LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH

(Reference: maternity service)

Members:

MS K TUCKER (The Chair)
MS K MacDONALD (The Deputy Chair)
MRS J BURKE

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 26 FEBRUARY 2004

Secretary to the committee:
Ms S Leyne (Ph: 6205 0490)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents relevant to this inquiry which have been authorised for publication by the committee may be obtained from the committee office of the Legislative Assembly (Ph: 6205 0127).

The committee met at 9.01 am.

THE CHAIR: I declare open this public hearing of the Standing Committee on Health and welcome Mr Peter Matthews from the ACT Insurance Authority to speak to us about our inquiry into maternity health services in the ACT.

PETER MATTHEWS was called.

THE CHAIR: You need to understand that these hearings are legal proceedings of the Assembly, protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal action, such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Can you give us a general summary of what the insurance situation is, particularly in relation to midwifery indemnity issues?

Mr Matthews: The core of this issue is cover for midwives, in particular home births. When the cover was withdrawn for private midwives in the territory, government attempted to set up an alternative service and to source insurance for that. We approached the reinsurers that cover our medical indemnity program for government, and we were rebuffed. We went back with some additional information, with much the same result.

Meetings were held with some representatives from the Maternity Coalition. I said that I was very concerned that, if we went back to our reinsurers, we might prejudice our entire program. It wouldn't just be the midwifery services; we might end up with no medical indemnity cover for the territory in total. But I did say that, if some supporting documentation were put forward, I would be willing to do that. That was forthcoming. Barbara Vernon wrote a considerable paper, which was then given to Health. Health made some minor amendments to it, and I took that paper to London when we met with our reinsurers.

We got a glimmer of hope that they would consider it. In that meeting the under-treasurer at the time, Mike Harris, and Roger Broughton were with us, so it was a fairly high level representation from the territory. About two weeks after those meetings, we were told no. There were two separate meetings that may have had some hope for us. One was with Market Form, who were the lead reinsurer on our entire program. We had some hope that they might be interested. Another one was a separate group, and a fairly recent group: MLPC. They operate out of Gibraltar. Their chief came over to meet us in London and expressed some interest. But, once again, the answer was no.

One of the underlying reasons for that is that Market Form, if we take that company individually, had a 50 per cent backing from St Paul. St Paul withdrew from medical indemnity insurance worldwide. It was costing too much money; they just closed down and walked away. After that, Market Form had to find new capital to support their operations, and that new capital was institutionalised capital. In fact, a fair bit of it was from the banks. Being fairly vulnerable to showing positive results over the first couple of years with that new capital, they were reluctant to go into something like this.

MLPC were much the same, but the person heading that was virtually a split away from Market Form. They also had new capital behind them, and the suppliers of that capital asked them not to enter into something that they had seen as a risky class of business. That was about where we were left. There are no other markets; there are no other lead reinsurers that work into Australia; there is just nobody else.

THE CHAIR: The Western Australian government secured medical indemnity insurance for independent wives. Are you aware of that?

Mr Matthews: Yes.

THE CHAIR: Who was reinsuring them?

Mr Matthews: They cover it themselves. South Australia have something similar.

THE CHAIR: Right. So why could that not be done here?

Mr Matthews: Our problem is that we are such a small jurisdiction. They can absorb that into a budget. South Australia is probably 10 times our size and Western Australia something similar. For us it would be a financial disaster to absorb that without reinsurance behind it. Behind all the insurances we effect for government we have reinsurance. There's nothing that we would be prepared to cover where we don't have reinsurance support.

Medical indemnity is the area where we carry the greatest exposure ourselves. We carry $17½ million in any one year. So it's in the aggregate. But once the claims exceed that $17½ million, it's paid by reinsurers. We've never touched that limit. The thoughts were that births are things that drive our portfolio dollar wise. A bad birth is from $5 million to $15 million—that sort of money.

THE CHAIR: All the evidence shows that the risk is lower for community midwifery care, and we're not just talking about home birth. That model of care has a lower intervention rate and fewer issues, and the evidence is there, so I'm trying to understand why insurance companies think this is so high risk. I also don't understand why the more recent work done by Fiona Tito, which showed that where there is a relationship between the carer and the client—in this case the woman—there is less likelihood of litigation, even if there is an adverse outcome of some kind, isn't very significant in this matter and in decisions made by the insurance industry.

Mr Matthews: Insurers think historically, and most of these people have been hurt—the word they use is "burnt"—in the past by home birth covers that they have granted. We attempted, without outliving our welcome, to get a little bit more information out of Market Form. Apparently, they supported a particular arrangement in Canada some years ago, and the results were terrible.

I agree with what you said, and I've read the information put forward. It does seem that if there's continuing care there's less intervention. There are a lot of positive things there, but at the end of the day, reinsurers look at it and say, "It's hurt us before and we're not prepared to do it again." They don't take too much notice of what's in front of them, unfortunately.

MS MacDONALD: Do they look at evidence coming out of places like New Zealand or the UK where there are quite a lot of home births?

Mr Matthews: These people work worldwide, and they see whatever there is in any market in the world. It's a perception and, unfortunately, the perception overrules reality in some of these things—and, these days, insurers aren't looking for business. Premiums have gone up by a huge extent, particularly people out of London because their capacity is geared to how much premium they write. A lot of them have got more business than they can handle, so if they have even a vague doubt about something, they just say no. They're just not interested.

THE CHAIR: I'm interested in looking for solutions and at what you think are potential ways that this could be addressed. Obviously, we don't have a no-fault scheme, like New Zealand, and we've seen governments bail out obstetricians who are stuck with medical indemnity problems as well. From your perspective as an expert in this field, where do you think a government could go if it wanted to ensure that there was the capacity for independently practising midwives to exist?

This isn't just about home birth; we as a committee are looking at maternity services, and we've looked at different models around the world. As Ms MacDonald said, we've looked at New Zealand recently, where midwives who practise as independent businesses still support women to have their babies in hospital, if it's their choice, or at different units. Some of them aren't associated with the tertiary hospitals; some are. Some are just birthing units—primary units—which are not home births, but they're also not associated with a hospital. There are all sorts of possibilities for this committee and the government to look at. What do you think are the possible ways for us to go?

Mr Matthews: You've raised two completely different things there. The first one is that insurers have a problem with home births, and nothing else. They are entirely supportive of the midwifery caseload model—and they should be because it works in their favour. It is just that isolated risk of home births. That is the sticking point, nothing else.

THE CHAIR: What if you had a primary unit, like they have in New Zealand? That's like a health centre where midwives go with women and support them through birth.

MS MacDONALD: It's like the birthing centre at the Canberra Hospital but not at the hospital.

Mr Matthews: That could well be the end of the problem. I'll go through perceptions, because it is all about perceptions. Their thinking is: if something goes wrong in a home situation, first of all, the people who've elected to have a home birth, the potential parents, may be reluctant to seek care as early as it's indicated. The midwife, who may be supporting that same position, may be reluctant to seek care as quickly as it may be indicated. Then there is delay in transferring the lady to more intensive care.

It's all of those things—where a relatively small problem that intervention might lessen the effects of becomes a major problem because of time delays. We've looked at the fact that the time delay in transporting somebody is probably not much different to wheeling somebody down the corridor from a birth suite into the theatre.

THE CHAIR: In a place like Canberra, definitely.

Mr Matthews: We know those things. But the perception is that there's this delay and the problem escalates because of the delay. It all revolves around that, whether it's reality or perception.

MRS BURKE: Who's driving the perception, Peter? Doesn't there come a point where we draw a line in the sand and say, as the chair has just alluded to, "We've got so much information now about less intervention with home births"? Why do we continue to allow perception to be reality? Who is pushing—pardon the pun—the case for home births to be that choice for women to have?

Mr Matthews: In our instance, with our insurance, I thought the paper that Barbara Vernon put together was very supportive and we pushed that very heavily. Everybody accepted it and said, "Yes, that's very nice," and then came back and said, "But we're not going to do it."

THE CHAIR: It's ultimately their choice. That leads to the second part of my question: where else can we go with this?

Mr Matthews: There's only one answer to the second part of the question. The conventional insurance market is not going to be of any use to us. The only way I can see the answer to this is that we, as the insurance arm of government, look at a totally different structure of how we insure and reinsure government. It would probably involve us taking a greater degree of risk ourselves.

On the other hand, we may be able to purchase some reinsurance, but not in that conventional manner. The sort of thing I'm thinking about is where we purchase reinsurance for our property, medical indemnity, public liability and all of these things separately. We might say we'll take the first $50 million of risk in any one year and purchase reinsurance above that level.

We're looking at some of those things now. There are some possibilities there, but that's the only way. The conventional insurance market at the moment are travelling very nicely, thank you. They are not really in any mood to do anything they see might prejudice their profits. They're service providers but for a profit. They're not the same as government. Many other people will be service providers to help the community; their responsibility is to their shareholders.

MS MacDONALD: You said before that the possibility of having primary birthing units might be part of the solution to the problem. Would they need to be located on a hospital campus, or would we be able to have them in a couple of different locations, setting them up in a home-style atmosphere? Women would then know that they could go to a primary birthing unit without there being the risk of somebody saying, "We think you should have an epidural now," pushing for certain things to happen, which then leads to the whole cascade of intervention. My question is: would we be able to do that off the hospital campus?

Mr Matthews: I don't think the location is important. The question comes back, in the event of something going wrong, to what facilities are available at that site.

MRS BURKE: There are practices and procedures within that.

THE CHAIR: They'd use the same arguments against the home birth, though, because there wouldn't be the technology that primary birthing has.

Mr Matthews: If it got to the stage where an emergency caesarean was necessary, where would that take place? It's the logistic type things. Logically, "At the hospital" is the easy answer, but it is probably not the only answer.

MS MacDONALD: If the government set up a birthing unit in a house in Garran and one in a house in Aranda, both very close to hospitals that perform emergency caesareans, and a process was set up so that, if a caesarean was needed, it could happen and the transfer time was not that great, do you think that would be possible?

Mr Matthews: That would definitely be a possibility. It comes back to your point about procedures being in place to make sure that that transition happens very quickly if it needs to. That's the other part of the problem: once again the perception that people will persevere with a home birth beyond the time that they should really do so for the safety of the mother and the child.

THE CHAIR: You're looking at different ways of managing risk. What's your timeframe for that? You said there was potential for buying insurance across all areas.

Mr Matthews: We renew all our reinsurances in June. At the moment, we are halfway through our marketing campaign to gain renewal of those insurances. We are contemplating doing something a little bit different this year. To do something like what we're contemplating here, June would probably be too late. We would need longer a lead time which, in theory, throws us back to June next year.

THE CHAIR: You said that you've taken information and advocated for this in London and wherever you went. Is there any other way you can actively support independent midwives to gain insurance?

Mr Matthews: Only by internally looking at restructuring how we do it. As far as gaining insurance in the conventional market goes, no. I say that because we researched all the markets previously and there are no more markets. In fact, there are fewer markets now than there were 12 months ago.

THE CHAIR: I understand that you're looking at the broader picture in terms of how you might be able to do that. Is there anything government could do?

Mr Matthews: There are two completely different aspects. One is a centre—something along the lines that you've mentioned, which would have to be equipped to a reasonable level, with set procedures in place and agreements with Calvary or TCH, whichever site we're looking at. That would be one aspect. The other aspect is something that's being contemplated right now: government allocating additional capital funds to the insurance authority. Those capital funds give us more security and allow us to take more risks. It is one of the things we're looking at right now.

THE CHAIR: Are you looking at that specifically because of this issue, or generally?

Mr Matthews: Generally. But it would fit well with this because it would allow us to take more risk and have more flexibility in how we approach things.

THE CHAIR: Can you explain that a bit more to me? To be honest, I don't quite understand how this works. If government funded you better, gave you more money—

Mr Matthews: Yes.

THE CHAIR: your position would be improved in terms of your capacity to cover what are deemed to be risky ventures. Is that it?

Mr Matthews: Not risky but ones that take more insurance in total. At the moment, we cover the first $17½ million for medical malpractice. On property we carry the first $5 million, and on public liability we carry the first $5 million. In total, we carry the first $34 million of loss in any one year, across all those classes, and it's highly unlikely that we'd ever be asked to do that.

Our capital, after the bushfires, is negative. We've had some losses that aren't covered by our reinsurers that we are bound to pay agencies. Our capital at the moment stands at about negative $800,000. If we had a significant cash injection, which would balance our capital against our exposure, we would be able to do more. At the moment we are technically overstretched. If we were a commercial insurance company, we would be insolvent at the moment.

THE CHAIR: Because of the fires?

Mr Matthews: Yes, yes, because of the fires and also because we try to keep our premiums to a minimum so that we're not dragging money in from agencies that could be expended on something else. We run a very fine operation. If we were a commercial insurance company, any profit you make, no matter how exotic, would be good. For us it's not the case. We would like to generate a small profit to boost our capital somewhat, but to generate a large profit we're taking funds from other areas that should be using them on community services.

MRS BURKE: Going again to the whole risk thing, the perception out there is that it's much safer to have a natural birth. It's the "first is natural" debate against obstetrics, and it takes away the choice in many areas. It seems odd that we've got so much evidence that natural birthing is becoming safer: "Let's get back to where we used to be, without all the machinery and intervention." I wonder what and who is driving the agenda.

I've got my thoughts, and I'm sure the rest of the committee have too. That's why I alluded earlier on to why we can't drive the safety of natural birthing and, possibly, home birthing. I was one of four born at home, and I think I'm fairly healthy. We can all tell stories about that, but we seem to think that society's much safer because we've got all the machinery around. In fact, there's a lot of evidence that would say no.

Mr Matthews: In Australia in general, we've got a very high intervention level.

MRS BURKE: Extremely.

Mr Matthews: That doesn't make sense at all. If I were to look at it from my very narrow commercial aspect, the less intervention there is, the less chance there is of something going wrong and the fewer claims I'm going to pay. That's forgetting all the social factors.

MRS BURKE: Exactly. Why don't insurers see that, though, if the evidence is there? It doesn't compute.

Mr Matthews: As I said, they look at history. They're not really looking for that evidence, and they're not really in the mood at this point in time to be helpful. They don't need to be.

MRS BURKE: We need more women on the boards. It just seems—I know you're sitting there agreeing.

Mr Matthews: It's disappointing.

MRS BURKE: It is, extremely.

THE CHAIR: When you said that one potential way out of this is for the government to give you greater funding, what sort of money are you talking about?

Mr Matthews: What sort of money? A very large sum.

MRS BURKE: As much as they've got.

Mr Matthews: I'd rather not discuss it. I can; but I'd rather not.

THE CHAIR: Okay. I just thought that if you had a figure it would be interesting.

Mr Matthews: It has to be a very large figure because our intention is to operate independently and to keep large losses from budget. The bushfires, for instance, would cost about $10 million in our organisation, and we will have to recover that over time from agencies through premiums. Our total losses are about $150 million. That's how we achieve our purpose. That doesn't go onto the bottom line of budget.

With any additional risk we take on we'd have to try and look at the same thing: that somehow or other within our facilities we could contain that. Medical indemnity is a good one because the time between the actual occurrence of the loss and the final payout is usually many years, so we have time to reserve that and time to accumulate funds to pay that claim when it eventually becomes payable.

We couldn't be nearly as ambitious on property, for instance. With the bushfires we're aiming to have all the claims settled within 18 months. Our own funds could never withstand that cash flow in that period of time.

MS MacDONALD: You said before that the insurance companies aren't looking for business, and they're not inclined to be helpful. I understand how it has ended up in that situation; it's worldwide. Do you see that situation changing in the next 20 years?

Mr Matthews: I don't think it will change greatly. One of the things that has changed, and I think has changed for forever, is that, historically, the capital behind insurance companies was private individuals investing. Much of that capital now is institutional capital, banks and financial institutions that want a return on their funds. A considerable portion of the funds of one of the companies I mentioned is now from banks. They have a financial reporting structure every month, and there are a number of targets they must meet. If they don't meet those targets, it is queried why.

That worries me because insurance is such an intangible thing, and monthly targets are almost an impossible task. That change in capital was one of the things. In some of the articles you read you see how much capital has disappeared out of the insurance markets over recent years. It's not so much that capital has been withdrawn; it's that capital has been destroyed by poor results over the years, so it's not there to come back into the market. What is coming in is institutional capital, which purely wants a return on its investment.

MS MacDONALD: You say we need to start thinking about things differently and doing things differently, and that applies to all types of insurance. I find that very alarming since it changes the whole nature of what insurance is supposed to be about. People get insurance as a protection but, if the people who put up the money where the protection is needed or put in the money for the capital that is ultimately supposed to provide the protection are saying that you can't have it, that takes away from the whole purpose of having insurance.

Mr Matthews: Yes. It's an increasing problem, and it's not going to go away. I'm afraid the nature of it has changed.

MRS BURKE: It's the mighty dollar, isn't it?

Mr Matthews: Yes. Talking about capital, if we look at what they call the "long tail classes"—medical indemnity, professional indemnity and public liability—it takes about six times the amount of capital to service that type of account as it does to service a property account because of the uncertainties of the long tail nature of it. The capital that is coming back into the market is coming in at the easy end, into the property and that sort of thing. There's still a dearth of capital available for liability classes.

MRS BURKE: What you seem to be saying is that the litigious nature of society has driven the fact that insurers have become more risk averse—averse to funding that end of the market—and that they'll go for the simpler end, which is bricks and mortar and less risk attached.

Mr Matthews: Very much so.

MRS BURKE: That's dreadful, isn't it? As Ms Macdonald said, where are we going with all of this if we're putting buildings and return on investment before people?

THE CHAIR: We have seen governments assisting the obstetricians with this problem. Can you outline for the committee what you understand that assistance to have been? Can you tell us that? We know that we have passed legislation here, the Civil Law (Wrongs) Bill, which capped entitlements. That was to assist obstetricians.

Mr Matthews: Yes.

THE CHAIR: We have also seen assistance with paying the premiums.

Mr Matthews: Yes. Is this in regard to the effect of the tort reforms that have gone through and that sort of thing?

THE CHAIR: Yes. I am interested in understanding what you see as the different situation for obstetricians and independent midwives. That is how I understand it and I am asking you to tell me if I have missed anything. That is how I understand there has been assistance given to obstetricians. Is that your understanding, or have I missed anything there? The second question is: is there any reason you can see that independent midwives could not be supported in the same way?

Mr Matthews: Theoretically, whenever obstetricians become involved in the birth process, there is a problem. So, by the very nature of it, their occupation is high risk. Most births within the hospital situation are probably under the care of midwives rather than an obstetrician.

THE CHAIR: That is not true. We could give you the stats later, but go on.

Mr Matthews: I only look at our own observations from what we see. The obstetrician may be in charge of the procedure, but in many cases the actual birth itself is more a midwifery exercise than an obstetrical exercise. When we see the insurance side of it where something has gone wrong, that's where there has been an obstetrician involved. As you said, the shift in community attitudes is such that, if something goes wrong, somebody must pay. There is no thought that there wasn't really anybody at fault. If there's an adverse outcome, then somebody should pay. Many of the case files that I read would bring tears to your eyes. In some of them you can see actual fault and in others unfortunate circumstances that have led to something dreadful, but what do you do about it? But every one of those will be litigated, irrespective.

MRS BURKE: That's interesting. I am totally confused now.

THE CHAIR: Can we continue? Go on, but I don't want to lose the question I asked. I understand that background and I am happy for you to explore it further, but I am interested to know whether there is any reason that you can see, as an expert in this field, why we cannot see the same support being given to independent midwives as has been offered to obstetricians to assist them with their insurance problems, their medical indemnity problems.

MS MacDONALD: Does it come back to—

THE CHAIR: No, let him answer it.

Mr Matthews: No, it comes back to that one question I answered before in that we cannot gain reinsurance behind it. The obstetricians operate in the public system. We have reinsurance behind our arrangements.

THE CHAIR: Because it's in a public system.

Mr Matthews: Anything in the public system falls within the broad cover that we provide. So, if they are specialist medical officers, employees, it is automatically covered. If they are visiting medical officers and it's within the public facility—so it's public work, not private work—it falls to us; we cover it. I think we come right back in the circle to this perception.

THE CHAIR: So you've got the reinsurance covered if you're in the public system.

Mr Matthews: Yes.

THE CHAIR: Why can't we have independent midwives that are actually in the public system that have the same but have the capacity to practise as midwives in the community, providing midwife support for women who are birthing?

Mr Matthews: We can do all of that until we mention home births, and then it's out.

MS MacDONALD: So it's the setting and it goes back to the perception of—

Mr Matthews: Yes, every time it comes back to just that perception about home births and what could go wrong and how.

THE CHAIR: Okay.

MRS BURKE: But you've just said that, whenever obstetricians become involved, there's greater risk and there are always problems, because they are perceived to be at the end of the line.

Mr Matthews: Yes.

MRS BURKE: How mad is that? What are the insurers looking at? Natural birth, maybe hand birth, could be risky. Obstetricians are very risky, but you will insure them. It doesn't compute in my head.

Mr Matthews: The logic defeats me, too.

MS MacDONALD: It is, once again, just the perception that, if obstetricians are involved, they're doing it in a hospital setting where all the bells and whistles are.

Mr Matthews: In a hospital, yes, and they're professionals.

MRS BURKE: But there is more litigation. You have said that the evidence has shown that there is more litigation when obstetrics becomes a part of the process than in any other way. If a woman is in control, she can say, "I've got a team of people around me and I've made this choice and, if something goes wrong, I'm not going to blame the world", whereas if she is in a hospital with bells and whistles she will expect the bells and whistles to work and is going to blame that hospital if something goes wrong.

Mr Matthews: There is evidence to suggest that, in the first scenario you outlined,

people are less likely to take legal action, because it is a team and they've gone through that procedure with the same team. But there's always the chance, when they're confronted with a child that is badly damaged and they're looking at millions of dollars of future care, that they will change their mind on whether to take action.

MRS BURKE: Okay. Opposed to that, what are the statistics? Have we got any proof that says that those have been babies delivered in that setting and those circumstances as opposed to obstetric intervention? Do we know?

THE CHAIR: No, the evidence goes the other way. I know it doesn't seem logical. Can I put something else to you, then? If home birth is the big issue, what do you think would be the situation if we had a model similar to the New Zealand one? At least you have a situation where you have independent practising midwives who have admittance rights to hospitals to support women through birth and do the postnatal care as well. So they are independent practising midwives who are the primary care giver for women who don't do home births, but they have admitting rights to hospitals and they do the whole thing. Would that be a problem?

Mr Matthews: Not to me. I'm not sure—this is probably a question that the department of health should answer rather than me—whether that would fit into their model.

MS MacDONALD: No, that is not the issue.

THE CHAIR: No, I am not asking you to respond to that. Say we've achieved that and the department of health says that that is in the best interests of health services in the ACT. Is there an insurance problem there, do you think?

Mr Matthews: There shouldn't be, because—

THE CHAIR: No, because you think it is only the home birth or you are telling us that it is only the home birth that is the problem.

Mr Matthews: It is. I know it is only the home births. It is nothing else. Whether that's reality or not is a different question, but it is just that narrow—

THE CHAIR: I understand. We don't need to go there again.

MS MacDONALD: Can I go back a couple of steps to where we were talking about the model of having primary birth units or birthing centres outside a hospital campus. You spoke before about the processes and the equipment. How much equipment would they consider necessary?

Mr Matthews: I don't know the answer to that question. This is something we'd have to put up to insurers and see what they'd be looking for. I'm not sure. I think that part of the answer is what you've already said. If the situation was relatively close to a major institution, obviously the equipment within that facility can be less. I do think probably an even bigger point is procedures, as you mentioned before. If something goes wrong, there is something formal in place so that escalation to a greater standard of care takes place. Just speaking to the reinsurers, I think that is one of their great worries, that people who elect to have home births are fairly definite in their views and would be reluctant to

seek intervention even if it was necessary. That is a view I'm sure they hold quite firmly.

THE CHAIR: Obviously, there are lots, I would suggest, of problematic misconceptions on a number of levels. I just want to make sure that we've got the main points clear. As I understand it, you are not sure, but you think there may not be a problem just with that general cover for independent practising midwives as long as they weren't doing home births, but you think there could be a possibility for that issue to be dealt with if there was an injection of funds into the Insurance Authority, that even the home birth or primary units idea could be covered.

Mr Matthews: Yes. The only thing to remember when we talk about independent midwives is that the authority cannot insure an independent midwife. There would have to be some relationship through the department of health, similar to the organisation for the VMOs.

THE CHAIR: So it's a question of the description of the practice. When you think about it, obstetricians have autonomy within the public system.

MS MacDONALD: But they have contracts.

THE CHAIR: Yes. You could have contracts for the midwives so that they have the autonomy of practice, not that they are not working with hospitals, as they are with New Zealand, and no-one is saying that you don't have a role for the clinical response to a birth that requires it. No-one is suggesting that. But it's a way of trying to enable midwives to practice in a way that is not dominated or influenced by the clinical where not appropriate. There are issues there that have come through the evidence to this committee: if you've got a birthing unit in a tertiary setting particularly, you're going to have those influences and that is a problem. That is why some people are uncomfortable with the birthing unit being in a tertiary hospital. But why couldn't you have a relationship like the obstetricians have with public health?

Mr Matthews: If it was that sort of relationship, yes. Because we're a captive insurer, we cannot insure anybody other than government and government employees, nobody at all, so the relationship has to be indirect. With the visiting medical officers, which include the obstetricians, the health department offers them an indemnity and then we insure the department for its exposure to that indemnity. Our relationship is with the department. Then they have to have a contractual arrangement with the VMOs. The same sort of relationship could be set up. Once again, how it was structured would be for health. But for our purposes, we would have to do it in that two-step process.

THE CHAIR: That's interesting. There being no further questions, thank you, Peter.

Sitting suspended from 9.45 to 10.01 am.

MARY KIRK was called.

CHAIR: I recommence this public hearing of the health committee on maternity services by welcoming Mary Kirk from the Nurses Board. I need to make you aware of formal requirements and your obligations as a witness before an Assembly committee.

You should understand that these hearings are legal proceedings of the Legislative Assembly, protected by parliamentary privilege. That gives you certain protections, but also certain responsibilities. It means that you are protected from certain legal action, such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Please state your name and the capacity in which you appear.

Ms Kirk: My name is Mary Kirk. I am here as chair of the Nurses Board of the ACT.

THE CHAIR: Would you like to make an opening statement?

Ms Kirk: Yes. I am a nurse and I am a midwife. I hold postgraduate qualifications in women's studies and experience in women's health in both developed and developing contexts. I am also the director of nursing of the Queen Elizabeth II family centre in Canberra. With that background, I will speak. I will mostly speak about response, especially in relation to the work of the board, but I have been invited to bring my other hats with me at the same time. I haven't prepared a formal statement, per se.

THE CHAIR: Do you just want to give us what you see as the main issues or would you prefer that we go straight into questions?

Ms Kirk: Go straight into questions and, if there are any gaps, I will fill from there.

THE CHAIR: Okay. I have some questions about the Nurses Board and the Nurses Act, before we go into some of the broader issues. In your view, are the current legislative provisions in the Nurses Act adequate for midwives?

Ms Kirk: The current provisions are. However, by definition, it is called the Nurses Act; therefore, potentially it creates attitudes to the practice of midwifery which could restrict midwifes from practising within the full definition as per the world health definition. However, the new bill,—the proposed Health Professionals Bill—certainly broadens that out. It is proposed in that bill that we have a nurses and midwives board. I suppose it would then stop the silencing of midwifery. Does that make sense?

THE CHAIR: Yes.

Ms Kirk: The board itself has worked towards that change. The board in this last year in its strategic approach has developed a vision and mission for the board and in that is integrity in nursing and midwifery; so we've begun the work of not silencing midwifery. We've come to he conclusion that those countries in both developed and developing

contexts that value and recognise midwifery as a profession in its own right have best health outcomes for women. So the charter of the board is to protect the public, the safety of the public. The best health outcome, we believe, is very much in our charter. That is the direction that the board has taken in anticipation of the new bill.

THE CHAIR: I am sorry if you just said so, but I was reading my notes at the same time. Did you say that there will be an acceptance of midwives who are trained just with a midwifery course, or do you have to be a nurse to be a midwife?

Ms Kirk: We have to register people under the current act as nurses and what we have to do if somebody has midwifery only qualifications is to put conditions on their registration that they can only practice in midwifery. Inherent in that, I believe, is a truth that midwifery is nursing. Midwifery is not nursing. I'll make my statement now that midwifery is not nursing; one the other doesn't make. There are areas of overlap.

THE CHAIR: Does the Health Professionals Bill deal with that problem?

Ms Kirk: It does. The Health Professionals Bill does, because it talks about a nursing and midwifery council and in that we develop the schedules accordingly, recognising—

THE CHAIR: The requirement to be a nurse. They're separate and you've got a board for midwifes under the Health Professionals Bill.

Ms Kirk: It will be one single board. However, it recognises nursing and it recognises midwifery. It is not a separate board.

THE CHAIR: Would it be better to have a separate board?

Ms Kirk: There is certainly a case for a separate board. I think the size of the jurisdiction probably would mean it would be costly, potentially. It means we would be duplicating the same thing over again. I think if we can get the respectfulness and the acknowledgment that one the other isn't, however we certainly complement each other, then potentially we can meet the needs of both groups. In a large jurisdiction, I would think ideally you would have a midwives council and a nursing council or board.

THE CHAIR: With the Health Professionals Bill you can't register unless you are insured.

Ms Kirk: Yes.

THE CHAIR: It is obviously a problem at the moment when you have independent midwives not able to be insured. Would it be better not to have that in legislation, but to leave that registration to the board?

Ms Kirk: My understanding of the last round of the bill was that that had been changed slightly. It might be worth checking.

THE CHAIR: We can follow it up. I don't know how it has been changed; I wasn't aware of that.

Ms Kirk: Just check it, because that was my understanding.

THE CHAIR: But if that is not the case, would it be a concern if it were there and was enshrined in legislation?

Ms Kirk: If it were there, it would be absolutely discriminatory, because the only group at the moment who cannot get insurance is midwives. It is not based on evidence. It's based on supposedly birth is high risk. Birth in whose hands, where and under what circumstances? It's not midwifery. So it would be frank discrimination, really.

THE CHAIR: Yes. All right, we will take a look and see what we have with the latest version of that bill. The government's submission—you have dealt with this briefly, but I wouldn't mind you saying a little bit more—claims that direct entry midwifery courses are only a short-term solution that will reduce the current flexibility of the nursing work force. Do you want to respond to that?

Ms Kirk: I would say that was an ill-informed statement. I'm shocked that the government would make that statement with the evidence that's there.

THE CHAIR: Good. I am interested to know what professional standards and codes of practice the board sets for midwives.

Ms Kirk: The board uses the code of conduct and standards of practice of the College of Midwives. The Nurses Board for the last four years has had nurses, midwives and enrolled nurses sign against those competencies that they are competent to practice. We will move into an approach where they have to hold portfolios and demonstrate evidence of competence. But we use the College of Midwives standards at this moment in time for midwifery.

THE CHAIR: I want to have a look at something. Do you have any questions?

MRS BURKE: Not directly, no.

MS MacDONALD: I am just formulating some. Last week we visited New Zealand and had a look at the model in use there. The New Zealand legislation required a change which was brought about in 1990. They needed to change it because the legislation actually stated until then that a doctor had to be present at a birth. It was then changed to a doctor or a midwife. We don't have such restrictions on us. I was just thinking through things that I would like to ask about. It was very interesting to look at the model in New Zealand, but I don't believe that we can directly transfer to Australia the model that they have over there—I think the rest of the committee would probably agree with that—because they have a quite different situation in terms of insurance. It operates on a no-fault basis, which they have had for a number of years and which provides other problems for them, but it also means that they don't have the insurance issues.

What has been emerging in my mind, I suppose, is that we take out the issue of home births. I know that there are women out there who really want to have a home birth, but I wonder whether some of those women, if there were the option of a birthing centre which wasn't located within a hospital setting, would be prepared to go into that situation. I suspect that there would still be a small number who would be unhappy about

going into that setting, but it would probably satisfy a number of people who want to take out the medicalisation of giving birth because they don't believe, if the birth is going normally, if it's a normal birth, there is a need to have the medical profession involved to a large extent.

That was a long ramble about what is going on in my mind but, in terms of adopting what they have in New Zealand, I suppose I have been coming to the idea of having some birthing units possibly located within reasonable distance of, say, Calvary and Canberra hospitals so that if anything were to go wrong the transfer from the birthing unit to the hospital would be easy enough to do. We could set up the processes to deal with that and also have, I suppose, a minimal amount of equipment necessary in a primary birthing unit. If we were to go about doing that, would there be enough midwives out there to cater for it?

Ms Kirk: I suppose I would go back and say I wouldn't anticipate what the women would say because women are more than eloquent to say for themselves what they would do and what they would like.

MS MacDONALD: That's true.

Ms Kirk: What I would say is go to the evidence, just go to the evidence. The evidence shows the better the separation from the acute facility you have of the provision of birthing services the better the health outcome because the cascade of intervention goes down, so I would say that. On your proposal about separating it from the acute service, if you go back to the 1980s you will see a beautiful submission amongst probably boxes of stuff—it may well have been trashed by now—wanting the birth centre, just that, that was at Canberra Hospital, that there was a will to have it not part of the campus because of the cascade of intervention. The closer you have it, the easier it is—or not even the easier it is; you slip into the paradigm.

MRS BURKE: It becomes the norm.

Ms Kirk: That's right. With all good will, you are in that paradigm; so, if you can't provide what is best, then provide what is next best, I suppose, and the evidence is there to show that if you take it away from the centre the better the outcome.

THE CHAIR: Going back to what we were talking about before, we just checked the act and it is left to regulation. I guess we would need to clarify with the minister whether the regulation for midwives is the same. If the regulations are the same, there would be a requirement for insurance because it would be the same as for nurses. We just need to check on that, but you seem to think that it has been dealt with, which is good.

Ms Kirk: Yes, but do check.

THE CHAIR: We will check.

Ms Kirk: The sands shift.

THE CHAIR: In terms of the reality of the situation in Canberra with the number of births being a factor to be taken into account, we are having conversations about

increasing access for women to have a midwife as a lead carer. The government said in its submission to us that it is committed to providing choice to ACT women and will expand midwifery services, particularly on the north side of Canberra, to respond to demand for their services. However, given the number of births is not expected to increase, this expansion will need to be planned in such a way that it does not undermine the viability of the essential tertiary service at TCH and it may be necessary, therefore, to look at remodelling other services so that the expansion of the midwifery services does not limit the viability of this service.

That is an interesting statement in terms of what it means for the women of the ACT, because there are lots of submissions saying how good it is for the ACT to have the tertiary service at the clinical school here. As well, a number of submissions from doctors have said that this is important, but the argument has been raised that we do not need to have the two services and that the issue of viability could be dealt with by looking at that question.

I guess my question for you is: if we are seeing the choice of women impacted upon by the need to have a tertiary service, what does that mean for the health outcomes for women in the ACT? Do you have a view about how we could organise the hospitals better—for example, only having one, which is what some submissions are saying—or is there the potential for having both Calvary and Canberra public births but with a streamlined administrative arrangement? An argument against that was put in one submission. It was said that you would not have the capacity for the technology at both as it is too expensive, but you would have to have the technology at both and it would be expensive.

One more thing: is it possible to deal with this by having doctors in their training actually being taught by midwives in normal births, which possibly would be a useful experience for a young doctor? That suggestion has been put to this committee as well. Do you wish to make any comments on those things?

Ms Kirk: I'll go to the comment of the department. I am appalled that the needs of the service are paramount over the needs of the women. We're on the slippery slope back of the people for the service, not the service for the people. It is beyond 2000. My heart rate is at 120; I just can't believe that today we're saying this.

There are some excellent models of care where resources can be used more efficiently and effectively to meet the needs of, if you want to put people into risk categories, high-risk women in Victoria, in the western region out at Sunshine. In South Australia, the Royal Women's in Adelaide has just introduced a continuity of care model. Surely to God, if they can do it in these places, we can do it here.

While ever funding is equated to how many births you have managed to have in your place, the needs of the women and their families is not going to be paramount. We have to go back before this, and under what models do we fund things? Under what model are maternity services provided? Are maternity services an acute care need or a primary health need?

If we get it into our head that they are a primary health need, this is a normal life event until that 15 per cent might trip into the needs of acute services. If we have our heads

around that, then we'll have our heads around the provision of services that meet the needs of the women as opposed to the provision of services that meet the needs of the service.

People can still have valuable experience. We can still get our resources where they need to be. I don't buy the argument; I just don't buy it. It's an expensive argument that they're making, based on what? Where's their evidence? I'm appalled that we're talking about what is best for the services rather than what is best for the community.

THE CHAIR: But the argument is that the community benefits from having a tertiary institution.

Ms Kirk: The community benefits from having the availability of medical services when they need them; that's what the community benefits from. The facility isn't the benefit to the community; it's the service that the facility provides. Where is it best to provide that? Is it best to provide it in both places? Is it best to provide that level of service in one place? That's something that we will have to get down to. I don't pretend to have the ability to say, off the top of my head, that it should be one, two or 10, but what do we really need to be providing and where to produce what outcome?

I think that, as a community, we need to declare what outcome we want for our families and what outcome we want for our women and go from the outcome we want back to what services we need to provide and where to achieve that. Other acute services are providing models of care more efficiently. The South Australian model that has just started off, they're anticipating spending $1,000 less per birth because of the continuity of midwifery care model. That is $1,000 that we can put back into the toys, if we want. There could be a redistribution of dollars back into that 15 per cent. It is medicine at its best.

MRS BURKE: Working smarter, not harder.

Ms Kirk: Yes. If we do that really smartly, we know—the evidence is there—that about 15 per cent of births need medical intervention and it is medicine at its best when it's that 15 per cent. When it starts spilling over to the 50 or 60 per cent, it's a paradox, it goes to the opposite.

MRS BURKE: We have heard that, and that is the lunacy of all of this, isn't it?

Ms Kirk: Yes.

MRS BURKE: They are getting insurance, but midwives doing it naturally or hand birthing cannot, yet that is the safest way to do it.

Ms Kirk: It just doesn't make sense. But I would say that we've got to go back, we've got to stop talking about what the services need.

THE CHAIR: Let Mary answer my question.

Ms Kirk: Sorry.

THE CHAIR: That's good, that's interesting, but on the question in terms of the clinical school using the midwife-led care as part of their training?

Ms Kirk: Midwives historically have taught doctors about birthing—historically, from always—and that won't change. There is no reason why that should change. I really see it as a midwife a doctor doesn't make and a doctor a midwife doesn't make, but it's like concentric circles that overlap. There is a bit in the middle, shades of grey, where if we collaborate, cooperate and learn from each other on that the other becomes even better. It's really important that we maintain that and that we enhance that. I can see absolutely no reason why not. Whether it's recognised and valued is another thing. It has always gone on, but whether it is recognised and valued for what it is—midwifery teaching medicine—is another thing.

MS MacDONALD: In regard to that, for a year or so in New Zealand the medical students were being trained with the midwifery students, so that the medical students ended up having a caseload as well and learned about the birthing process in that way. I understand that that went by the by when the Australian obstetricians got involved with it. While the New Zealand College of Obstetricians did not have an issue with it taking place and the medical students were actually enjoying the process going through, once the Australians got involved there was the issue of the Australian medical students having to attend a certain number of births before they could actually become an obstetrician. I would probably be better off asking the department and the minister this question, but do you have an understanding as to whether an obstetrician or a student has to attend a certain number of births before—

Ms Kirk: I don't know what the situation is for medicine.

THE CHAIR: We can ask the department about that.

Ms Kirk: I would say to you, though, that numbers don't make competence. They would have to be careful about the numbers game because it doesn't necessarily make competence. An individual could see 200 and not be competent and somebody else 20.

MRS BURKE: I would like to take you back to the direct entry training. I would like you to expand on your thoughts about that.

Ms Kirk: The bachelor of midwifery. Underneath, there is a premise: is midwifery nursing or is nursing midwifery? I am a nurse and I am a midwife. I make the case that one the other doesn't make. My nursing background enhances my midwifery practice and my midwifery background enhances my nursing practice, but one the other doesn't make. There are lots of things that we share. It's again those concentric circles. There are things that we do share, but one the other doesn't make.

We do know that countries that have midwives respected and valued as part of a profession in its own right have best health outcomes for women. So it's time Australia came on down. We did have it. We lost it, it became subsumed into nursing, and now it's coming back again. I don't think it is a short-term solution; it is the solution. It is the solution for best health care for women.

The other argument I would make is that if we go back to the World Health definition of

midwifery and in this country have midwives in there practising within that full definition we will, in fact, free nurses up to fill the gaps in the acute sector.

MRS BURKE: That is a good point; it's primary, not acute.

Ms Kirk: That's right. This is not a gap-filling exercise; this is what should be. The College of Midwives went and developed bachelor of midwifery education standards which are being applied in the university schools across Australia. Achievement of an education program to those standards results in a national standard of practice which the work done by Brodie-Tracy-Barclay showed was so variable in this country to be scary. It creates a national consistency and best practice. Also, midwives coming through that program will be able to have their qualifications acknowledged internationally, while at the moment that is not the case. So, for health bureaucrats not to see that for what it is, is shocking, I think.

MRS BURKE: Thank you for that. We are all about trying to get recognition and lifting them to a higher level so that things like insurance become more acceptable and the perception becomes that they are a professional body within their own right.

Ms Kirk: Yes, that's right. There is one school that is running a double degree of nursing and midwifery—at La Trobe. There are big concerns about that because the midwifery degree is dependent on the individual finishing the nursing degree, while the individual can finish the nursing degree and not finish the midwifery degree. The professional concerns of midwives across the country is that that is not appropriate.

MRS BURKE: It is just like a bolt on; it is not really a double degree, is it?

Ms Kirk: It's not a double degree, no. But that's what it's being called. They're coming out with a bachelor of nursing and bachelor of midwifery, but the midwifery is dependent on the nursing. It's not appropriate, no, not with the evidence that we've got in our hands today.

MRS BURKE: We have to lift the image and esteem of the profession. After all, if it is going to be standalone, it has to stand alone, not be bolted on to something else.

Ms Kirk: Yes, not bolted on.

MS MacDONALD: Mary, for how long does the so-called double degree run?

Ms Kirk: Five years, I think.

MS MacDONALD: How long is the midwifery component of that?

Ms Kirk: I am not familiar with the fine detail of the program itself. But from the profession's point of view, the fact that the midwifery is dependent on the nursing is unacceptable.

THE CHAIR: Do you have any comments on the insurance issue?

Ms Kirk: What can I say? I think the biggest single thing that is of great concern is the

fact that midwifery is the profession that has been excluded and it is the profession where there is not the evidence that it should be excluded. It just doesn't make sense. I know that the College of Midwives had in their accreditation of independently practising midwives that they had to be insured. The college had to drop that because, at the end of the day, there was no way that they could get insurance. The work has been incredible with trying to achieve insurance for midwives and it is simply not possible in this country.

THE CHAIR: Do you see the possibility of alternative arrangements being made? For example, you could have midwives contracted as visiting medical officers. Could you see a system working where you had the midwives as public employees but still practising in the non-clinical model in a community base?

Ms Kirk: Absolutely.

THE CHAIR: Do you think that there are ways that we could deal with this?

Ms Kirk: I think so. If nothing else, afford midwives the same courtesy as has been afforded medicine in relation to insurance and support in that from government.

THE CHAIR: The Insurance Authority has said that the hurdle is the home birth, that if independent midwives were put on contracts they would have some issues, although he had some suggestions about how that could be dealt with in terms of money going in from government to better support the Insurance Authority. I am interested in pursuing the potential for them to be public employees but keep the integrity of midwife-led care and not be in some way compromised by being situated in the hospital as hospital employees.

Ms Kirk: There are some good models. It's worth, if you had time, talking to St George Hospital about the model that they've introduced.

THE CHAIR: Where is that?

Ms Kirk: In Sydney, most particularly Pat Brodie there. Sally Tracy at Ryde. Sally has introduced a model similar to that. Most importantly, because it has been going for some time, Vanessa Owen from Sunshine in Victoria. Sunshine is particularly interesting, because they have introduced community models in what is deemed a high-risk area and it couldn't possibly work, blah, blah.

THE CHAIR: We have evidence on that.

Ms Kirk: But particularly have a good look at what Sunshine has done. Of course, the latest is what has gone on in Adelaide at the Royal Women's. Again, they're managed from these institutions but the midwives are out where the community is and practising in collaboration. There are some really good models of working in collaboration with community services. You can walk in and the midwives are in that room and the maternal and child health nurse are in that room. They are out there in the community.

I suppose the short answer to your question before is that those models can be implemented; I can't see why not. If we take the focus off the needs of the health

providers in those services and focus on the needs of the women, it will just fall into place. The crazy part is that the services are enhanced by it.

THE CHAIR: The New Zealand model of having independently practising midwives who have the practices that they set up was quite interesting to the committee in terms of work force issues and the fact that the women can make a team that they are compatible with and then share the work in ways that suits their individual lifestyles. Also, there is the fact that they have admitting rights to hospitals and the cultural tension has broken down considerably in the 10 years. It has certainly had challenges, as you would expect. Do you see that sort of model as useful as well?

Ms Kirk: Very. I can't see why we can't do it, particularly in a community like Canberra. We're so well set up for it. We've tried for many years to get visiting rights in the public hospitals and a chicken and egg situation has gone on. Probably it has dropped off since our independently practising midwifes haven't been able to practice, but certainly the big obstruction was the visiting rights.

MS MacDONALD: What has been the reasoning for not having visiting rights or an access agreement, as they're called in New Zealand?

Ms Kirk: It goes back to the clinical practices committee of the public hospitals. You would have to ask them.

MS MacDONALD: I will.

Ms Kirk: And look at the profile of who sits on them and who makes the decisions.

THE CHAIR: Okay. We have to wrap up, but I just want to ask you one more quick question. I don't know if you're familiar with it, but the government is setting up a consultative committee. Are you aware of that?

Ms Kirk: I am aware.

THE CHAIR: It will be reporting to the administration. It will not be a ministerial advisory council. Its membership will be about five consumers and about 10 public servants. In terms of consumer participation and the role of particularly the community, do you have a comment on that?

Ms Kirk: I will talk with my hat on from the QEII family centre. It's a unique service in this town, run by an organisation that kicked off all maternal and child health services in Canberra in its day, and it doesn't have a guernsey on the maternity services review. It just intrigues me about who is included and who isn't.

THE CHAIR: Okay.

Ms Kirk: Could I just make one comment and take us back to the education and preparation of midwives. You asked a couple of times about the availability of midwives. As chair of the board, just in our last round we did provide some grants and scholarships to nurses and midwives in the ACT. We had advice from the department, and midwives coming back to us, that they weren't going to grant scholarships to midwives to do the

graduate diploma of midwifery because there were plenty of midwives, there were enough.

I'm really concerned that there is a perception that there are plenty of midwives in this town. Calvary Hospital advertised not that long ago. All we have to do is scan around and look at the age of the midwives that are practising now, and I think something like a third are going to leave in the next three years. We know that once somebody graduates to be an expert they have to be practising for at least five years. So we're heading for a cliff face. The board has picked up that gap and been providing midwives with scholarships, because it seems that there is this attitude that there are enough midwives. I'm really concerned.

THE CHAIR: Okay. Thank you for raising that.

MRS BURKE: When are the grants going to stop?

Ms Kirk: The government grant scheme is fabulous. There is no doubt that the scholarship scheme is fabulous. But if midwives don't have access to it, a big swath of our maternity services in the future is going to be in trouble if we don't have that appropriately prepared and qualified work force to meet that need.

THE CHAIR: The minister is here and has heard that, so we can raise it with him. Thank you very much.

SIMON CORBELL,

TONY SHERBON,

SUSAN KILLION and

PETER MATTHEWS

were called.

THE CHAIR: Thank you for giving us your time today. I imagine that, as public officers, you are aware of the legal responsibilities of witnesses. I am happy to read them to you if you would like. Would you like me to read to you the legal requirements, or are you familiar with them?

Mr Corbell: I think the officers are familiar with those.

THE CHAIR: Please state your name and the capacity in which you appear.

Mr Corbell: Simon Corbell, Minister for Health.

Dr Sherbon: Tony Sherbon, chief executive, ACT Health.

Ms Killion: Susan Killion, executive director of policy and planning, ACT Health.

Mr Matthews: Peter Matthews, general manager, ACT Insurance Authority.

THE CHAIR: Thank you. Minister, would you like to make an opening statement?

Mr Corbell: Thank you, Chair. I thank you and the other members of the committee for the opportunity to appear before your inquiry today. I do not want to make a detailed statement. I think the government has provided quite a detailed public submission and I am very happy to take questions from the committee on any issue arising out of that.

I would like simply to outline that the government has already indicated that it is taking a range of measures to improve access to a range of maternity services in the ACT. Before saying that, it is worth making the point that we have, I think, an outstanding level of service already, but there is always room for further improvement. But the quality of maternity services in the ACT is, I think, very, very strong.

The government has outlined a range of measures to further investigate improvements to maternity health services in the ACT. For example, we have already announced a detailed planning study to enable the expansion of access to midwifery services in the ACT. We have established the maternity services planning advisory group, which the committee was raising with the previous witness and which includes clinicians and consumer representatives, to provide advice on maternity services in the ACT.

There is also work under way to develop a coordinated package of information for women about pregnancy, birth and postnatal care. This process, again, involves obstetricians, midwives, GPs, consumer representatives, staff at our public and private

hospitals and other stakeholders, to allow women to have a broad range of information available so that they can make an informed choice about the type of care they wish to seek and receive during their pregnancy and after their pregnancy.

Further, cabinet is considering a range of other issues currently to expand a range of existing programs, particularly in the Aboriginal health area, and also in relation to services to new-born children. So the government is taking quite a broad look at the range of maternity services available in the territory and the policy settings for those and, as Minister for Health, I have taken a particular interest in these issues and will be continuing that as the policy work we have commenced continues. With that, I'm happy to answer any questions, as are my officers.

THE CHAIR: Just picking up on something you just said: I am not sure whether you called it a strategy, but you said that you were developing some kind of plan concerning access to midwifery services. What did you actually say?

Mr Corbell: A planning study to look at expansion of access to midwifery services in the ACT.

THE CHAIR: Obviously, this committee's report will assist you with that because we have had an opportunity to work with the community on exactly those issues.

Mr Corbell: Yes.

THE CHAIR: Is it your intention that this committee's work will inform that study?

Mr Corbell: I think that's inevitable, Kerrie.

THE CHAIR: What is your timeframe for that study?

Mr Corbell: It certainly is work that would occur over the coming financial year and the remainder of this financial year. So it won't in any way seek to pre-empt the work of this committee investigation.

THE CHAIR: No. Are you talking about a year and a half or so? What are you talking about?

Mr Corbell: I will ask Ms Killion to give you a more definitive outline, but it is certainly not work which will preclude the work of this inquiry.

THE CHAIR: No, I wasn't worried about that. I was assuming that this committee's work would assist. But I am interested in your timeframe; that is all I am interested in.

Ms Killion: We are currently doing the work for a clinical services plan, which is a broad overview of all the services that the health portfolio does in the hospitals and community health, and the timeframe for that is the end of April. That is quite a broad-brush approach and there are some specific issues that will be coming out of that, maternity services being one, and there will be a longer timeframe required to look at in-depth needs and planning around that. So we would be looking at some time in the next few months after April, probably up to three months after April, to get something

together along maternity services, which is why we have reconstituted a maternity services planning committee.

THE CHAIR: I know that a committee was set up to meet with you over the last six months. What did you call it?

Ms Killion: We have had a series of maternity services working groups. We have had a working group and then we had a specific working group about home births which was looking at the home birth indemnity issue.

THE CHAIR: How many meetings were there of that group?

Ms Killion: I am not sure off the top of my head, Ms Tucker. The working group lasted for quite a number of months and the home birth group was a shortish group because we were looking at the issues and then there was some work to be done in terms of looking at insurance packages throughout the world, really.

THE CHAIR: So you were really focusing on insurance in that group.

Ms Killion: In the home birth group.

THE CHAIR: Could the committee see the conclusions of that work?

Ms Killion: Yes.

THE CHAIR: Thank you.

MRS BURKE: I have a quick question on the consultative committee. It seems that lots of committees have been set up to look at a range of things, which is good. As to the consultative committee, Mary Kirk mentioned that there would be about five consumers and 10 public servants. Did she say that she had some alarm about how those people were chosen? Perhaps you could tell us about that.

THE CHAIR: She said that QEII was not on it.

MRS BURKE: Yes. I am not familiar with the committee. Who is on it and why were they chosen?

Mr Corbell: The committee has been established by ACT Health. It is not a committee established by me, per se, to advise me. It's a mechanism to advise the department on its policy.

MRS BURKE: But you would be looking at the outcomes of that committee.

Mr Corbell: Absolutely. It is perhaps wrong to characterise it just as public servants. A number of those people would be clinicians.

MRS BURKE: I said five consumers and 10 public servants, we were told.

Mr Corbell: A number of those public servants would be clinicians and people with

clinical expertise in the area, but again I'll ask Susan if she can outline the details on that for you.

Ms Killion: Essentially, the way we set up any committee is to look at who the major stakeholders are and usually in the first and second committee meetings we look at the terms of reference. Part of the terms of the reference is who is at the table and who isn't at the table who needs to be. We are quite open in the process in terms of deciding if there are other people who need to be there. We're always happy to invite them in. We started out with former committees and the relevant stakeholders that were in those previous committees—consumers, GPs, et cetera—and we would use that as a starting base.

THE CHAIR: So this work is sitting within the clinical services plan.

Ms Killion: Yes.

THE CHAIR: I am sure you are aware of the submissions that have come to this committee and the tension that exists across the world between clinical and natural birth. How would you respond to claims that, if you are situating this committee within a clinical services plan, there might be concerns that, in fact, it is not properly recognising the non-clinical aspect of maternity services, because you say in the government submission that the viability of your clinical tertiary institution cannot be threatened by increasing particular services to women in Canberra? Obviously, there would be a concern there that there could even be a conflict of interest if you were situating the development of maternity services in a clinical plan.

Mr Corbell: I don't think the government was suggesting in its submission that other services shouldn't be established because they threatened the viability of existing clinical maternal health services. I think the point was being made that the ACT has a declining birth rate and that has implications for the viability of the range of services that we provide, particularly at the tertiary/high-acuity end, neonatal intensive care areas in particular.

But I think the government is supportive—in fact, I know the government is supportive—of providing as broad a range as possible of maternal health services and allowing women to have that choice. I think the government simply wanted to make the point in its submission that, with the declining birth rate, the government does need to ensure that we are able to sustain the services that we need to sustain, particularly for children, mothers and infants who need that high-acuity service.

In terms of the tension, I understand the issue you raise that there are philosophical differences in terms of the delivery of care and that it could be perceived that the establishment of reviews or examinations of maternal health services in the context of a clinical review process could inevitably lead to a clinical focus. I don't think that's necessarily the case. I think it is incumbent on the government and health service delivery to make sure that we take account of all health service delivery within the framework of the system that we have. We're a small jurisdiction and we can't have planning happening in isolation from other parts of the health system, but that doesn't necessarily mean that it inevitably ends up with a clinical focus. But Dr Sherbon might like to elaborate on that.

Dr Sherbon: The clinical services plan will encompass the vast range of clinical services provided to clients/patients/consumers in the ACT, so it will be a very broad plan. Maternity issues and issues relating to the delivery of services to mothers and babies will be a key part of that, but the term "clinical services" is not meant to imply that for all services we will necessarily be adopting a clinical philosophical approach.

I guess the terms are distinct in context. The clinical services plan is a plan to help the minister and ACT Health work through a long-term strategy for improved services to the public in the ACT and it draws a distinction between our other key plans, which are human resource plans, IT plans, et cetera. It is not meant to imply that we will impose a clinical philosophy on midwifery. The work that Ms Killion referred to will draw from some key needs identified in the clinical services plan, but will not necessarily impose a particular philosophy on the recommendations to government, I can assure you of that.

THE CHAIR: Minister, I appreciate your response to the claims you have made in the submission, but I am still a bit concerned. If you are saying that it wasn't correctly expressed, I will feel reassured, but it says that you are committed to providing choice to ACT women and will expand midwifery services. However, given that the number of births is not expected to increase, this expansion of midwifery services, which is what you seem to be saying, will need to be planned in such a way that it does not undermine the viability of the essential tertiary service.

Let's just have plain language. The committee has been led to understand that if you have more women—we know that the birthing centre can't meet the demand now— and if we expand significantly midwife-led care for women, the tertiary function might be in trouble. Doctors and others have submitted to this committee that we have a basic problem in Canberra because we have too many hospitals.

I know that this is a big one, but that is what is coming up really clearly through this committee, so members of the committee are interested in hearing from you what you think the potential is for addressing that big issue, because you say you are committed to giving women midwives as lead carers, if that's what they want, but how are you going to deal with this problem for the tertiary institution? A few proposals have been made through submissions which I imagine you are familiar with, but if you are not—

Mr Corbell: No, I haven't seen the terms of the submissions.

THE CHAIR: Okay. I thought you would have been briefed on that. Basically, people are suggesting you can look at Calvary and not have the public facility there or you can leave the public facility there but have a mainstream administration. There have also been suggestions—this is something for the educators—that you actually look at providing the experience of birth for doctors by also enabling them to witness and work with midwives in natural births. So it's about being flexible here around how you actually make sure the tertiary function, which everybody values, is able to continue, but that isn't at the expense of women who want to have a midwife as their lead carer.

Mr Corbell: I want to make it clear that there is no conspiracy to try to stop midwifery services in the ACT, and sometimes that—

THE CHAIR: Expand, we're talking about in your submission.

Mr Corbell: Or to stop the expansion even. The government has funded an expansion of midwifery services through the midwifery program at TCH, so we have already given additional support to expand access to midwifery services. We did that, I think, in the last budget or the budget before the last, two budgets ago. There is no conspiracy here.

THE CHAIR: I know; it's perfectly open. You said it in your submission.

Mr Corbell: No, I think there is an element of a conspiracy theory there, that there is some evil agenda by doctors to prevent the expansion of midwifery services. Whilst I accept that there are different philosophical positions—

THE CHAIR: With respect, there is no need for the loaded language around evil. This is about real tensions around important services, clinical and community.

Mr Corbell: I understand that.

MRS BURKE: Page 30.5.4 of your submission might be a point to look at, too, Minister.

Mr Corbell: I'm just making the point that I know that this can be a highly emotive debate, but I think it doesn't need to be. All I am saying, if I can finish, is that there is that tension. We seek to accommodate that tension. There are different philosophical views about how women have their children and what sort of care they receive when they have children. From the government's perspective, we want to try to ensure that as broad a range as possible of options is available to women so that, whether it's a non-interventionist or a more interventionist approach, more holistic, more clinical, it's there for them.

THE CHAIR: Can I ask you one question there?

Mr Corbell: I'm just trying to answer the other points you put to me, if I could just try to do that.

THE CHAIR: Okay. I just want clarification.

Mr Corbell: You raised the issue about the fact that we have two public hospitals, both providing maternity services. Yes, we do, and it is problematic, and it is problematic for a range of reasons. Our major growth areas in the territory are currently on the north side and we are seeing a significant number of younger families living on the north side of Canberra—Gungahlin, west Belconnen.

Obviously, the most immediate hospital for those people is Calvary Public Hospital. But, because of the reorganisation following the closure of Royal Canberra, our tertiary treatment hospital is TCH, which is on the south side. So we do have this imbalance, if you like. I don't think there's an easy way of resolving that and I think the government is obligated to provide a range of maternity services on the north side as well as the south side. I don't think we can get away from that. I think it's only reasonable, given that that's the growth area, that we make provision for that at Calvary.

That said, I think the issue that we will continue to have to manage as a community is that we are seeing declining birth rates in the ACT and just the fact that there are declining birth rates can have the potential—it doesn't at the moment—to threaten the clinical viability of some services. We need to keep that in mind when we are planning the provision of services into the future. I think that's all that statement says—nothing more, nothing less than that.

MS MacDONALD: Mrs Burke has referred to page 30.5.4 and it's a question that keeps coming up in my head. On page 30 of your submission, you say that there needs to be a sufficient level to ensure that the service can provide a patient load to meet the training obligations as prescribed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and to maintain the high quality of care provided in professional service. Can you tell me what the training obligations are currently?

Mr Corbell: I'm sure that Dr Sherbon can answer that.

Dr Sherbon: I can comment in general terms and perhaps provide more detail on notice. The training program for obstetricians and gynaecologists is a formal accredited program under the Australian Medical Council. It involves, I understand, five years of extensive training in both obstetrics and gynaecology and registrars are expected to perform a number of procedures during that program. I cannot tell you exactly the numbers, whether there are minimum requirements in terms of numbers, but they are expected to receive an appropriate exposure to allow them to enter independent practice. It is a rigorous and well-established program that has been expanded in recent years to take on the more complex components of the care of high-risk mothers and babies. It is a well-established and extensive program. We can certainly get you more information on notice about the actual components of the program.

MS MacDONALD: I'd appreciate that. You were talking about the high risk and I accept that there is a need for obstetricians and gynaecologists in their training to get that experience at the high-risk end, but surely they can get the experience at the normal birth end by actually working with midwives and being present when a midwife delivers in a normal capacity.

Mr Corbell: Many of our clinicians do that already. I think it's worth making the point that many of our clinicians do that already.

THE CHAIR: Yes, but this is a question about your throughput problem, which is your language for women.

Mr Corbell: I'm sorry, Ms Tucker, I didn't—

THE CHAIR: You said, "In addition, throughput at TCH needs to be at a sufficient level to ensure that the service can provide a patient load."

Mr Corbell: Yes.

THE CHAIR: This is the Australian and New Zealand College of Obstetricians and Gynaecologists.

Mr Corbell: Throughput is a common term for—

MRS BURKE: Throughput is a buzzword for women.

Mr Corbell: No, throughput is a term used to apply to all people who use our public hospital services. We mean not just women.

MRS BURKE: I realise that, Minister. Let's not get too arrogant here.

Dr Sherbon: Perhaps with your permission, Chair, I can return to the question. The experience of a registrar is by its nature meant to be operative; it's not observational. The registrar is there to learn to do procedures. So a coupling of a registrar and a midwife would be a learning experience and, as the minister says, it occurs minute by minute. As we speak, the registrar is working intimately with midwives in a very productive clinical partnership. But the question is getting both midwives and registrars appropriate procedural experience and they have to do things to learn to do them well and they have to do quite a lot.

MS MacDONALD: But with a normal birth—

THE CHAIR: You don't have to do anything; the woman does it.

MS MacDONALD: With a normal birth, the woman can be guided through by the midwife and in lots of cases, as I understand it, the midwife doesn't even intervene, other than to monitor.

Dr Sherbon: Exactly. But that's happening.

MS MacDONALD: I have to say that I'm hearing different stories about what actually happens with normal births.

Mr Corbell: I think it comes down to information. We have a range of ways in which women can choose to have care in the lead-up to labour, in labour itself and post birth. Perhaps women who go into a hospital setting don't appreciate when they go into a hospital setting—say, it's just a normal public hospital and they go in to have a baby in the delivery suite there—that the style of care is not the style of care they wanted. Perhaps it's more interventionist than they really wanted. That's why I think we need to provide further advice and information to women about their choices, so that perhaps CMP is a better option for a woman who wants a less interventionist, less clinical style. I think it's as much about information provision, so that women are making an informed choice about what options they have.

But this is a very complex picture. During the birth of my two children when my partner was in labour, we went through the Canberra midwifery program on both occasions for both of our children and on both occasions, because of the nature of the delivery, we ended up where my partner had to give birth in the delivery suite in Canberra Hospital. But even when it was going into the clinical setting, if you like, my experience through CMP and my partner's experience was that the midwife continued to lead the birth, continued to work with my partner in achieving the birth of our children. Whilst there

were certainly clinicians present and observing, the level of intervention was very low. In fact, it wasn't a case of the clinician walking in the door and saying, I'm going to take over." The midwife continued and conducted, with my partner, the whole birth, and the clinician was there in case there were further complications, but it wasn't the interventionist thing that I thought it would be.

That's my experience. I appreciate that people have lots of different experiences. Obviously, only those who were directly involved can speak for their own experiences, but I just want to make the point that I think there is a great variety of activity and level of cooperation—less interventionist, more interventionist—than perhaps is characterised at times.

THE CHAIR: I would like to pick up on that. It is not just about philosophies; it is about evidence and it is about looking at the evidence and deciding where are the best health outcomes. The evidence that has come to this committee is quite clear in that it shows that cascades of intervention are not good for health outcomes for women or babies and that the setting and management of labour are absolutely critical to health outcomes and to the level of intervention. We know that the level of intervention is too high. We know from the evidence that the setting is absolutely critical in determining the level of intervention.

I think that, as the Minister for Health, that is something you would want to address with this committee. It is not just about a philosophy. Of course women can have a particular view. But as the Minister of Health, you look at the levels of intervention and the different settings and the relationship between them. I would like you to comment on that for us. Also, you said that you are supporting midwifery options in the ACT, but we know that the service in Canberra does not meet demand at all. We have had a number of public forums and we know that people basically have to write their name down the minute they know they are pregnant, and even then they might not get in.

So, in terms of your government's commitment to supporting opportunities for women to have midwife-led care, what is your assessment of that need and how do you intend to address it?

Mr Corbell: If I can come back, first of all, to the issues around intervention, yes, I accept that there is the potential for that cascading effect; I accept that. At the same time, I think it is worth pointing out to the committee table 3 in the government's submission, which outlines the levels of intervention that occur in public and private systems in the ACT and the types of intervention that occur and their percentage.

THE CHAIR: Yes, we are familiar with that one.

Mr Corbell: It's worth, I think, highlighting that around 70 per cent of the births in Canberra Hospital are normal births, so I think we are achieving good outcomes in our public health system.

MRS BURKE: Does the percentage of C sections trouble you there, Minister?

Mr Corbell: I think it's worth making the point that Canberra Hospital is the tertiary hospital. It will inevitably get the difficult cases, so that will show up in the numbers.

Perhaps of more concern to me is the number of caesarean sections in the private sector.

MRS BURKE: Yes, I am talking across-the-board. That is probably a separate issue that you will want to comment on.

Mr Corbell: I do have concern about the level of caesarean section in the private sector but, clearly, that's either a choice that women themselves are making or which they are convinced is appropriate by their specialists. I think it's just worth making that point. I'm sorry, I've forgotten the other points you raised, Ms Tucker. Perhaps you could refresh my memory.

THE CHAIR: You said that you had not seen the submissions, but take a look later at submission No 20 from the Home Birth Association, which has a table comparing transfer rates for the ACT birth centre, the Canberra midwifery program and Western Australia. There are some interesting figures there, too. What was my second point? The minister has forgotten and so have I. We talked about intervention.

Mr Corbell: Measuring demand.

THE CHAIR: The demand issues; that's right.

Mr Corbell: I'm not familiar with the processes we have for that. I ask Ms Killion to respond to that.

Ms Killion: Our understanding is that there are about 60 people a year that would like to get onto the CMP but cannot.

THE CHAIR: What is happening with that? How are you measuring that?

Mr Corbell: The government allocated an additional $100,000 in the budget before the last, designed to improve the number of cases that the CMP could take on, and that is something that the government will be considering further through the mechanisms I outlined to you when I gave my opening statement.

THE CHAIR: Given your particular rationale for saying that it is important to have services on the north side of Canberra, are you considering providing some kind of midwifery care facility on the north side?

Mr Corbell: Yes, I have indicated to the department that I want that to be considered as part of this process.

MRS BURKE: On page 30.5.4 the government's submission states that new initiatives in the area of maternity services need to be cost-effective and not result in the underutilisation of other services. Can you flesh that out a bit for us?

Mr Corbell: As with all health services, cost-effectiveness does have to be a consideration.

MRS BURKE: Yes, I appreciate that. I am just wondering what the other services are.

Mr Corbell: That is what that sentence is saying.

MRS BURKE: What are the other services? It just seems like you are going to take one at the expense of the other, because it says that it needs to be cost-effective and not result in an underutilisation of other services, particularly in the area of maternity services. That is what it relates to.

Mr Corbell: I think it is about ensuring that whatever service we deliver is cost-effective and can be justified in the context of the demands on the health system overall. That is the constant juggling act all governments have to undertake and it is what I have to undertake as Minister for Health.

MRS BURKE: But you don't know specifically what you mean when you say "other services".

Mr Corbell: "Other services" means other services in the health system—maternity health services and other services.

MRS BURKE: No, here it relates specifically to maternity services. Maybe it's just the way it is written.

Mr Corbell: It is just other maternity services and that's at both the high-acuity end and the low-acuity end.

MRS BURKE: You go on to talk about the remodelling of existing services, so I am just not sure about the first paragraph.

Mr Corbell: I don't know whether I can explain it any clearer.

MRS BURKE: Do you have an idea of what you are going to remodel of the existing services?

Mr Corbell: No, the government has no agenda. It is undertaking a review to assess the capacity and the demand for a range of maternity services. We will make decisions arising out of that in concert with work with consumers and health professionals. The sentence simply states the obvious, that is, that any decision about the expansion of services does need to be on a cost-effective basis. That is what the Assembly and the community expect.

MRS BURKE: I wouldn't argue with that. I just wondered what the other services were.

THE CHAIR: The costs are shown to be less for midwives at a care birth. There are cost arguments there for that.

Mr Corbell: Clearly, that's an issue which I would not be able to take account of and which your inquiry report, I hope, will contribute to.

THE CHAIR: Yes, it will. I am sure that you will find it very useful. At the end, the last witness raised the question of scholarships. Can you respond to that?

Mr Corbell: I will ask Ms Killion to respond to that.

Ms Killion: There is no policy to refuse scholarships to midwives. We know that the midwives cannot be guaranteed a job in the ACT after they complete their course, but we have had a total of 20 scholarships given to midwives over the past couple of years.

THE CHAIR: On that subject, your submission was a bit negative about having the midwifery degree. Your submission says that it is just a bit of a stopgap measure. That is not supported by some of our submitters, particularly the College of Midwives and the Nurses Board, and it isn't a philosophy; I really need to stress that. The evidence is in that midwife-led care is a safer option for women who are going through a normal birth. I can quote to you some of the submissions on that, if you like.

MRS BURKE: We are referring to page 30.

THE CHAIR: The evidence through all these submissions is making that quite clear. The interest we have as a committee is in why you are not actually supporting a position that acknowledges that the evidence is in for that. If you did that, you would not be saying that midwifery is a kind of nursing. It is a discrete skill. It is something that is recognised as having good health outcomes. We need more training in Australia. We certainly will have a shortage of midwives and it would be very useful to have the government able to support, for example, one of the tertiary institutions here offering such a degree in midwifery. I am interested in understanding why you do think that this notion of having these degrees is just a stopgap measure.

Mr Corbell: If you are referring to page 30, I am not quite sure that that is what's being said. Are you referring to page 30?

MRS BURKE: Possible future strategies, the second paragraph.

THE CHAIR: The short-term solution, page 30: "There has been discussion regarding a direct entry midwifery course to be provided by the University of Canberra. This may help to address this shortfall in the medium term, but may reduce current flexibility of our work force."

Mr Corbell: I don't think there is any suggestion that it is a short-term measure.

THE CHAIR: It may help to address this shortfall, but it's going to be problematic in the long run because you want flexibility; that is what I understand you to be saying there. I am interested in understanding why you do not think that, in fact, it's a really important thing to do for maternity services in Canberra to have women, or men, trained as midwives, because it's a particular and different skill from nursing.

Mr Corbell: I think the point is being made that it would be more beneficial in work force planning terms to train people that were able to deliver and have a range of skills that were needed in our health system; so that, whilst a person could be trained to become a midwife, it would also be valuable if they were trained to perform a range of other tasks as well because, with looming work force shortages in a whole range of areas, maximum flexibility in the work force is desirable. I am sure that Tony or Susan will correct me if I'm wrong, but I think that's essentially what is being said.

THE CHAIR: But if they're different skills, that's not appropriate. I don't know what might be another example, but would you say, "We need flexibility in the work force. Therefore, we won't have a discrete degree for specialising in gynaecology. We'll have a kind of gynaecology/obstetrics and back doctors altogether because that will give us flexibility?" Of course you would not do that, because they're really different and important sets of skills. The point that is being made to this committee is the same. So it is about a culture.

You seem to be saying that nurses and midwives are kind of the same; they are a bit different, but they are not. But what is coming through really clearly to this committee is that they are very different and, if you acknowledge that and the midwives are supported and qualified to do this specific work that a midwife does, the health outcomes improve for women, children and babies. If you don't agree with that, fine, you can say that to the committee, but that is the evidence that has come to us.

Dr Sherbon: Just by way of clarification: as the minister said, I don't think the government's submission is in any way advising against the direct entry midwifery course. I think we're just trying to point out that, particularly in the short term as potential nurse graduates make a choice to enter that course, rather than nursing, there is actually a direct knock-on effect, and that's something that has to be managed. But I don't think, per se, the government in this submission is pointing out any major concern about the concept. It's just the management of the transition and the consequences that follow in the short term that need to be considered by this committee.

THE CHAIR: The argument has been put, and I'll put it to you, that it has the opposite effect, because we have a nursing shortage; we know that. We have women who would like to be a midwife and not a nurse. So you have more women—or men; sorry, there are men as well, but women on the whole—who want to be a midwife but not a nurse. So you have the capacity to free up your nursing work force because you get more people who are interested in being qualified as midwives. So it's a good thing for the work force as well as in providing better health outcomes; that is the argument that has been put here. Is that not reasonable?

Dr Sherbon: I think that's recognised in the submission as likely to be a good thing but there may—the word "may" is used there—be a short-term consequence which needs to be managed. Certainly, the advice I have received from our chief nurse is that there are a large number of people who want to be midwives but not necessarily be nurses. This submission does not detract from that interest but points out that there may be short-term consequences. The short-term consequences may not be as great as they would have been, say, two years ago when we were having trouble filling undergraduate nursing places.

In the last two years, I understand, we've managed to fill undergraduate places locally through the standing of our nursing courses at the UC, and hopefully eventually at the ACU as well. There may have even been interested potential students who missed out. So it may not be as big a problem as it might have been two years ago when we were having trouble filling places. Nevertheless, in terms of advice to government and this committee, I think it was prudent to point out that there may be a short-term consequence.

MS MacDONALD: How far advanced is the consideration of the direct entry midwifery course?

Mr Corbell: It's a matter for the University of Canberra, isn't it?

Dr Sherbon: Yes, it is a matter for the University of Canberra, as the minister has put forward, but our chief nurse could provide you with that, or you can get it directly from the University of Canberra, whichever you choose. Our chief nurse is working closely with the University of Canberra on a wide range of nursing issues and we can provide information, if the committee is so minded.

MS MacDONALD: With regard to that, what is the proposed length of the course? Do you know that?

Mr Corbell: No, I'm sorry, I don't know that. But we could provide that information.

MS MacDONALD: If you can find out. I am interested in finding out how much consideration is being given to that, if they are seriously considering it, and how long they intend the course to run for. We heard last week when we were in New Zealand a bit about the structure of the course at Christchurch Polytechnic and I am interested in finding out the proposed structure of the course. In the final year at Christchurch Polytechnic the students are paired with a practising midwife and basically take on a caseload. They don't actually have much of a classroom setting at that point.

Mr Corbell: I am happy to provide that information, Ms MacDonald.

MRS BURKE: Minister, I refer to page 20 of your report. The section about the substance-using parent support service at the TCH talks about women self-referring. Given the exponential rise in dual diagnosis and substance abuse that we have at the moment, self-referring is a challenge. You can lead a horse to water, but you cannot make it drink. Can you expand on that for us and tell us whether there is an intention by your government to provide greater services for women in those areas of need? I am probably referring to mental health issues as well as dual diagnosis issues.

Mr Corbell: I'm sorry, Mrs Burke, I'm just trying to understand what you are getting at.

MRS BURKE: I want to know about the substance-using parent support service at the TCH. Perhaps you can expand on that and how your government is proposing, if it is, to enhance the program. Looking at self-referral, are there any moves to broaden what you are doing now?

Mr Corbell: Okay, if your concern is that we only rely on self-referral, that is not the case. Alcohol and drug workers, as is said there in the remainder of the sentence, also refer people. GPs can refer people. Any problems can also be identified, as is said there, at the initial antenatal appointment. So there is a range of points at which people can be directed to get that assistance. I am not familiar, I have to say, with the detail of that service. I might ask Tony or Susan if they are. I am sorry, I don't have that information. I couldn't give that to you today.

Ms Killion: This would be an aspect of the planning work that we would have to look at in terms of what the demand is for this, how people are actually getting in, so this is one of the key areas that we will be looking at when we're looking at expanding maternity services or reviewing the services as a whole.

MRS BURKE: Is this under review at the moment?

Ms Killion: Yes.

THE CHAIR: Hopefully, we are going to see the results of this planning study of services in the middle of the year.

MRS BURKE: Do we know when the review will be happening?

THE CHAIR: Yes, we heard about that.

Ms Killion: My understanding is this committee is due to report in May, so there would need to be ample time to consider that.

THE CHAIR: No, that is all right. It is just that you told us the middle of the year.

Mr Corbell: Mrs Burke, you have raised the issue of mental health services. Dr Sherbon can give you some more feedback on that.

Dr Sherbon: My team and I have been concerned about general practice availability for mental health clients, particularly long-term mental health clients, and we recently commenced trials of improved general practice access for mental health clients. One of the key early points, one of the key features of that service, is that there are better gynaecological and obstetric services available to women mental health clients, not necessarily young women.

It is an issue that is particularly prevalent in the chronically mentally ill, as I am sure the committee understands through your previous work. There is a concern we are addressing that the chronically mentally ill don't obtain primary health care in a general sense and we've already noticed some benefits for women in that process. We will have a lot more experience to share with you in six months. Our work is in an early stage, but it is a particularly important part of general practice support.

MRS BURKE: Can you give some details of that to the committee—the outcomes but just a broad overview of what the trial involves?

Dr Sherbon: Yes. It's early days but we certainly can.

THE CHAIR: And any work that you're doing because there is evidence, certainly around women who have been sexually abused, that the birth experience is quite different and they often are very uncomfortable, if it was a man that abused them, with a male provider of services, and midwife-led care and so on are extremely critical, particularly for vulnerable women.

Can I just ask you quickly, because we are running out of time, on the question of

insurance: do you see any capacity for your government to deal with the insurance issues for independent practising midwives?

Mr Corbell: I think the government is in a very difficult position and at this time we don't see any other steps that are viable for the territory to take. We have, as you know, explored the issue in significant detail and have done a very significant piece of work in trying to canvass and get the support of insurers and reinsurers to provide an insurance product to independent midwives, but without success.

Whilst I think the efforts of the Insurance Authority and ACT Health in this area have been very good in trying to obtain an insurance product for independent midwives, we just haven't been successful and, unfortunately, I don't think there are any other viable options open to the government.

THE CHAIR: There was one suggested this morning by Mr Matthews, but you can read the evidence later because we are running out of time. Just quickly, acknowledging those issues, have you looked at other models, so that you employ the midwives but you allow them a community base, blah, blah, blah, different ways that you could deal with these questions?

Mr Corbell: Yes, we have looked at what other states and territories do. In some jurisdictions there is, effectively, a level of self-insurance, which is not without its risks and is an issue which the territory has to consider very carefully. In other jurisdictions, as far as I'm aware, some people are employed directly through whatever the health service is, but again I think it comes down to an issue of self-insurance because of the nature of how the insurers, rightly or wrongly, perceive the nature of the work that those people do.

THE CHAIR: Could you combine with another state or territory in this regard, if we don't have the economies of scale?

Mr Corbell: I'm not familiar with the detail of it. I don't know whether Mr Matthews can give any further thoughts on that.

Mr Matthews: It's one of the issues that we canvassed a little over morning tea this morning. Each jurisdiction sees its profile as different from the other and there is a reluctance to cooperate; basically, that their profile would be downgraded by combining with somebody else. That seems to be current across all the insurance issues. If we look at the tort reform that all the jurisdictions have gone through recently, we will see huge variations from one jurisdiction to the other.

THE CHAIR: Yes, I do understand that, but I am asking the minister whether he has considered approaching another state—for example, Western Australia, which has an insurance system in place, so you could approach Western Australia. Are you interested in looking at that as well as a potential way through this?

Mr Corbell: I haven't specifically explored the issue. I think the government would rely on the advice of ACTIA in this regard about the viability of even considering that approach.

THE CHAIR: But has it been raised? We haven't talked about it before, have we?

Mr Corbell: As Mr Matthews points out, jurisdictions want to be able to manage the risk within their jurisdiction and it becomes problematic when you are seeking to—

THE CHAIR: Yes, I understand that, but it's worth a try, isn't it? You don't know you've lost it till you've tried.

Mr Corbell: With a limited capacity to do a range of things, Ms Tucker, you focus on those things which you think are going to get you the best possible outcomes.

MS MacDONALD: Last week we were looking at the New Zealand model and they have some settings where they have something like a birthing centre outside a hospital and they are not done as home births. They call them primary birthing centres, I think. I was discussing with Mr Matthews earlier translating the New Zealand model directly across to Australia, but it just wouldn't work because there are so many other issues. But we could have a house in, say, Garran and a house in Aranda, close to the two public hospitals in the ACT, which acted as primary birthing centres where there could be midwife-led deliveries. We were talking about the processes that you would need to put in place and Mr Matthews seemed to believe that that would address a number of the insurance concerns, especially the perception about home birth being the major problem with the insurance industry.

I would like to know your thoughts about that. Also, in discussions with Mary Kirk just before we were talking about how a lot of the midwives in New Zealand gain access agreements with the public hospitals in order to be able to deliver within public hospitals. I understand that in the past it has been an issue for midwives in the ACT to get an access agreement or the ability to go into the hospitals. I would like to know why it has been an issue in the past and whether there is a possibility of midwives being able to do that now?

Mr Corbell: Going back to the first part of your question first, it is not a model I have considered, but I certainly would be very open to considering that and, if that were something the committee wanted to outline in its report, I would be more than willing to look closely at it.

In relation to the second issue, I am not familiar with the history of the capacity to gain rights, if you like, to access to public hospital services for independent midwives. I am not sure whether Susan or Tony can elaborate on that. I'm sorry, I can't answer that question; I'm not familiar with the issue.

MS MacDONALD: I suppose my interest is not so much in that as it is in whether midwives would now be able to do it. I don't care, that is past, but whether midwives would be able to do it if we had some system set up whereby they were insured, having a contractual arrangement with the government, but they still maintained that certain amount of autonomy and were delivering in, say, a primary unit, as I have suggested, but then were able to follow the woman if she needed to go into the hospital setting because something went wrong, as was your own experience. Those women who feel reluctant to go into a clinical setting would be willing to into a primary unit. It is a question of whether there is that possibility of getting an access agreement arrangement set up for

midwives.

Ms Killion: You are talking essentially about translating the VMO model to midwives. That is certainly something that we know is being talked about and would be part of the review process. We would be interested in hearing what your committee has come up with.

MS MacDONALD: So you don't see any obstacles to that happening?

Ms Killion: It hasn't been fully explored. There may be obstacles, but it would have to be looked at.

Dr Sherbon: Thinking concept, it is something worth exploration and we can provide advice to the committee and the minister in due course.

THE CHAIR: We did have all this in about 1996. You went through all this work and there was federal money for a midwifery program in Canberra which actually supported home birth, under Kate Carnell's government. You are familiar with all that work, I'm assuming.

Ms Killion: I'm not greatly familiar with it, Ms Tucker.

THE CHAIR: Okay. I just feel like we keep redoing the same thing, that's all. Anyway, we have to wrap up because we are over time, so thank you very much.

The public hearing concluded at 11.37 am.