SELECT COMMITTEE
INTO PUBLIC OBSTETRIC SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
MONDAY, 13 NOVEMBER 2006

Members

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

Hearing commenced at 11.05 am

TOWLER, DR SIMON
Executive Director and Chief Medical Officer, Health Policy and Clinical Reform Division, Department of Health, examined:

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

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

Dr Towler: I have read, understood and signed the form.

Ms Maggs: I have also signed the form and read the document.

The CHAIRMAN: These proceedings are being recorded by Hansard. A transcript of your evidence will we provided to you. To assist the committee, please quote the full title of any document you refer to during the course of the hearing for the record and please be aware of the microphones and try to talk into them. Ensure that you do not cover them with papers or make a noise near them. They are for recording purposes rather than magnification purposes. 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 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: I will make a few introductory remarks. We are grateful for the opportunity to meet with the committee again and to look at the issue of community consultation regarding maternity services. I had hoped to bring three other people with me today but unfortunately Dr Anne Karrczub is interstate today. Anne has a strong background as a leading adviser on the development of obstetrician services in Western Australia. As an obstetrician, she has a very important role in developing a relationship with general practice. It is unfortunate that she cannot be here today. I have brought with me Ms Alison Maggs, who has introduced herself. I hope that will be of value to the committee. Alison has been very involved in the development of the document on the future direction of maternity care in Western Australia. Given the issues that were raised in the committee's letter to me, I believe that she will add value to the discussions this morning. Having made a fairly extensive opening statement the last time I appeared before the committee, I do not wish to make any other particular comments and happily invite the committee members to raise the issues that were outlined in our letter and to discuss whatever other issues arise from our conversation today.

The CHAIRMAN: Would you like to make any opening statement Alison?

Ms Maggs: I do not think so.

The CHAIRMAN: We will refer to a couple of documents that have been put on the table at which you are sitting. One document is the matrix regarding consultation and another is the table regarding the different GP models of care that currently apply across the metropolitan area. We will start by talking about consultation. I refer to the model that we talked about previously. Can you give us an indication of where the issues of obstetricians fit into the high levels or low levels of risk and where they fit into the simple or complex information that must be understood by the public? Where do the issues of consulting with the community about the future for obstetric services fit into that matrix model?

Dr Towler: I thank the committee for providing us with this matrix. It is a valuable tool to evaluate the way the maternity consultation document and our program work. The issues before us regarding consulting with the community on maternity care are quite complex and will require substantial amounts of information to be made available at different times. In developing the current plan, we have looked to address the issues that are outlined in this table. That is, to provide a substantial amount of fairly simple information which is easy to understand and which has been part of the thrust of the way in which the document has been prepared. We step forward in a consultative environment to use the framework developed by the document as a foundation for discussion and communication while pointing to extensive background material that is available either through the document's references or with the assistance of the Health Policy and Clinical Reform Division. We will then end up with a series of consultative workshops. We are stepping through a process in partnership with the community to develop what we believe is one of the most comprehensive consultation programs in the health system in Western Australia. It is also in line with the principles that have been developed for clinical networking. Consumer members are part of our advisory group within the clinical networking structure that we are putting in place. We have sustained a long-term relationship with consumers, clinicians and stakeholders. In many ways, this consultation has been a foundation for what we believe is the approach to dealing with large issues in a consultative framework that are facilitated by that relationship. Members have seen the development of the future direction of maternity care in the WA consultation plan. The first version was put together in consultation largely with clinicians. After very extensive phase 1 feedback, the document was dramatically modified to ensure that the language and material contained in it is appropriate for people to use as a basis for their advice and input to us. It also is the foundation for us in meeting with a broad group of clinical groups and the community. Hopefully, people who have recent experience in delivering a baby or who are approaching childbirth can be provided with information to ensure that the detail and the quality of the information we get back will fundamentally inform what we believe is a sound policy for the future.

In terms of this matrix, in trying to understand the risk issues we are not working in an independent advisory committee environment; we have direct involvement with stakeholders. In parallel, we will have consultative workshops that include them. With regard to the complex information, part of the challenge that has faced us to date in this consultative process is that it takes some time. That is why we have developed the three-phased consultation. We are putting aside substantial time and have tried to create an opportunity to ensure that the information we get in this next phase of the consultation process is well incorporated into putting together what will be the maternity framework for Western Australia.

The CHAIRMAN: That was a very long answer and I would like to paraphrase it. Are you saying that it is complex and that there is a high risk that it will have a potentially negative social impact? Is the consultation about obstetrics at the high end of both of those areas that we are talking about?

Dr Towler: I do not believe it is high risk in the sense that we are giving people a position. My understanding of the matrix is that we would want to be dealing with necessarily relatively complex information in the way suggested in the matrix towards the bottom right-hand corner of the table. I believe that we have set out a process which attempts to achieve that and which recognises that with regard to the breadth of information to be communicated to the community and to be assimilated by

people wishing to participate, we have tried to create an environment whereby we can reliably provide complex information when it is needed but wherever possible we have created a simplified framework for the consultation in the sense that I believe this process seeks to find community opinion and to incorporate it into the emerging framework document. I believe it is low risk and acknowledges the complexities.

[11.15 am]

The CHAIRMAN: If you had to point to one of those boxes, it is the lowest box on the right-hand corner. Is that correct?

Dr Towler: We would acknowledge that it is really the four bottom boxes on the right-hand corner. We will have consultative workshops that will involve people, but the program will attempt to ensure that it is appropriately consultative and, like any consent or learning experience, provide as much information as people wish in making their decisions and comment.

Hon SALLY TALBOT: Can we clarify the timetable with you, Dr Towler? We understood from original documentation that you were initially looking at a 10-week period for feedback on the draft document, the production of a final version and then a three-month consultation period.

Dr Towler: That is essentially our intention.

Hon SALLY TALBOT: We have a copy of the media release dated 8 November that I assume is the announcement of the release of the draft document. This refers to a closing date of 31 December.

Ms Maggs: That is for the consultation phase associated with the discussion document itself, "The Future Direction in Maternity Care". Following that phase, we will draft a policy and that is when the three-month consultation phase comes into being. It is a three-stage approach to consultation. We have already completed the first stage, which produced this document. The second stage is the one that we are now in. The third stage will follow the draft policy development.

Hon SALLY TALBOT: We were a little concerned to note that the time frame, which was initially 10 weeks, appears to have been truncated quite significantly. It is seven weeks in terms of calendar time, but if you consider the people who are likely to want to respond to the draft document, you are including the holiday period over December.

Dr Towler: As you can see from the document, we have provided multiple options for people to communicate with us. In moving to develop a draft policy, there has to be some point where a reasonable amount of information is created. It is my intention that we will continue to invite people to provide any additional information right through the development of the maternity framework. I am hoping that we will identify people who wish to continue to participate as we go through this process of clinical networking, meetings and consultation. That is a very common process. I have recently been involved in issues concerning the review of the Medical Act. We have continued to accept comment and input from people with an interest after the closing date for preliminary submissions. In the end, we are trying to create a framework that will address the concerns that exist, particularly around work force development and the early planning for new facilities at a number of sites. We had hoped in the original discussion that we would have had 10 weeks - until the early part of next year - to undertake this consultative framework. The extensive feedback on the draft document essentially resulted in a major rewrite. We have lost a little of our timetable, and I acknowledge that.

The CHAIRMAN: What is the pressure behind your giving people that extra time and then taking the end result out another three or four weeks?

Dr Towler: There is a need to develop a maternity document. I have tried to convey that we are in a fairly advanced stage of planning for some facilities. Although the date has been stated around the initial closure of submissions, I will happily invite ongoing commentary.

The CHAIRMAN: What detrimental thing would happen if 10 weeks was given?

Dr Towler: There would be a delay in producing the maternity framework document.

The CHAIRMAN: Would that cause detrimental problems?

Dr Towler: I am conscious that the longer we wait for a framework for maternity care, the longer the planning, which is already well advanced in the development of a number of new facilities in Perth, is not being informed by the framework. I acknowledge that we have some time pressure.

Hon LOUISE PRATT: A range of hospitals are currently being designed. Is there pressure to complete this document to further the development of those facilities or have many of those decisions already been made in the development of those facilities?

Dr Towler: The process of planning a hospital goes through a series of phases. The clinical services framework began to outline the scope of the sorts of services that would be provided in each site and what will be needed to support community services around that. The driver for going from a broad clinical view to designing what will be required to build a hospital, to understand how the clinical services are configured, what the layout will be and how the organisation supports those services is driven by a discussion on the models of care. Essentially, this document creates an environment in which we can try to define the models of care for those sites in a reasonably timely fashion. It does not in any way inhibit ongoing discussions about the development of models of care in a community setting or in other aspects of the service delivery for women and their children.

The CHAIRMAN: Which hospitals will be affected by the four-week time frame in terms of planning?

Dr Towler: As you know, Rockingham is already fairly advanced. The opportunity to change or realign the building has already passed. If we come up with models of care and views of how services should be delivered out of that particular site, opportunities for change are already being lost in terms of design variation and those sorts of things. At the moment we are in a fairly advanced stage of development with the business case for the Fiona Stanley hospital. Fiona Stanley is the other major active hospital. The discussions around the development of the new Swan Districts campus have been delayed because a project director has not been appointed. The principal area that is of interest to me at this time and why the organisation is keen to have an outcome from this process relates to south metropolitan planning in particular.

The CHAIRMAN: Who is the primary target of your consultation in this middle phase that you are in now? Who do you most want to consult in that time frame?

Dr Towler: We have had extensive focus up to now with clinician groups. We have taken advantage of a substantial amount of work that went on beforehand. The principal target now is the community and citizens.

The CHAIRMAN: If you had to pick a time in the entire year when women, families and the community generally would be least able to respond to you, what time would you pick?

Dr Towler: I think you are suggesting that Christmas is a bad time.

The CHAIRMAN: Not only is it a bad time but you have cut three or four weeks off it. The entire reason that we are even meeting right now is because of our concerns about the lack of commitment to genuine consultation with the community.

Dr Towler: We have outlined quite clearly that this is a three-phase process. This is a formative period. Beyond this phase, there is the opportunity for ongoing consultation around what is essentially the emergence of more specific discussions around models of care. It does not stop in January. It goes on during the development phase for the framework and then continues once the framework is in place. My greatest concern about the current document was that it may be criticised for lacking detail in that we have not specified any particular structures or outcomes. We

are very conscious of the fact that we do not want to pre-empt the discussion that comes out of this phase.

[11.30 am]

I believe in the development of a communication network around the next seven weeks and the commitment we have made to ensure that information is dispersed. We have seen today some very positive feedback from the *Kalgoorlie Miner* newspaper, encouraging people to submit. We have gone to a good deal of trouble to make it reasonably straightforward and to provide people with many opportunities. Yes, I would agree; in an ideal world you might argue that this consultation could have gone on for a very much longer period of time, but there is a balance between the two elements of what we are required to do. We are not in any way less committed to getting community input, even beyond this preliminary consultation phase. The point I was making about clinical networking was that we intend to establish a long-term relationship with the community by multiple pathways to ensure input to all policy development.

Hon LOUISE PRATT: Are you running any workshops or is this consultation phase simply a submissions process? Will you be inviting people to participate in a wide variety of ways? You mentioned some workshops.

Dr Towler: We have set up a particular workshop. Alison might like to give some details around that. It is my intention to try to create some opportunities to get out to non-metropolitan sites also to conduct a number of forums, once we have got some feedback and identified some interested local people. The intention will be that after the initial period for submissions closes, we will continue to go and meet people so that we understand the detail behind what they have submitted. In the development of the framework there will be an ongoing dialogue around what information we have received.

The CHAIRMAN: Do you want to say something, Alison?

Ms Maggs: As part of the stage 2 consultation we are setting up a half-day workshop with people involved in providing obstetric care in WA in the public health system. That incorporates representatives from every hospital, all area health services, associated groups such as the Royal Flying Doctor Service, Community Midwifery WA, the Health Consumers' Council, GP divisions, the Royal College of Obstetricians and Gynaecologists and the AMA. About 80 people have been invited to the workshop, which will be held in early December.

Hon LOUISE PRATT: Are you having any consumer-based workshops in this period?

Ms Maggs: The idea of stage 2 is for people to be able to provide input through whatever means they want. Some areas have said that they would like to run some workshops. For example, somebody e-mailed on Friday and asked if they could run some workshops for mothers with babies. We were very happy for them to do that.

Hon LOUISE PRATT: The department itself is not running those kinds of workshops?

Ms Maggs: Our focus in stage 2 is on submissions based around the actual document. Stage 3 has extensive public workshops and face-to-face meetings in a variety of locations, including rural and remote areas.

The CHAIRMAN: Just following up on that, one of the questions was whether the suggested future choices satisfy women's needs. You have talked about the second phase being a phase in which you are listening to what people say they want. I understand that in the third phase you will put that information into some form of policy document. The third phase in many respects is probably more about relating that information and educating people about what the future direction for maternity services will look like. I want to follow up a little on what Louise has said. To help inform the development of the policy document, without community consultation and without running these forums with the community will mean that it will be difficult for many people to let

you know what they want. Submission-based approaches will get to some people, but unless you conduct some forums with the community, you will miss out on that opportunity for the community to let you know what it would most like. I will now turn to the GP area. Another question is how the department views GP obstetrics in the metropolitan area; for example, should it be a widely available option or limited to just the outer metropolitan area?

Dr Towler: The department does not have a position about general practice obstetricians not being able to practise in a range of environments. Since the last time I spoke to you, I have learnt a huge amount more about the whole issues of metropolitan general practice obstetrics. It has been an interesting journey.

The CHAIRMAN: Would you like to tell us a little bit about that?

Dr Towler: Yes, I would. You will know that last time I was a little uncertain about the developments at Swan District with the closure of Kalamunda. I understand you have received a briefing from Beress Brooks and Dr Jes Sowden from Swan District Hospital and that you now know the details of what happened.

The CHAIRMAN: That is not correct. We have had a letter.

Dr Towler: A letter, sorry. In the first instance an opportunity was created to try to develop a combined obstetrician and general practice work force on that site. We were never able to successfully deliver an outcome that was satisfactory to both parties. I think that points to some of the difficulty that we are looking at with how you develop that sort of model. The outcome for Swan District for an obstetrician-based service has probably resulted in one of the best obstetric practice environments in Western Australia, where there is a 24-hour a day obstetric service available, basically immediately, which is well supported by good anaesthesia cover. A statistic that I found most compelling was that the caesarean section rate at Swan District is 17 per cent, which is extraordinarily best practice. In that environment where people are confident about the services that are provided around delivery, the type of outcome for people in terms of decisions and caesarean sections seems to be as good as we could ever hope it to be. Particularly challenging at Swan District is the number of high-risk deliveries that are conducted there, where women are under care from King Edward Memorial Hospital, particularly Aboriginal mothers who live further up the Swan Valley, who, fairly frequently according to a couple of obstetricians I have spoken with, will end up delivering in the Swan District environment, and they have been well supported in that setting. It is my belief, having spoken to both Beress and Dr Sowden, that every attempt was made initially to create a combined service on that campus, consistent with the recommendations from the original Cohen report. I am hoping that the discussions that underpin that, which we can revisit, will create an appropriate integrated model for the future, because it would appear to me to be a key issue in developing an environment in the future that ensures appropriate training and appropriate support for general practice obstetrics, which then results in a situation where mothers can be confident that in those cases where they get into trouble, the outcomes can be as good as they can possibly be. The success of the Swan District model has been particularly compelling. In looking beyond that, I went then to try to establish what was going on across the rest of Perth in general practice obstetrics. A particularly compelling figure I came across was that of the more than 30 training posts that exist in metropolitan Perth for general practice obstetrics, only five of them are occupied. To build a future based on a general practice obstetric model carries a substantial risk unless we can get a fundamental change in the way they are trained and supported. I am pleased to indicate to the committee that, not in the metropolitan area but in the rural sector, an initiative we have been discussing with WAGPET and the College of Obstetricians and Gynaecologists will, I am hoping, be a model for the future, when we are looking to the opportunity of supporting general practitioners doing the second stage of the RANZCOG diploma which allows them then to undertake all aspects of care of mothers at the time of delivery in a model supported

where they work in the country sector and where there is fly in, fly out consultative support where the principal educator is an established general practice educator.

For Western Australia, although I can clearly appreciate that there are substantial issues in the metropolitan area with general practice obstetrics, we are under a substantial amount of pressure to provide safe services to people in the country sector, which with the falling number of general practitioners engaged in obstetric training is particularly worrisome for me as a senior executive in the Department of Health. Beyond that there are fundamental changes to how general practice works with obstetricians. To be fair to the obstetricians, in many environments they are not well remunerated for providing backup and support. It has been a particularly challenging issue in the rural sector. I believe that the best possible outcome would be a combined work force, because I think most of us appreciate that in the vast majority of uncomplicated pregnancies the delivery is also uncomplicated, but the pressing issue for me is that for that small percentage of deliveries when people get into trouble, there is an absolute need to provide the best possible outcome. That involves not only the medical practitioners involved in midwifery and obstetric care but also all other practitioners. That is what we hope will emerge out of the consultation with the community - a greater recognition that best care is in some way or other based on a relationship with multiple carers during pregnancy. We have not wished to force the discussion in any particular direction. I am very conscious, as a senior clinician, of the increasingly difficult issues of providing 24-hour-a-day, seven-day-a-week care of any sort. For the individual clinician to support an environment like that is no longer possible, no longer safe and no longer appropriate. We had for a long time in the past depended on a model that assumed almost superhuman behaviour by individual clinicians. We need to go to sustainable environments, where clinicians support each other and where the work demands and the lifestyle demands are in fact sustainable. From my recent experience of working with junior medical officers, there is no possibility that the current generation of doctors is likely to behave in the way that people from my generation have done, where they have worked far too long, probably in relatively unsafe ways because of sleep deprivation and hours of availability. In looking at any question for a GP obstetric model, those issues need to be taken into account. If you then also extend any discussion around a facility and medical carers during delivery to supporting home delivery or any other environment, such as birthing centres, the issues remain the same. Timely intervention to protect the safety of the baby and the mother has to be provided by whatever model we endorse as a department, and I think as a community.

The CHAIRMAN: A little further on the document refers to the GP side of things but does not refer a great deal to costing and costs. I am really interested in whether the VMP-type arrangements around some GP obstetricians will be enabled to continue in a new model or whether the VM service arrangements are something that you are seeking to eliminate from the system.

Dr Towler: I do not think we have reached the point when we know quite what we will do with it. The VMP arrangement has supported the delivery of quality care in the outer metropolitan area for a long period of time. It is dependent upon a close relationship with the practitioner working in a private environment. It allows for a good deal of care to be provided away from the public hospital service. I, like you, see the challenges we face when we bring together those issues of seven-day-a-week, 24-hour care backup cover, and the issues of availability. I think if you come down to questions about continuity of carer, it becomes quite difficult to know what the right answer is. All I can say at the moment is that the Swan District model for the support of the senior obstetricians was a substantial departure from the traditional model of funding. It has been highly effective. I think the issues of funding arrangements in support of the service need to be addressed as we define what the service options are. I think the VMP payment structure has challenges for us, but it has in the past remained an attraction to maintain those clinicians working in the area. This is not an easy discussion, as you will well know.

[11.45 am]

The CHAIRMAN: In particular, it applies with general practitioners who are operating their daily practices.

Dr Towler: Yes. I would be happy to consider in an obstetric setting a discussion around whether general practitioners would consider following the model obstetricians have taken - that is, saying, "I will take a day out of my practice to work in the obstetric environment." It concerns me that the training positions that are currently not being filled fundamentally work on that type of basis. There is not a great deal of uptake. It is challenging, and I see this as one of the difficult issues that will come out of any discussion about models of care.

The CHAIRMAN: Mention is made on page 9 of the document of the significant drop in the number of private obstetricians and the fact that the decrease will flow on to public hospitals. I am interested to find out whether you think this is a bit of a vicious cycle. I am of the view that obstetricians drop out of the public obstetric services system before they drop out of the private system, rather than the other way around. I am also interested on that basis about whether any analysis has been done on government policy contributing to that vicious cycle of general practitioners dropping out of the system.

Dr Towler: Is that general practitioners or obstetricians?

The CHAIRMAN: I was talking about general practitioner obstetricians, but the same thing could apply to obstetricians.

Dr Towler: Sorry; I thought, when you started the question, you were talking about specialist obstetricians and my mind wandered off. Would you repeat the question, please?

The CHAIRMAN: You mention on page 9 the survey by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists that revealed the numbers of private obstetricians dropping out of the public sector and then dropping out of the private sector - it states that this exacerbates the work force issues. I think it happens the other way: they drop out of the public system first and then they drop out of the private sector because they cannot do enough work in the private sector to sustain the things that they need to sustain. I am interested to find out whether there has been any analysis of the extent to which government policy on models of obstetric services contributes to the drop in the work force or the looming work force crisis, or whatever it is that you want to talk about.

Dr Towler: I am not personally aware of a major review of that particular aspect of general practitioner obstetrics. From what I have read since my first visit to the inquiry I have tried to get a clear view of what the Australian Medical Workforce Advisory Committee has to say about general practitioner obstetrics. There was not a great deal of what I would regard as contemporary information. There was a substantial review of the specialist obstetric work force, but I think that the issues we discussed last time of work/life change, the indemnity crisis and the related issues and decisions for specialist obstetricians and gynaecologists to give up obstetric practice and focus on gynaecology were, I think, reinforced by the AMWAC paper. I have searched but have not located a document that indicates the way in which the combined policies of state and federal governments underpin or do not substantially underpin general practice obstetric services. One recent important change was made. The development of the Australian College of Remote and Rural Medicine as a credentialling body for general practitioners for rural practice has included within it - as I understand from recent meetings with representatives of that emergent college - a special module to address obstetric care. The training model that I talked about earlier that is being developed between the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Western Australian General Practice Education and Training Ltd is an attempt to further underpin the maintenance and development of the general practitioner obstetric work force in the rural sector. It is my hope that we could use some of the same approach, but that is what I was partly hinting at during the discussion about the need for general practice to consider adopting some slightly different work practices in order to support it. I do not believe that there is a

comprehensive review of the drivers and other issues to do with sustaining the general practice obstetric work force. We know that current positions are not being taken up and there has been no increase in the figures we have been able to obtain from the Royal Australian College of General Practitioners for accredited general practitioner obstetricians in the metropolitan area. One of the key elements in the process of looking at models of care is that if general practitioner obstetrics is seen to continue to be a critical element of what the community decides is the appropriate way to care for mothers and babies, it will need to be addressed very specifically in order for those models to be successful. From my point of view, that is one of the key issues around this preliminary consultation.

Hon SALLY TALBOT: Have representatives of those bodies been specifically invited to the half-day forum?

Dr Towler: They have - very specifically for those reasons. In meetings I have had with WAGPET on a range of training issues for future general practice, we are very challenged by the fact that the model of general practice is itself changing. In trying to decide priorities for general practice education for the next five years, it is actually fairly difficult to know where effort should be invested, because it is not quite clear what the future general practice model will be. I am sure people, having established the traditional practice model, will continue with it through to retirement. However, as I am sure the committee is aware, many women general practitioners work in group practices, and work a few days a week. There are substantially different models of general practice and primary care emerging across Australia. Unfortunately, we do not have that range of options being demonstrated in Western Australia. Planning for a future in general practice has been made an even more difficult discussion, taking into account the particular nature of the Western Australian environment in which there has been less development of diversity. Some outstanding examples exist on the east coast, in places like the New England region of New South Wales and in some of the metropolitan primary care practices, in which general practitioners are now engaged in very different ways of working. Within that context, I believe there are opportunities to redevelop a relationship with public hospitals. A program we are developing called the community residency program for recent graduates - which we hope the commonwealth will support - will underpin creating a much closer relationship between outer metropolitan hospital practice and general practice. It may well be that roles such as hospitalists, in which general practitioners could go back to working in hospitals, are possible for the future. Such roles will be key to discussion about sustainability, training environments and viability for whatever model of care is actually adopted.

Hon LOUISE PRATT: The documentation provided shows a very diverse range of models of care and hospitals with very different structures and locations. Is it envisaged that after an understanding of the differing levels between hospitals has been gained, a universal plan for a whole-of-system approach to the provision of care at different facilities will follow?

Dr Towler: I see that as one of the fundamental challenges of this process. One of the reasons we chose not to be explicit about particular preferences or directions is that even if only the principle public hospitals in Western Australia that are providing an obstetric service are considered, substantial variety will be found in what is around them, the nature of the medical community around them, the nature of the people who live in the area and the different community profiles. We hope that a series of principles will emerge from this with respect to what might be taken into consideration in providing service to a given area. There are some potentially valuable things, but I do not want to pre-empt the outcome. Our priorities and the direction we have taken have been very much around safe practice and the principles that are outlined in the early part of the document.

Hon LOUISE PRATT: One of those principles concerns the provision of choice where possible. On the evidence available to me, and after speaking to constituents, women go to a local facility and assume that it is the only choice available to them. In the provision of greater choice, a more

universal sense of what models of care should be available to women is needed, and recognition should be given to the expectation that if a particular setting meets requirements, women should have the capacity to make choices. Do you have any comment to make about that as it relates to that question? I understand that there are regional differences.

Dr Towler: The other side of the discussion is the issue of affordability. In the end, the provision of an appropriate facility that can provide continuous and safe care can only be replicated so many times. The reason the Health Reform Committee Report endorsed the current paper largely related to the question of what can we have as a sustainable foundation. What goes on beyond that is what a lot of this consultation is about. Extensive discussion took place last time about the idea of creating a regional base for a variety of care options within Western Australia. A number of private sector providers of obstetric services are in the metropolitan area as well. That influences what is available within a given community in the sense of where services can be delivered and in the availability of practitioners. I do not have a clear view of the outcome. I have a clear view of the principles. That is the way in which we have tried to fashion the document.

The CHAIRMAN: I would like to look a little at community based midwifery options. The "Future Directions" document states that the midwives will be able to support women during labour and birth in the most appropriate setting etc - either at a hospital or at home. This option would seem to require quite fundamental changes to the current structure and involve issues such as clinical privileges for midwives - even Medicare perhaps - and the availability of medical and other support services. Do you see this as an option in the short term or as the long-term goal? Also, why is Western Australia so far behind or slow in picking up the model in comparison to the situation in other states?

Dr Towler: I do not know why Western Australia is so far behind. We have been very conscious that that is a key element of this consultation and discussion. I noticed in Dr Cohen's transcript some comment about shall we say difficulties working together, which I think we discussed once before. I believe that we are interested in a discussion that if the community and clinicians endorse the idea that we should look to optimise and improve midwifery-led services in an appropriate framework, that will require appropriate credentialing for somebody to be part of a hospital staff. We are currently involved in extensive discussions about clinical credentials in the scope of practice for all clinicians, not just doctors. It is being developed at the moment largely in relation to doctors. There is clear understanding that you need to be able to demonstrate competence, and it needs to be transparent and people need to be able to be confident that a person has been appointed to a role that he or she can deliver on.

[12 noon]

The CHAIRMAN: Is that being done in conjunction with community midwives as well?

Dr Towler: Not at the moment, but I am referring to the clinical governance principles that are outlined in the document. One of the issues here is that in order to progress in all these areas and to have people appointed to staff, we will have to decide on what scope of practice issues apply and who can credential - just like we already do with dentists and other people who work in hospitals. I do not see that in the end being an impediment. We are by nature looking in hospitals to accredit people to take on roles that are different to traditional hospital roles. I think you are absolutely correct if that is the direction in which the consultation and the discussion lead us. That will be a key issue; I think it is certainly something for which there seems to be interest. I do not see that as necessarily an impediment.

Ms Maggs: I was just going to clarify one comment that Dr Towler made. I understand from Community Midwifery WA that they are in very preliminary discussions with King Edward about having credentialling associated with the community midwifery program.

Hon LOUISE PRATT: It is my understanding that it might be a case of be careful what you wish for in the sense that, as they expand and get more recognition for that kind of practice, I would imagine that these models of care would become incorporated in the kinds of things that are listed in the discussion paper; that shift away from community control for those models might not perhaps be accepted in the mainstream. That might involve some renegotiation of those types of relationships. Would that be right?

Dr Towler: I would think that is an absolutely correct statement. There is no doubt in my mind that the underpinning principle of this consultation and one of the reasons we have probably taken as much time as we have to get to this document, and a lot of the rewriting and reworking of the first version was due to extensive discussions with all clinical practitioners involved in obstetric and midwifery care. There are some telling factors if you look at the recent peri-natal mortality report, which was reinstituted. We do not have the current triennium, but with the one before the point was made that the accoucheur - the person delivering the baby - is, in over 75 per cent of cases, a midwife. That is a reality. Many obstetricians I have spoken to will say that they have absolute confidence in many midwives. The rest of the comment is left unsaid. It is critical in this environment that there is a transparency around accreditation capability. For hospitals that is the same issue as there is in scope and practice credentialling. I personally have little doubt that we can move in this direction with the appropriate framework.

The CHAIRMAN: We will move on to family birth centres. You make it fairly clear that the expansion of the family birth centre models will only be for centres that are adjacent to hospitals. Have I got that correct? If so, would stand-alone facilities in a nearby radius - that is, 15 to 30 minutes to a hospital - also be considered? I am referring to page 24.

Dr Towler: Yes. I was looking for my other briefing note. The issue of birthing centres is an interesting one. Dr Sharon Stewart, who is the other principal officer who was working on the development of this document, was herself extensively involved in community consultation around exactly the same material in the UK before she came to Australia.

Hon LOUISE PRATT: Who was that again?

Dr Towler: Dr Sharon Stewart. She got her PhD while she was working for us. Sharon was involved in a program where, in fact, both types of facilities were put in place. The level of uptake in the UK of the independent freestanding birthing centres was much lower. Again, I do not wish to pre-empt the outcome. Referring again to a lot of the principles that were espoused by Dr Cohen and I think restated in his transcript to this committee is that the issue is not so much travel time from the centre to where you can undergo whatever is required in an acute centre, it is actually the time from when the event happens to when you actually get a definitive outcome. The practice he is espousing and the message we are getting is that it should be 30 minutes until you have your outcome, not 30 minutes until you get from A to B. I think that produces a challenge. As a person with a strong background in critical care medicine and intensive care, I can assure you that the issue of having to transport people is a difficult problem. Even with the best will in the world, unless there is a very well-refined system with basically 24-hour ability to provide support, the ability to transport people even relatively short distances that need ambulance intervention is very difficult to sustain. What that says is that if we were to adopt a model of that nature, we would have to address the issue. I think that produces substantial challenges. Again, we have not excluded the discussion.

Hon LOUISE PRATT: You cannot unless you are going to exclude homebirths from your models of care.

The CHAIRMAN: Obviously, you are familiar with the Ryde Hospital project.

Dr Towler: No, I do not know about it.

The CHAIRMAN: It is a very small hospital. I think it is less than 30 minutes away from wherever their nearest place is. There has been quite a lot of study done on that proposal.

Dr Towler: There is a very strong theme that runs through a lot of the discussions around those sorts of roles, which is the ability to identify at-risk patients and ensure that they are not cared for in those environments. Unequivocally, Western Australia has done particularly well at that over a long period of time because we have lived in that environment for a very long period of time. But there are still cases where people get into trouble. That is the discussion that needs to be held. I will happily go and look into the Ryde model and find out how it works.

The CHAIRMAN: It is worthwhile. We will be visiting there, I think, as part of the inquiry.

Dr Towler: Good. I look forward to finding out more about it.

The CHAIRMAN: Just talking a little bit about hospital options, can I ask whether the department or the government has changed its views about Osborne Park and Bentley?

Dr Towler: I am not aware that we have changed our views.

The CHAIRMAN: Are there discussions?

Dr Towler: There are discussions going on. I think one of the issues at the moment is that there has been a significant increase in the number of deliveries.

The CHAIRMAN: Especially at Osborne Park. Has there been an increase at Bentley as well?

Dr Towler: I am not sure what is happening at Bentley. In fact, I heard a suggestion that one of the senior obstetricians at Bentley just retired and there might be service difficulties. A lot of the modelling around service sites and needs was based on projections forward. What we are seeing now is a substantial upturn in the number of children being born. At the moment Osborne Park is being maintained.

The CHAIRMAN: What do you mean "Osborne Park is being maintained"? The numbers?

Dr Towler: No, the service is being maintained at the moment.

The CHAIRMAN: So there has been a shift away from the previous position of closure?

Dr Towler: At the moment we are sustaining the service because there is a need for the service. I am not an area chief executive and I do not have responsibility for that service. At the moment that service is being sustained because I think we are seeing an increase in the number of deliveries.

The CHAIRMAN: Are you able to be that clear about what is happening at Bentley?

Dr Towler: No. Discussions with a number of senior obstetricians recently make it appear that there may be a retirement. It goes to the very challenging issues of maintaining the workforce. I have no direct responsibility for Bentley. I will have to find the answers.

The CHAIRMAN: I want to ask some questions on hospitals. I think you partly touched on this particular issue but I had it written down. I am interested in making the comment and asking the question of how you balance the competing interests of continuity of care and rostered doctors' arrangements in hospitals.

Dr Towler: From my point of view, that is one of the fundamental challenges of the consultation we are about to try and undertake in that I do not quite understand what people expect. I have a sense that some of those expectations may not be real. What we are seeing in the information coming from other jurisdictions where people have developed team care during pregnancy is that, essentially, the continuity of carer - carer in the plural and not in the singular - means that a person is encountering a range of people who they become familiar with and have confidence in. Part of that team will be the people providing the care at the time of delivery. We all know that women in private practice constantly joke about the fact that the obstetrician never turns up. Obviously, they do turn up, but many, many times they are not there for the actual delivery if everything seems to be going well. I think this is a very challenging issue. I am not sure what people reasonably expect. I am quite sure that general practitioners involved in obstetric services are constantly presented with

the problem of competing pressures at a time when a delivery may occur suddenly. What we are hoping from out of the process is to broaden out the concept of continuity of carer contact. If you are involved in caring for very few people, I am sure you can guarantee to potentially be available. There are certainly midwifery models where the midwife does not take on very large numbers of people. Those high-intensity models are also difficult to sustain. How they relate to the rest of the operation of the health system needs to be resolved. We have interesting new professionals in health like patient advocates. Our whole practice is changing because somebody new is in the environment. The ways in which we work with the patient, the mother, in those environments are lessons I hope we will learn from some of the consultations, such as with Ryde. I do not believe that the idea that an individual is available to the mother all the time is actually a sustainable model.

Hon SALLY TALBOT: Before we move from hospitals, I think we have given you a document that shows the different models that are in place at various public hospitals around the metropolitan area.

Dr Towler: Yes.

Hon SALLY TALBOT: We were surprised to see the complexity of those models. Does the department share our slight concern about the extent to which models change from hospital to hospital? In framing your answer to that, I do not know whether you had the chance to look at the hearings we did most recently where we talked to some obstetricians. It is reasonable to say that, although they were reasonably well aware of the local provisions in terms of their capacity to deliver private and public services, they were working only in a quite small geographical area. When we got to the point of talking to them about upgrading skills or GPs acquiring skills to enable them to deliver obstetric services, it was very evident that the lack of clarity about what was acceptable in different public hospitals around the metropolitan area was very much a part of their decision-making process about whether GPs are likely to take up opportunities to retrain or upskill.

Dr Towler: I think that historically the development of the models that exist in different places has not been driven by any overarching principle. It has occurred on the basis of local pressures, local clinical availability and local clinical leadership. We have a fairly arbitrary structure. I think one of the outcomes with King Edward in the current report and the things that have followed from it is that, for the first time, we are genuinely starting to look at the overall questions around the provision of these services. There are challenges in the way the state-administered system interacts with the services provided through commonwealth funding. I think the point behind this consultation is that we are aware of the huge diversity of outcomes; that we have some sense that we have not really considered the scope of practice and the credentials of the different models of care as they operate.

[12.15 pm]

What we are trying to do out of this process is to define for people what is available, give them a broader view of what the options are, and in that sense you create choice by information and awareness as much as whatever you can achieve locally. In this process we start to set an appropriate standard that we can all be confident about. One of the really fascinating outcomes, when you start to look at this material, is that currently Western Australia has extraordinary high-quality outcomes in obstetric care, which I think attests to the extraordinary commitment of the people who have been doing it for a very long period of time. But I see that there are risks with a changing work force and changing experience. An article in the paper on the weekend talked about the loss of skills at dealing with vaginal delivery and said that we have an inexorable rise in the caesarean section rate. I think it is profoundly challenging. I was reassured by learning about the outcome at Swan District, where you create an environment where people are confident and the caesarean section rate is in fact lower. So the issue you raise I think is one of the fundamental challenges in this system, particularly when you look at some disadvantaged groups, when you look at the question of meeting the needs of people with - I noticed in here you have put down things like

diabetes services and chemical dependency. You could put any one of the special needs groups into this discussion. My preference would be that where the needs of the patient are not extreme, they can be cared for within whatever unit is available to them - most appropriately on a geographical basis, but some of them will clearly need to be transferred to the care of other units and tertiary care areas, because they then form high-risk groups.

I think this whole process heralds, from the state jurisdiction point of view, a very substantial focus on the whole question of maternity care. That is what we are trying to get to. The minister has been very committed to that really ever since I encountered him in my new role.

Hon SALLY TALBOT: Can I just clarify in my own mind: do you see the sorts of different services that are outlined in that document as being an indicator or a result of a profession, or a couple of professions, that are in transition phases, or do you see it as being a sort of - they say that the camel was a horse designed by a committee? Is it more a piecing together of locally available services? I am very interested to know whether you think that this is something that is going to be ironed out in the next 12 months or so.

Dr Towler: I have not looked at this document in great detail; I must apologise. I would believe that the sort of rich tapestry behind what has happened in the history of obstetric services will come forward in this process, and will, I am hoping, throw up to us the challenges around how you provide sensible advice and appropriately plan for the future. At the recent Excellence in Health Care conference there were outstanding examples of what can only be seen as extraordinary care being provided by just passionate people who work together effectively. I am hoping that in one sense part of this process has those collaborative features and that we learn from what has been successful in some locations. That very point that you made about people's lack of awareness of what else is going on can be overcome. The collaborative principles are being used extensively at the moment in things like organ donation and a number of other areas. I am hoping that we will get that learning for the first time, laying on the table some of these opportunities, but it is not easy.

Hon SALLY TALBOT: Obviously this inquiry is driven to a large extent by what we perceive to be the need to take consumers' views into account, but I must say that my reaction from seeing that document was that the person whose heart would sink most significantly would be the provider of the professional services. A GP fronting up for their first day of the six-month diploma course in obstetrics would wonder what they had walked into.

Dr Towler: Yes, indeed, and that is one of the things about the in-place training option we have been looking to develop in the rural sector. I think it addresses some of those sorts of problems. There will still be the need for what you might call "tailored solutions", depending on particular regions, particular areas and particular future work forces. I am sure you are aware of the problems we have already with general practice work force full stop, in many areas around outer metropolitan Perth, where I regularly sign documents recommending that the minister maintain the declaration of area of unmet need. In the recent program - with assistance from the metropolitan hospitals - Country Health Services has been stepping overseas doctors through what is essentially a true credentialling exercise before they go to independent practice in the rural sector. Many of those people have been found not to have adequate skills, so have not been placed.

The CHAIRMAN: I want to ask you a little about the caesarean section rate in WA being as high as it is. Obviously it has been reported in the papers and is something that we were pretty interested in as well. You pick up on it on page 12 of the document as well. It is coincidental that the *American Journal of Obstetrics and Gynaecology* has put out a paper in these last few months about what should or should not be an ideal caesarean rate. Basically the American journal says that caesarean rates are a consequence of individual value-laden clinical decisions and that the caesarean rate is an indirect result of - in this case - American public policy. I am really interested in what you believe is the reason for WA having such a high caesarean rate. How much does government policy contribute to it and what practices need to change? You make comments about practices

needing to change. Is it sensible in a state like ours to have a notion of a caesarean rate at 17 per cent, or whatever it is, that you are thinking is a good level or number? Where are we going and what is happening about caesarean rates?

Dr Towler: I am not an obstetric expert. I have done a lot of reading recently about some of these issues. Some of the discussion in the media around caesarean section rates and women's choice and private medicine - there are substantial numbers of women who are choosing electively to have caesarean section.

The CHAIRMAN: Why? What is it that is causing that?

Dr Towler: I do not know the answer to that. I have not reviewed that particular issue in terms of elective caesarean section.

Hon LOUISE PRATT: It is any number of reasons to do with the age of women giving birth, working arrangements. It is very complex - expectations.

Ms Maggs: There has been some research undertaken by Curtin University of Technology in consultation, I think, with Queensland around the reasons behind caesarean rates. I can provide the details of that. You may wish to talk to them.

The CHAIRMAN: It would be interesting.

Dr Towler: And certainly that is more of an Australian setting than the US data.

Hon SALLY TALBOT: I think that the chair's question leads - it is a very pertinent way to draw attention to one of the specific terms of reference of this inquiry, which is about the collection of evidence. It has seemed to us - many times during the months that we have been on this inquiry - that one of the primary problems that we have is the lack of balance between the voices of various stakeholders in this discussion. Any legitimate process of consultation is probably one of the things that we have come back to over and over again. Let me put that differently: for a process of consultation to be seen to be legitimate, there has to be a way somehow to address that imbalance in the strength of the voices. You do not have to read very subtly between the lines of our letter to Dr Fong - which is what led to you being here; you can see how those different voices have reacted when asked about how they thought consultation had gone so far. Are you prepared to comment at this stage, in light of what you have outlined to us about stage 2 - between now and 31 December is into stage 2; can you say with any degree of confidence that that imbalance between the voices of the stakeholders is going to be something that you are going to be able to specifically address, so that when you move into the policy formulation stage, you can start being able to respond to some of those questions? Let me take you in a circle back to the chair's question to you about caesarean rates.

Dr Towler: I absolutely agree with where you are coming from. In doing some reading in the last few weeks before coming back to talk to you - I have recently been appointed to the National Health and Medical Research Council, which has a very interesting document on public consultation. Given the nature of the NHMRC and the way it operates, its consultation, discussion actually refers more to public guidelines, which would be very much like our phase 3 consultation, where, when you have got to the next bit, you then have the thing that starts to look like what you are going to work to, and you have another consultation around that.

Hon SALLY TALBOT: Which is more like seeking a mandate.

Dr Towler: Yes, but it has to have the permission that says if we are not right then we change it. We are not seeking to have a draft framework which is then a fait accompli. We have been very conscious, in thinking about the consultative phase and in developing the framework, that there is an absolute need for a strong evidence base, wherever it can be found. We have done a fair bit of research looking for the evidence base, and it is largely covered in a lot of the bibliography. It is information that we are happy to make available. Our discussions this morning, though, have

focused on the fact that there are a number of unique issues for Western Australia. To put it bluntly, I think some of the evidence is missing. We have not been able to find absolute answers to some of the questions which I think are inherent in the positions taken by different clinical groups in making the statements they make. There is some information. At the moment we are increasingly improving our reporting structures within the public health system. We are starting to develop a much clearer idea on outcomes. The new clinical government structure is resulting in better reporting on who it is who is in hospital and what happens to them, and that is including aspects of obstetric and midwifery care. There was a point when the director general was considering engaging an external consultant to simply do the work of pulling all the evidence together. I am quite sure he will not mind being named, but Neale was very keen for D'Arcy Holman to do that, but D'Arcy was not available. It is a significant piece of work. We have not been able to find a suitable other person, so we have probably put a degree of greater dependence on what I think is a substantial amount of international and national data that has been pulled together by other states and jurisdictions undertaking a similar exercise to what we are doing. The strength of having somebody like D'Arcy look at that would have been his ability to tease out what was locally relevant and what was not. The short answer to your question is, wherever possible we are trying to establish whatever is a strong evidence base, so that there is a balance in that conversation. It is my belief at the moment that we have not been able to identify clear evidence outcomes in relation to knowing how to resolve some of those questions, and there will be a balance in this consultation. That is going to be the hard part.

The CHAIRMAN: Yes, you are right.

Hon SALLY TALBOT: That is the part, presumably, that you see as ongoing rather than confined to the next six weeks.

Dr Towler: Absolutely. I believe that it is critical to be ongoing, but as we begin to understand the particular regional nuances and we understand what the evidence base is, we will try to have a discussion which is locally relevant but state orientated in its basis. There is a fair amount of information. Much of it will depend on the extent to which people accept that evidence developed somewhere else is actually "acceptable to me where I am". That is the aspect that I am encountering.

[12.30 pm]

Hon LOUISE PRATT: Clearly, these issues are ongoing for now and the future. I imagine that, in the coming weeks, given that a range of stakeholders are all pushing their own point of view, you will be trying to bring together that evidence to gain consensus among stakeholders.

Dr Towler: Consensus is probably a little generous.

Hon LOUISE PRATT: Granted; I absolutely agree with that. It is very difficult.

Dr Towler: The critical issue for us in that area is for those people to recognise that we have done the best we can to ensure that their position is understood and that it is informed by the best evidence that is available.

Hon LOUISE PRATT: I am really pleased to hear you say that in the sense that you need to have a fairly strong appetite. It is one of the reasons these things have not been addressed in the past.

Dr Towler: I think that is why it was given to the clinical network part of my division to handle. Quite honestly, the expert clinicians in these areas did not have the appetite for this consultation.

Hon LOUISE PRATT: You need to bang a few heads together to create some kind of future vision by which you can get all stakeholders on board.

Dr Towler: From my point of view, it is a critical time in asking people to put aside a few of their personal positions for long enough to have a sensible discussion. The future obstetric services in the state are very dependent on the outcome of this process. We must put the resources into the

right environments to ensure that we have an appropriate reference. All of it is looking challenging at the moment.

Hon SALLY TALBOT: We received this morning a draft of the WA health consumer care community engagement framework. With is the status of the document?

Dr Towler: It is still in draft form. It has been with the Health Consumers' Council for some time because the council has wanted to give it a 10 000-consumer throughput.

Hon SALLY TALBOT: Do you know when that will draw to a close?

Dr Towler: No I do not, but that is where it is at the moment. The Health Consumers' Council was very involved in its development. We ran a clinical senate meeting called "road-testing the consumer engagement framework". It is at the point at which it is getting extensive external input. I think it is an outstanding document but it is not endorsed by the organisation at the moment. It is very much in its phase 3 consultation. That is what it amounts to, which is why I think it was a little slow getting to you, and I apologise for that. I am not sure what happened.

Hon ANTHONY FELS: What privileges do GP obstetricians have as a result of gaining the six-month diploma compared with a GP who has not done that? What is to prevent an ordinary GP who has not done that diploma and who might be the only GP in a town from being able to practise obstetrics?

Dr Towler: Under the public health system, unless a doctor has a diploma he will not be allowed to practise obstetrics. It is a credentialling issue.

Hon ANTHONY FELS: Unless it is an emergency situation.

Dr Towler: If someone is threatening delivery and the clinician must manage it, the clinician will obviously provide the best care available.

Hon ANTHONY FELS: What is the situation in small towns where there is only one GP and he is not GP-obstetric qualified?

Dr Towler: The challenge faced by Western Australian country health services is to work out what will be our future model for maternity care in the non-metropolitan area. In his commentary to the committee, Dr Cohen made substantial comments around this issue of the need to develop a sense of regional capability. We believe that, given the fact that we need to be able to provide both service delivery, potentially anaesthesia recovery and services to resuscitate a baby to get the triad that is critical to covering the needs of obstetric in midwifery and delivery services, the debate in the country is similar to that at the metropolitan level in trying to develop a hub locally. This is the tricky balance. It is the same debate. Dr Cohen made extensive commentary about the situation in the past when there were local small hospitals and many people had a successful delivery and everyone looked on those institutions favourably. However, the messages that came from the King Edward inquiry and our greater understanding and scrutiny of when there are unnecessary adverse outcomes have made this a much more difficult discussion. In the public sector, a GP wanting to deliver babies needs to be appropriately credentialled. I do not know the details of every town in the Country Health Service. I do not know the historical basis for the need. I imagine there are general practitioners who have been delivering babies for years and may still be doing so. Under the standard set under the new Australian College of Rural and Remote Medicine, they need to be trained and appropriately credentialled. Does that answer your question?

Hon ANTHONY FELS: It is obviously an issue in areas in which there might be GPs in every town for a couple of hundred miles and no GP obstetrician.

Dr Towler: It is an issue. That is the whole point.

Hon ANTHONY FELS: As you said, there might be GPs who have been delivering babies all their careers but who do not have the qualifications.

Dr Towler: I think that the system has recognised that. My concern is that a GP on his own cannot manage by himself a birth that goes wrong because more than one practitioner is required. The public system inevitably must provide care in adverse events as well as in the ones that do not go wrong. There is a sense of trying to develop a regional hub where a more risky delivery can be safely managed or where someone can choose to go. Young Aboriginal women who are pregnant leave their community many weeks before delivery to be in an environment where, if they choose to, they can be successfully cared for.

Hon HELEN MORTON: That was the exact point I was going to make but I was going to provide you with information I received when I was at Fitzroy Crossing recently. The problem for some of those mothers is that when they go to Broome or Derby or wherever the regional birthing place - Kununurra perhaps - they move into a hostel for the three weeks, but the hostel does not accommodate the other children; therefore mothers are deciding to stay in the community for fear of leaving their children behind and to take the risk of delivering in a small facility such as Fitzroy Crossing District Hospital that does not have specific obstetric services. They see that as a lesser risk than leaving their children behind in the community.

Dr Towler: I agree. If you take the whole-of-life view, there is a much bigger question than simply the optimum management of childbirth. It is challenging. I spent some time north of Broome a few weeks ago. I understand without question the difficulty. Even for other mothers, simply leaving the local community to spend some time somewhere else waiting to deliver a baby is partly why people are choosing a planned delivery. It is not an easy issue, particularly for Aboriginal women, among whom there are substantial numbers of low birth-weight babies. That is a very sad decision to make if they are in that group because the baby is at risk in that situation.

The CHAIRMAN: Thank you for your time. It is nice to have met you, Alison. Your name has come through on quite a few documents.

Hearing concluded at 12.39 pm