interventional services when they are needed. One of the challenges at the moment is that general practice is not as strongly engaged in obstetric care in the metropolitan area. I believe that there are some options particularly around prenatal and postnatal care whereby people have a strong relationship with their GP and they may be very keen to remain involved with general practice. We would like to ensure those options, in terms of developing not only a rural workforce at the procedural level, but also a metropolitan workforce in terms of overall care, if that is what people require. I think I made some points during the last visit when we emphasised the increasing age of women having their first babies and some of the problems with comorbidity and some of the issues around emerging obesity. There are often medical issues that need to be dealt with in parallel. We are very keen to create a framework in which the involvement of general practice is appropriate and to provide a training environment to support that.

The CHAIRMAN: I want to also ask you about the options for birthing. In the document you referred to hospital services, I think. This is on pages 31, 32, and 33. Then you talk about hospital in the home. I know that somewhere in here you talked about family birthing centres, but I have not quite picked it up again at the moment. Are we now talking about freestanding birthing centres? Are you saying that community clinics are not going to have birthing or labour services associated with them? Is it an option to have freestanding family birthing centres?

Ms Maggs: We have looked at two types of family birth centres. Essentially, what we are talking about in the draft policy is that a family birth centre is a centre that is adjacent to a hospital - that is, on the hospital grounds - but a freestanding building.

The CHAIRMAN: Yes, I know that, but what about freestanding as in without a hospital anywhere near it?

Ms Maggs: We have looked at that and certainly the research looked at that. That is an option that we will take feedback on from the community.

The CHAIRMAN: Is it documented as an option in here?

Ms Maggs: On page 44 is probably the section that you might be looking for where we talk more specifically about family birth centres. We actually say that family birth centres should be an alternative to a hospital and could be either located on hospital grounds or be freestanding in local communities. We actually leave that open for the community to provide feedback on.

The CHAIRMAN: You make the comment that there is no difference in health outcomes for those people on either of those options.

Ms Maggs: That is true, but that is based on a number of assumptions, including access to safe transfer facilities. Even if they were located off hospital grounds, you would need to make sure that you could absolutely guarantee a transfer when it was required, because the research shows that a significant percentage of people need to transfer to hospital facilities, such as theatres, or want access to increased pain relief, which cannot be provided at a family birth centre.

The CHAIRMAN: Is that an area that is going to get a bit more coverage than that little section there? It is not a new concept in other states or countries, but in Western Australia it is an incredibly new concept for people to get their head around.

Ms Maggs: At the moment we have one family birth centre, and what we are suggesting is that the community may wish to provide feedback on having more than one; that is, more family birth centres located closer to home. A significant number of people would be aware of the family birth centre concept, but certainly once the policy is out, we would need to be looking at promoting the different options that would be available under the new policy, but that is after we have gone through a consultation process whereby we get feedback on whether the community wants that type of facility.

Hon LOUISE PRATT: In relation to the GP shared-care models, it is envisaged that a midwife would work with the GP team. I was a little confused about who will be the likely person to be the birth attendant in those circumstances, or could it be either the midwife or the GP?

Ms Maggs: I think the GP practice clinic is the one that you are probably referring to, which is similar.

Hon LOUISE PRATT: Yes, that is right.

Ms Maggs: This was a suggestion from the clinical reference group and was made by a GP obstetrician who thought it was a worthwhile idea to have an alternative model. The idea was that the midwife and the GP obstetrician would work closely together and both could be at the birth, which would occur in a local hospital.

Hon LOUISE PRATT: Okay; so they would both be there, or it could be one or the either.

Dr Towler: This model actually exists in the rural sector. There are a couple of people I had the privilege to meet on a recent trip to Geraldton on a trauma course who run a combined midwife-general practice - almost locum - service and they work as a team routinely and that delivery is both of them together.

Hon LOUISE PRATT: I would see models like that being quite desirable in some parts of my electorate where there are lots of families, very busy GP clinics and lots of children being born into a community. That continuity of care is really important. However, according to the way these things are usually practised, it would be quite unusual for something like that to be set up within that kind of metropolitan setting. I would really like to see options like that become available. You made some comments earlier, Simon, about problems with the commonwealth and the funding.

Dr Towler: We believe there is a substantial amount of interest in this type of model. I suppose you could say that there are practice nurse roles being funded. It is my view that I would like to get an endorsed framework of this nature and then take the issue straight up to the commonwealth and say, "In terms of how we make general practice more effective in maternity care, this is clearly one of the key elements." I have talked to a number of practitioners who were involved in the Kalamunda model, and those people with a strong community-based background see real advantages in this model. One of the great problems facing Western Australia at the moment in general practice is that we have 12 per cent fewer practitioners per capita compared with any other jurisdiction. GPs are incredibly busy. If you want to ask them to take a greater role, they are at the moment asking me constantly in chronic disease and a number of other caring models what is in it for them in terms of how they make their practice more effective and how they meet the needs of their patients. If we have a strong framework that indicates how that type of care would fit into an

overall model of maternity service, we can lead the debate with the commonwealth. That is what I would like to do. Certainly, outside Perth with the regional centre models that are being put in place, it would underpin, I think, dramatic improvements in maternity services around major regional centres where we are trying to bring some specialist support in so that the full range of services is available.

Hon LOUISE PRATT: I would advocate that those kinds of births should be able to take place not just at a hospital, but also at a family birth centre, but I do not know the reason behind limiting it to a hospital.

Ms Maggs: Family birth centres traditionally have been midwifery-led centres, and GPs have utilised the services of a hospital. That would be a change. From the research that was done, I do not believe there is actually any family birth centre in Australia, and perhaps in most countries, in which GPs utilise the family birth centre facility, but if the community provides that feedback, that is what we want to hear about.

Hon LOUISE PRATT: That would arise in part because midwives are so defensive of their scope of practice and they have had to fight very hard to establish that territory. They have a mandate to practise that is reinforced and supported in lots of other ways. Who knows what is possible in the future?

The CHAIRMAN: I think I am saying the same thing as Louise. What appears to me to be the options for birthing in this document limit GPs to working in a hospital if they want to be the deliverer of a baby. If they want to deliver the baby, they have to go into a hospital to do it. The examples that we saw in which midwives had a more complete responsibility for the antenatal care, the delivery and the postnatal care, and it was a midwife-led service from start to finish without necessarily involving doctors, enabled them to provide the amount of deliveries that they did. However, in this case, I think you are giving us a model that requires a doctor's involvement but, at the same time, excludes them from delivering in a family birthing centre. It is like a mixed model, and probably the mixed model needs to enable GPs to deliver in family birth centres as well if they are to get involved in low-risk, straightforward birthing.

Hon LOUISE PRATT: Hypothetically, a midwife operating from a community clinic with various forms of independent practice could have practice rooms from a GP clinic, if it were available for that to be set up that way and do referrals to and from the local GPs. I am wondering whether these things are still open for discussion.

[2.30 pm]

Dr Towler: There is a lot going on in parallel with this document. We are working on a whole range of issues around primary care strategies in Western Australia at the same time. One of the limiting features in this state at the moment is that there is not a lot of what New South Wales is now heading up very strongly; that is, integrated community health care centres. We are trying to develop those discussions in a very substantial way, and when you come to this document at the moment and you look at what is available in WA, you tend to be a little restricted by what we already have.

In my view, we are trying to promote discussions about diversity. What we are trying to do in primary care is about creating diversity in the primary care environment. There is no stipulation about where community clinic models will be based or how they will operate. I am very keen to get them away from hospitals so that they are in the community. It may be at the same time that in some of the discussions around ambulatory services in the non-tertiary hospitals, which are coming through in the planning at the moment, they are talking about whether there is a primary care presence on the hospital grounds. Sometimes that is advantageous, because one of the great challenges in primary care at the moment is a lack of allied health services. If you look at a regional hub model, it may be best that we put these things approximate to where there are other

health professionals. It is not because the hospitals and the doctors are there; it is because the health infrastructure in terms of personnel is there. The challenges around community access vary depending on whether you are talking about metropolitan or rural areas. I am interested that your perception is that the document excludes general practitioners from participating in birthing centres. It is not something I had thought through, so it is exactly the kind of feedback we are looking for. I would be ecstatic if the attitude of midwives about doctors being present in birthing centres were relaxed.

Hon LOUISE PRATT: I think that relates to their defensiveness about their traditional scope of practice. They might need to be seen as the lead carer and as soon as they see a doctor, they think they are there to be busybodies and to interfere in their practice.

Dr Towler: I think our view, from the feedback that we have been getting, is that where strong community-based team care is put in place, those relationships will hopefully change.

Hon LOUISE PRATT: I would hope so too. I think you are right.

Dr Towler: Maybe they are more likely to change between general practitioners and midwives than some other practitioners and midwives. That one will come back to bite me!

Hon LOUISE PRATT: I think we can probably work out what you mean by that.

The CHAIRMAN: Will regulatory and legislative changes be necessary to implement the changes that are coming through this policy?

Dr Towler: I do not think so at the moment. We will be looking at all those issues in great detail over the next four months during the consultation. We are not aware of any. Given the competency framework, scope and credential of clinical practice activities that are going on, I do not believe this has those issues. We will be checking, because it will be important at the implementation stage. Thank you for raising it.

The CHAIRMAN: Are Western Australian doctors willing to support alternative models of care?

Dr Towler: By "Western Australian doctors" do you mean all doctors?

The CHAIRMAN: You cannot speak on behalf of all Western Australian doctors. However, we want to get a sense of the level of support that you will get from WA doctors on this issue.

Dr Towler: One of the things about the consultation around the phase one part of the project and the discussion document was the very substantial level of engagement. It is my opinion that there is a diversity of view amongst medical practitioners about change. The process we have been through has on many occasions resulted in people being fairly complimentary about the considered way in which we have approached this. I do not think I can put a position on behalf of all doctors. Practitioners in the rural sector are working more closely with some of these models and some other clinicians. We have received fairly positive feedback around the way we have developed the model and the way it links to the previous Cohen report. I think there will be tensions around the scope of practice that is proposed. We do not shirk from that at all, in the same way that we are not shirking from the issues that are involved in reforming other services. Doctors are very important practitioners in our health system. When women need interventional care in obstetrics, doctors are critical because at the moment they are the only people able to do that. We are seeking to be respectful in our engagement with clinicians. We are quite committed to this process and to what the evidence and the community is requesting we should embrace.

Hon ANTHONY FELS: You said that you want to encourage services through GP practices. How will you do that? I expect that it is a commercial decision for them if they wish to do it. The metropolitan areas are full of patients; therefore, I imagine they would not want to take on anything that will take up their GP time. How will you make that happen? Will there be financial or business incentives? In country areas there is a shortage of doctors in some areas, particularly in wheatbelt towns, to provide a service in the first place.

Dr Towler: The challenges you put before us are substantial challenges. In the metropolitan area, I believe there are some general practice groups that are interested in obstetric care. Certainly, it is better when you have groups involved in obstetric care so that they can share responsibility for registered patients. I go back to my comments at the beginning that in terms of a business model for general practice to make this team-based care more attractive and effective and, from a business point of view appropriate, we need opportunities around additional funding flowing to the general practice if we have a team-care model that involves practice-based midwives. We know from the clinical psychology work that has been going on in general practice that that results in business changes, which general practitioners frequently endorse quite willingly. There is a need to have a conversation with the federal government about the business model for general practice based care. In the rural sector in Western Australia the issues are a bit more diverse, because often the state government is the employer of those practitioners, particularly those who work in the north west. We have opportunities in those environments to create team-based models of care where the practitioners are largely salaried. However, that is not going to the issues you have raised. In areas like the wheatbelt, I think these things are very challenging. You often have relatively small towns. The whole service model for the wheatbelt is a challenging issue for health care, full stop. We are seeing planning around what the regionalisation of services. We are looking to strengthen the relationship between wheatbelt towns and metropolitan providers. However, in terms of a service at a locality, I do not have the expertise to answer all the dimensions of the question you asked. They are challenges in terms of a suitable business model in smaller rural centres. The issue behind just having sufficient general practitioners in rural Western Australia is something that we will be dealing with for a number of decades to come. However, the increasing number of medical graduates in Western Australia, which will begin to take effect from the beginning of 2009 will, I hope, start to alleviate the supply of general practitioners to the rural sector in this state, particularly when taken in parallel with the strong development of the rural clinical schools, because undergraduates are exposed to the rural sector much earlier. The recent accreditation of the ACROM training model will mean that you can have a training stream that exists almost entirely in the rural sector, from medical school right through to being a full practitioner. The preliminary feedback we are receiving is that that is beginning to attract people already.

Hon ANTHONY FELS: What is the situation at the moment and into the future with the state government covering insurance costs for doctors, particularly in obstetric services? Some rural towns have more than one doctor in the town, but they are flat out servicing all the other areas, so as much as they might like to do obstetrics, they have enough to do as it is. We must encourage more maternity services. They are probably doing that in those sorts of clinic anyway.

Dr Towler: I do not have the answers to all those things. The whole foundations document for country health services and the strong focus around developing a regional service plan is, when compared to this process, back at phase one. We have really looked at the way we deliver country health services and now there are not so many regional boards and local issues to deal with. There is a strong driver around improving the overall range and quality of services in the rural sector. When it comes to back to individual general practices, though, many of them, particularly in wheatbelt towns, are very much a private sector based model. There is a model in Merredin that involves a joint employment basis. We will need to be creative to create environments for general practice that build practices over time and increase their capacity to deal with a broader range of clinical issues. We are seeing the same thing in chronic disease management. We would like general practice to be much more engaged in longer-term care, particularly a wellness model. However, in those towns those guys and girls are busy just delivering a service. This is where, again, a practice nurse model or an allied health model or something in parallel, which was partly built into the Australian better health initiative, and some of the opportunities around allied health support become very important. There are a lot of parallels with what is being proposed in this

maternity model of care, which seeks to give greater authority, competence and opportunity to non-medical practitioners to participate in a community health model.

The CHAIRMAN: Can it be initiated without federal government involvement?

Dr Towler: That is partly what happened with the Australian better health initiative. You can initiate components of it within the resources that you have available. The state is funding self-management components of that program, which will engage consumer groups and lay people in getting groups of community members together to deal with common disease issues. Within the resources that are available, those things must be considered.

The CHAIRMAN: Who do you envisage will pay for the midwives to work in the community clinics?

Dr Towler: I will be very blunt. I do not think it is the state's responsibility to take over all health care in the state. WA is already disadvantaged in the great wash-up between the federal government and the state in terms of overall resourcing. We already take on a strong role in the north west and other remote locations. We will continue to acknowledge those responsibilities.

The CHAIRMAN: I want to be clear about this. What you are suggesting is that these initiatives may be dependent on the federal government agreeing to include -

Dr Towler: I was talking mostly about general practice. When it comes to the GP practice clinic options, general practitioners will make their own choices, as they have been doing in my discussions with them about chronic disease management.

The CHAIRMAN: I am talking about community clinics.

Dr Towler: I am not talking about community clinics.

The CHAIRMAN: Who will fund the midwives who work in the community clinics?

Dr Towler: I would hope that we would see opportunities for private sector development of some of them. We recognise that within our area health service models, we will be seeking to make this a fundamental component of how the areas provide maternity care.

The CHAIRMAN: They will be state funded.

Dr Towler: Some of them will certainly be state funded. That is the direction that this has taken. I do not believe they should be restricted to do that. If a private sector model with a strong community clinic basis can be promoted, which is what is happening in New South Wales through its integrated health centres, it should be promoted. When one considers maternity services in Western Australia, 30 per cent of deliveries are provided entirely in the private sector. I would like to see the diversity we are pushing in the public sector spread to the private sector over time.

Hon ANTHONY FELS: There has been increased interest on birthing centres and homebirths. Indeed, there were articles in the press over the weekend. Is that new to the Department of Health; if so, what has been the cause of that? Is it because our inquiry has created extra publicity? Is the department starting to address this issue because it has become a cost issue?

Dr Towler: Homebirthing is not a cheap model. The information we have suggests it is quite an expensive model. The reason we are in the position we are in now is that we have a health network and a program around trying to develop models of care, which are a key element. There is no doubt that maternity care is something that the community is very interested in. That has facilitated us looking across the issues that are before us. The discussion paper produced 83 responses. We were very pleased about that. We set up a framework for the evidence base to seek what the evidence was around the breadth of opportunities. I have no doubt that the reason you are seeing a much more inclusive document is that we have looked at what is happening around the world. We have looked at the evidence that is available, but we have also had a good deal of interest. I am quite

sure that some of that interest has been created by the knowledge of this committee and its activities.

Hon ANTHONY FELS: It seems a bit more than coincidental. I am not criticising it for happening.

Dr Towler: It keeps me focused.

[2.45 pm]

The CHAIRMAN: Based on the research and evidence, the document "Future Directions", which is the report on themes taken from submissions etc, the Maternity Coalition raised concerns about the research review being limited by the interests of those involved.

Dr Towler: I do not know.

The CHAIRMAN: What is your response to that concern?

Ms Maggs: The Maternity Coalition submission came in prior to 31 December, or in the first week in January, which was while the research was being undertaken. The coalition made that comment based on the premise that its concern was that a particular group of health professionals would have carriage of the research being undertaken, and it was concerned that it would be slanted in a particular way, whichever way that was. That was their concern. Our response to that was to provide them with information on the research group that was undertaking the research for us, which was independent. The research was done by the Women and Infants Research Foundation. In our request for a quote, we specifically insisted on having a bipartisan research team consisting of an obstetrician and a midwife because we were aware that there would be concerns about any profession looking solely at the issue on its own. By having both midwives and obstetricians involved in the research, it became a more even response. That was fed back to the Maternity Coalition and it accepted that.

The CHAIRMAN: Thank you for that. Another comment I will make is that they also said that the consultation process was too short. Will there be ongoing consultation? Will there be formal systems and processes in place to ensure ongoing consultation? Basically, I think you have addressed some of those matters, but I am interested to know whether you have any other comments to make about the concerns that were expressed about the consultation process being too short.

Ms Maggs: The Maternity Coalition did mention that because it was one of the few groups that had a concern about the deadline. That was fairly easy to deal with in terms of providing additional time to put in submissions. We also then explained to them the whole process that the consultation was taking. By going back and talking to them regularly - indeed, I am meeting with them next week - that has allayed some of their concerns. To clarify that, we received submissions right up until mid-February, and we were quite happy to take them and incorporate them in the information.

The CHAIRMAN: Also in this document on page 4 is a comment about seeing no major justification for a major system change, based on the satisfaction and demand of women currently. Is that a suggestion that women are not seeking any changes to the system?

Ms Maggs: The document you have is a raw document and it summarises the comments that were made. That comment was made by a couple of health professionals in terms of what is wrong with the health system. We are quite happy with it now. We have taken every comment that we have received as it has been said; we have not reinterpreted it or tried to dismiss any comments based on their face value. We have taken each and every comment and compared it with the research base that we were provided with by the independent research. Also, of course, the reality is that if the community as a whole was saying to us that it would like more variety, obviously we would look at that. Where there was a difference in opinion - for example, the system is fine as it is now versus we would like more choice - that information was taken to the clinical reference group that we

established and we talked through the issues with them and they provided the advice back to us, which is what we included in the document.

Hon ANTHONY FELS: On the issue of birthing centres, you said it was not anticipated to locate them away from the hospitals, but that would limit them to only a few hospitals in the future. Is any consideration being given to have birthing centres away from those hospitals and to have smaller units established around the community?

Ms Maggs: We have said in the document that they could be located either adjacent to a hospital or freestanding. We have not made a suggested direction. We will await the community's and the health professionals' response to that idea.

Dr Towler: There are clearly problems with isolated birthing centres because a proportion of women need intervention. We had a discussion when I came last time about the time from decision making to intervention when it was required. What one hopes, as has been evident from the homebirthing programs that exist at the moment in Perth, in most cases when a transfer is required, it is done well in advance and it is timely and things go well, but there will always be a small number of cases where the transfer is a little more urgent and there needs to be access from any birthing centre to a facility where intervention can be provided if it is necessary or, as you heard before, if pain relief during childbirth is required. We are trying to take those issues into account. We will look at the feedback from clinicians and the community. We hope that those conversations will be very much balanced by providing good information.

Hon ANTHONY FELS: I will ask something on the costings because they are not covered in the draft report. You might be able to provide me with some more information later on and give me an indication of what the total budget is on obstetric services for the state, the number of births per year and the make-up of the costs of intervention or specialists required birthing versus others.

Dr Towler: I could not provide you with that information at the moment. We have some broad figures but they do not go to the range of issues. We would have to provide that afterwards.

Hon ANTHONY FELS: I am interested in seeing what the size of the whole pie is that is split among those services. Without having to spend additional funds, could we get a better service under the different models than what we are getting at the moment?

Dr Towler: One of the challenges, if you consider something like a regional service, is that you might be able to disaggregate or identify that component in the main that relates to obstetric or maternity care, but it may be a very different costing structure if you take it out and put it somewhere else. One of the issues is that in situations where you do need to intervene in obstetrics, you require services from anaesthetists, paediatricians and obstetricians or whatever the appropriate clinicians are in the environment. Sometimes when you remove the service, it costs substantially different amounts of money to run it. In terms of what we are trying to do in getting an overarching model of care, you can look at an investment across the model that will result in the best possible return. There are a number of other things to remind you of. One is that we are rebuilding large elements of the system. The decisions made out of this framework in a timely fashion will help to inform the infrastructure costs. I go back to some of my opening comments about the workforce. One of the critical issues is to ensure that we have a workforce development framework that makes it possible to deliver and develop the appropriate range of models of care that the community is seeking. A lot of the financing work has not been done.

The CHAIRMAN: Can I ask you some questions about the early discharge comments that are made in the report? Can you just outline how early discharge will be supported, and in particular I am interested in the elements around the support other than by that provided by health professionals; that is, home care and home help support?

Ms Maggs: The home visiting program, or the early discharge program, is actually up and running already. There is some difference between what currently occurs and what is suggested as a

possibility in the document. One of those differences would be the length of time that a woman stays in hospital. In this document, based on research, we actually talk about it being reasonable for someone to leave the hospital after six hours. That would be a difference compared with the current average of 48 hours. However, we are very clear that that needs to be supported with a coordinated and effective home discharge program. Those programs already exist; it would just be that we would need to ensure that they were able to cater for that additional time.

The CHAIRMAN: Would they be more intensive?

Ms Maggs: Perhaps. We would take advice on that. The policy approach we took was to put up the suggestions made by the community that were supported by research. If those suggestions get taken up in the final policy, then we will sit down with the relevant people and develop the clinical guidelines, the policies and procedures to underpin a safe and quality type of service. We have not gone to the extent of all the detail behind each and every part of this document because we think that also needs to be done in consultation with the relevant people.

The CHAIRMAN: Is that non-professional home help service available to early discharge maternity mothers now?

Ms Maggs: It is not currently available. It was a suggestion made by the clinical reference group that the community ought to be able to comment on.

The CHAIRMAN: When you made a comment a little while ago that this committee helped you stay focused on this particular issue, it suddenly alerted me to ask the question that I had already written down, which is: what is going to help you - not you personally - to keep the department focused on moving and delivering on these policy suggestions and options? One of my concerns is that in the absence of a committee such as this, and had this committee never been established, for example, the direction in which this has moved may not have come to fruition and the incentive may not have been there to do the significant amount of work that has been done in opening it up to a broader consideration of options and a broader consultation with the community etc. What I am asking is: what will you put in place to make sure that these are delivered on?

Dr Towler: The issue of guaranteeing that the outcomes are delivered on is something I have to take up with the director general. Through health networks, we are developing a policy frame work that is highly referenced to the community. We have taken our responsibilities very seriously around the Department of the Premier and Cabinet's working document on working together and involving community stakeholders in decision making. WA Health is in the very final stages of endorsing its consumer engagement framework, which means that the landscape in the future will be very different from that which existed when we started this process. My compliments go to the Health Consumers' Council of Western Australia and its very vigorous involvement in and development of that framework. I hope an announcement will be made some time in the future. The translation of good policy into its detailed implementation is one of the issues that was revealed through the Reid report. The current structure of health, which is much more unified in that there is a clear process for policy endorsement to inform area health service activity, is in fact what will go forward from this. We will take this document to inform all service planning for area health services. There is a strong performance framework in place between the director general and the chief executive officers. There is an expectation around outcomes based on agreed policy. Performance agreements exist between the CEOs and director general with deliverables that are based on the operational plan. In this year's operational plan, outcomes from some of the early networks consultations have been built into the chief executives' performance framework. My view is, and it is my understanding, that those policies that are endorsed by the state health executive underpin the future of operational planning. That is how you get the outcomes that are necessary from those changes; we are doing it in stroke, we are doing it in primary care, and we are looking to do it chronic disease management. This particular document is up there in one of the very early

statewide model of care processes. One of the reasons that we have been very pleased and very keen to be engaged in this process is that we see this as a model for our future policy development.

[2.30 pm]

The CHAIRMAN: Thank you again on behalf of the committee. I think that if there is any ongoing role that we could see ourselves as having - I do not know whether there is or is not - it would be to monitor the performance of the department in terms of the maternity services plan.

Dr Towler: We are looking forward to reading your report.

Hon LOUISE PRATT: Hopefully it will help contribute to your mandate to get on and do these things.

Dr Towler: I am sure it will. Thank you very much.

The CHAIRMAN: Thank you very much.

Hearing concluded at 3.00 pm