SELECT COMMITTEE
INTO PUBLIC OBSTETRIC SERVICES

TRANSCRIPT OF EVIDENCE
TAKEN AT BUNBURY
MONDAY, 27 NOVEMBER 2006

SESSION THREE

Members

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

Hearing commenced at 2.03 pm

MULLIGAN, DR JON
Regional Medical Director, South West,
WA Country Health Service,
61 Victoria Street,
Bunbury 6230, examined:

NAUGHTON, MR DAVID
Director, District Hospitals, MPS and Aged Care, WA Country Health Service - South West,
61 Victoria Street,
Bunbury 6230, examined:

REYNOLDS, MRS KATE
Nurse Unit Manager, Bunbury Regional Hospital (Maternity and Paediatrics)
PO Box 5301
Bunbury 6231, examined:

The CHAIRMAN: I welcome you to the hearing. On behalf of the committee I welcome you to the meeting. Can you please state the capacity in which you appear before the committee?

Dr Mulligan: Regional medical director, south west. WA Country Health Service.

Mr Naughton: I appear in my regional capacity.

Mrs Reynolds: I appear as a representative of the obstetrician services that are provided.

The CHAIRMAN: You will have signed a document entitled information for witnesses. Have you read and understood that document?

The Witnesses: Yes.

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

Would you like to make an opening statement to the committee?

Mr Naughton: I will give a little context to the WA Country Health Service in the south west. Our region covers more than 29 000 square kilometres and has a rapidly growing population of more than 140 000 people from the 2005 ABS data. Obviously, the regional centre is Bunbury, and the growth of population is along the coastal strips. In saying that, there is also growth of the population in the inland areas. We must look carefully at the services we provide those districts.

The south west is a relatively healthy place. There are statistically no variances in health outcomes in the south west from any other region in the state or across the metropolitan area. The regional health service is part of the greater WA Country Health Service. The south west is one of the seven regions. There are 12 hospitals and a range of community health programs and mental health programs. We have a number of visiting medical practitioners who are GP obstetricians - there are 33 across the south west. We have a number of nurse midwives across the south west. That is a major summary of the key issues.

The CHAIRMAN: When you say 33, was that GP obstetricians or 33 GPs of whom some are GP obstetricians?

Mr Naughton: It is 33 credentialed GP obstetricians in the south west. There are 16 in Bunbury, five in Busselton, three in Margaret River, two in Manjimup, three in Bridgetown and four in Collie. The important point is that we have 12 hospital sites across the south west, and not all are obstetric hospitals. Bunbury, Busselton, Margaret River, Manjimup, Bridgetown and Collie are obstetric hospitals.

The CHAIRMAN: Are the health services predominantly VMP arrangements with regard to the GPs? Do you have no rostered type arrangements?

Dr Mulligan: All of the GP obstetricians are VMPs.

The CHAIRMAN: And the specialist obstetricians?

Dr Mulligan: There are four specialist obstetricians.

Hon SALLY TALBOT: Do you have any historical data suggesting there has been a fall in the number of GP obstetricians available in those centres? I ask because we have evidence suggesting that the numbers have decreased in the past eight years from 50 per cent to 25 per cent of rural GPs who are now GP obstetricians.

Mr Naughton: I do not have that data with me, but that has been my observation in the past few years - there has been a reduction in the number of GPs practising obstetrics.

Hon SALLY TALBOT: It would be interesting to see. Could you provide that data on notice?

Dr Mulligan: We could endeavour to get it. Of greater concern is the future. Although the numbers the member has been given reflect the people recognised as having the training and skills to practice, not all of them are practising or practising at the same level as they were over recent times. Of more significance is the future whereby the number coming up is a cause for concern.
[2.10 pm]

The CHAIRMAN: The evidence we heard this morning was about a change that is taking place at Bunbury Regional Hospital in the past three or four weeks about the ability of independent midwives to bring a patient of their own into hospital and to continue with assisting that person in the delivery of the child as a casual member of staff. What prompted the change in that time frame?

Mrs Reynolds: I worked at King Edward before, and we had issues there when a patient came into a hospital for a transfer and there was no real clarity about who was the primary caregiver given that independent midwives were not employed by the hospital. A situation arose whereby staff were unclear about a similar circumstance here when an independent midwife came in with a private patient regarding who had primary responsibility. The midwife is also employed at the regional hospital. I discussed it with the coordinator of acute care services who agreed that in that situation we could put the staff on a casual shift; in that way, they maintained responsibility as the primary caregiver, as long as they operated within hospital policy.

Hon SALLY TALBOT: That was not an independent midwife?

Mrs Reynolds: She was practising as an independent midwife with that patient, but she works part time with that hospital. We were able to put her on for that shift. She was not rostered on at the hospital as a casual.

Hon SALLY TALBOT: Was that a one-off arrangement?

Mrs Reynolds: It was a one-off, but we have agreed that in future if midwives are employed by BRH and if they come in with independent patients, they can be given an extra shift.

Hon SALLY TALBOT: The precondition is that they must be employed by the hospital?

Mrs Reynolds: If they were not employed by Bunbury regional, we could not do it. We would have no contract or details of the person's qualifications and competencies. Whereas, we have details for the girl we employ.

The CHAIRMAN: Can that be changed? If they gave you their details, and you accredited them -

Mrs Reynolds: I would have to investigate that, but, yes, I guess we could look at implementing that type of system. I am not aware of it being put in place anywhere else. It is something we could investigate.

Hon LOUISE PRATT: If a midwife who is currently working independently and who is currently working on shift at the hospital, are you able to sometimes release them from their shift and attend to a patient?

Mrs Reynolds: I have not been in that situation. We would have to take each circumstance on its own merits. Depending on how well the ward was staffed, and what our acuity was, we could consider whether we could release them.

Hon SALLY TALBOT: In a sense, your midwives wives are taking private patients outside the hospital?

Mrs Reynolds: Independently, yes.

The CHAIRMAN: Getting back to some of the elements about the consultation and the model development that is taking place in obstetrician services across the state, have any of you been involved in the development or in the consultation processes involved with the Cohen report, the Reid Report and the clinical services plan that was put up by the Department of Health? Has anyone been personally involved?

Dr Mulligan: The Reid Report was undertaken before I returned to Western Australia, so I did not have any involvement in it. Certainly, the Cohen report was developed in consultation with practitioners in the south west, and I personally had some participation in those consultations. I do not recall how organised that was. It was very much Dr Cohen and his team visiting and meeting groups of people, rather than being organised through the department. As far as more recent consultation is concerned, the paper on the future of maternity serves has only just been released for consultation. I personally did not have a role in the development of that paper, but the opportunity is there for us to now respond to it.

Mr Naughton: Similarly, the recent report was released in October. My role in that is to ensure that the information is provided a conduit out and that people have the information provided back. I did not have a role in the Cohen report because obstetrics is not necessarily my area of clinical expertise. People across the states were consulted about the Reid Report as it was developed, and it was a process to have a lot of comments back and forth.

Mrs Reynolds: I did not have any involvement in those reports, only in "Future Direction in Maternity Care" and the consultative role for public comment.

The CHAIRMAN: I am interested that none of you has mentioned the clinical services plan. You have talked about Cohen, Reid and the latest document, which is the future of maternity services plan. What about the clinical services plan -

Dr Mulligan: The clinical services plan is very much oriented to metropolitan Perth, as the committee would be aware. There certainly have been opportunities for us to provide comment on its relevance to this part of WA Country Health Services, primarily around the linkages that form in the centres between Perth and the support of the regions. The omission was simply because, for me, this is focussed more on obstetric care.

The CHAIRMAN: The committee has heard evidence from the Department of Health, from Simon Towler - whom I know you know relatively well - that there is not a concordant voice among the health professionals who provide maternity services. The committee was also told that the department would seek to recognise and address the needs of the different professionals, so that future obstetrics policy provides choice for consumers while ensuring clinical safety. With that in mind, what are your needs in relation to obstetric services to work through the new model that is being considered?

Mr Naughton: One of the key points is attracting and retaining the required clinical skills mix, particularly GP obstetricians and also midwives - my work force is more to do with midwives. One of the issues in the south west is that we need to employ RN midwives because of the nature of the district hospitals. They need to be able to work in an emergency department, in aged care as well as in midwifery because they are small district hospitals with perhaps 20 beds. Therefore, it is important to have someone who is multiskilled. For some midwives, that is not an attractive thing to be doing. We must look at how to attract midwives into those roles. Maintaining the skills set of existing staff with a relatively low delivery rate is another issue. With rapidly developing technology, investment in the infrastructure is required. Developing new models of care such as shared care is another issue. We have midwives and GP obstetricians. We have issues with transport around the country settings. A big issue is explaining to the rural population the changes happening in obstetrics, and the focus on safety, quality and good health outcomes.

The CHAIRMAN: What is your view regarding the future provision of obstetrician services and the models in and around the south west? What will be the outcome in 10 or 15 years?

Mr Naughton: There is a lot of opportunity with the shared care model of midwifery. That would provide continuity of care for both the patient and the staff - they would monitor the person throughout the entire pregnancy, work with them, develop a relationship and work with the GP in a shared care model to free up the GP a bit and free up the midwives a bit to focus on their area of expertise. That has a lot of merit and fits nicely with the future directions of maternity care document. We need to realistically look at what we can provide safely in a small setting and how far is a reasonable distance for people to travel to access this type of service.

[2.20 pm]

The CHAIRMAN: Do you have a view about the establishment of a family birthing centre?

Mr Naughton: I do. It is another thing that we need to look at. The Birth Choices people have written a very comprehensive paper, which we have received and are reviewing. We will look at how we can incorporate that, if possible, in the future. I think that if we had a birthing centre, it would need to be in a regional centre, rather than in a town such as Busselton, which is smaller. I would have thought that the birthing centre would need to be in a place where there are resident obstetricians, as well as a greater number of GP obstetricians, and access to 24/7 trauma care.

Mrs Reynolds: Bunbury is particularly ripe for a birth centre type model of care. The infrastructure that we have now is just managing the number of deliveries. Births have increased by 29 per cent since 2001 and 20 per cent over the past year. Even if we did not build a birth centre model within the health campus, we would have to extend and increase the number of birth suites to accommodate the sharp increase in the number of births. Now would be the prime time to establish a birth centre within a regional centre that has access to specialist support.

The CHAIRMAN: I got the impression from some of the discussion that we had earlier that you are under enormous pressure in the obstetric unit, so much so that women are not able to take the time that they need to progress naturally through the various stages. I got the impression it was sped along.

Mrs Reynolds: As with any medical model of care, there is always increased intervention depending on workloads. If we established a birth centre with midwifery models of care, it would reduce intervention rates and the length of the stay, increase the time spent with women antenatally for better education, and empower women with better choices. I can see that that would work both across the maternity unit that we have now and by offering new midwifery-led services. They would complement each other to increase those types.

The CHAIRMAN: Is your obstetric service currently spreading over into the medical unit?

Mrs Reynolds: We have taken over four beds from the medical ward because of the increased number of births.

Hon LOUISE PRATT: On the one hand, there is an increasing number of births in Bunbury, but, on the other hand, you have said that it is not viable to put such a service somewhere else to spread the load. Could you unpack that a little more for me?

Mr Naughton: It is not so much not viable, because the place with a larger amount of resources has already been established in a regional centre. Busselton has the second largest number of deliveries and averages 160 or 170 deliveries a year. It is a busy place and could probably do more. Part of the plan with the development of the new hospital in Busselton is to look at how we can expand and improve that service. However, it all depends to some extent on the staff who are available and the ability to attract and retain staff in those areas. Building the building is not the issue; the issue is having the right people, standards and safety systems in place to provide a service.

Hon SALLY TALBOT: How many GP obstetricians are there in Busselton?

Mr Naughton: Five. That is in the Shire of Busselton, which includes Dunsborough.

The CHAIRMAN: Are there specialists there too?

Mr Naughton: No, they are all based in Bunbury.

Hon LOUISE PRATT: Are you aware of any independent midwives working in the Busselton region, and do they simply hand over their patients if they require intervention?

Mr Naughton: I am not sure.

Mrs Reynolds: I am not sure about that either. I think they operate in conjunction with one of the GP obstetricians and probably manage the patient in hospital.

Hon LOUISE PRATT: The GP obstetrician takes over at the hospital. That makes sense.

The CHAIRMAN: Do they do caesareans at Busselton?

Mr Naughton: Yes, they do.

The CHAIRMAN: GP obstetrician and GP anaesthetists do that.

Mr Naughton: We have a general surgeon at Busselton who does caesareans and we also have GP obstetrician and a GP anaesthetist. Busselton maintains that service.

Dr Mulligan: The surgical capacity is not available 24 hours a day, seven days a week. There is only a single surgeon in Busselton. If he is not available for any reason, such as he is on leave or is simply out of town, patients who require a caesarean must go to Bunbury.

The CHAIRMAN: How often has that happened in the past 12 months?

Dr Mulligan: I cannot answer that, unfortunately.

Mr Naughton: He is a very hardworking surgeon and he is around a lot. However, elective caesareans can be managed better in Busselton. We have to look at whether we can get a team together for emergency caesareans and if we cannot get a team together, it cascades up to the regional centre.

Hon LOUISE PRATT: Do you think that women's insecurity about being able to have a caesarean in an emergency if they need it is encouraging women to elect to have caesareans?

Mrs Reynolds: At Bunbury Regional Hospital it is always an option, so that might be more of a consideration for the district sites in smaller places, but not from Bunbury's point of view.

The CHAIRMAN: Has there been any consideration of changing or downgrading the current obstetric service at Busselton?

Mr Naughton: No.

Dr Mulligan: From a planning perspective, we are keen to retain services in the peripheral sites. Bunbury is being overloaded, as you have heard. We must retain the capability of servicing Bunbury as the safety net for the region. We will always try to support Bunbury if it is a choice between Bunbury and other sites, so that a comprehensive service is available in the region. In practical terms, that has not arisen and we have taken some positive steps to try to solve the problem with GP obstetricians in Margaret River, for example, to retain the capacity in that location.

The CHAIRMAN: What has happened at Margaret River?

Dr Mulligan: There were some difficulties with the rostering of obstetricians in Margaret River a year or so ago, but they have been solved.

Hon SALLY TALBOT: How seriously did you view the decline in the number of GP obstetricians?

Dr Mulligan: It is of great concern. The consequence of every pregnant woman needing to make a choice about travelling out of her community to have her baby delivered is difficult. The capacity of Bunbury is constrained, as you have heard. That is the only place at the moment that really provides an alternative if a service cannot be provided in the local community, or they can go to Perth. We are talking about public obstetrics, but there is a private option in Bunbury.

Hon SALLY TALBOT: Can you talk a bit about what you think needs to be done to increase the supply of GP obstetricians? Perhaps we can take it one step at a time. What are the major factors that are making people withdraw their services from that field or not take up the field in the first place?

Mrs Reynolds: I think the reason for the withdrawal is the age of GPs. They are a little weary. There is a lot of on-call work. It is a stressful business. Certainly the GPs we are losing in Bunbury are retiring from obstetrics.

Dr Mulligan: I do not have anything to add to that. The financial rewards of obstetric practice for general practitioners are not particularly great. I cannot comment about practice viability, but I hear enough GP obstetricians expressing concerns about the level of fees. We know that there are sensitivities for consumers in the co-payments that GP obstetricians charge. In the south west, because we have a VMP-driven model of care - at least the medical aspects of that - there are no publicly funded medical antenatal clinics. There are a couple of midwife-driven ones. That means that women who require a medical consultation see a private practitioner and make a co-payment. I think that some adjustment of fees to recognise the total involvement of obstetricians in the care of a pregnant woman, whether it is on a frequent-visit basis or an infrequent-visit basis, would help. It would help consumers as well and remove some of the disincentive to use alternative antenatal care arrangements.

[2.30 pm]

Mrs Reynolds: It disadvantages the lower socioeconomic groups, which usually have the highest risk in pregnancy as well. It is difficult for them to access free antenatal care. That is a disincentive and is often why they do not present for their appointments, which puts their pregnancy at further risk.

The CHAIRMAN: Is that in Bunbury?

Mrs Reynolds: Yes, certainly in Bunbury. The same situation applies at the rural sites.

The CHAIRMAN: What about be the cost, over and above what they get back from Medicare, for a woman to have -

Mrs Reynolds: It depends on each practice, I think. It depends also on whether the women complain loudly enough about having to pay money from their own pocket.

Hon LOUISE PRATT: Would case-load midwifery assist in these situations?

Mrs Reynolds: Depending on how it was funded, yes. If there was no out-of-pocket expense for consumers, that would greatly help.

Hon LOUISE PRATT: In view of the fact that you are servicing rural and regional areas, if case-load midwifery was supported by the government, and if you could enable midwives to work at the hospital with their clients, would you draw the line on homebirths if that had been sanctioned by the government - particularly in view of the fact that people need to travel if they require an intervention - or would you prefer the liability to rest with an independent midwife as opposed to one who works within government? That may be an issue that you will need to assess in greater detail.

Mrs Reynolds: That is a proposal that has been put to the regional director. That will be part of the issues that we will examine when we review that proposal and develop a working party to look at the viability of that as an option.

Hon LOUISE PRATT: That is the review of the birth choices proposal?

Mrs Reynolds: Yes.

Dr Mulligan: Having said that, the issue of liability should not override a woman's personal wishes, assuming that the woman has made her choice on the basis of proper information. What is sometimes forgotten in this is the impact of that liability on the other practitioners involved. The assumption that an obstetrician will be willing to pick up the reins in mid-labour, in circumstances when there may not have been any prior briefing about the woman's previous history etc, is not a safe assumption to proceed on. Some delicate negotiation would be required even if there was a willingness to accept at a policy level that the state should wear the risk.

Hon LOUISE PRATT: Does that also in a regional area affect the catchment area within which such a service must be provided? Clearly you must be addressing that issue now. If independent midwives are opting to work in situations in which the birth is taking place a fair way from a hospital, clearly GP obstetricians and specialist obstetricians are not undertaking that type of practice. How do you accept the fact that a woman is a fair way through her labour before she fronts up to hospital? Should there be a policy for rural and regional areas that tries to work with people who are working independently to provide some explicit guidelines on that?

Mr Naughton: It would be very difficult to develop a policy for all the state because of the different demographics, and particularly transport issues, that are faced in the more remote areas. It would need to be looked at on a regional level so that the services were managed against the need. I suppose the activity that happens in the district hospitals is low-risk planned activity. Anything that is higher-level risk and that we know about in advance goes to a regional centre. The only reason that a woman with a higher-level of risk would be delivered in a smaller site would be if it was an emergency and she presented at the emergency department. That is a rare occurrence. Outside of Bunbury, they tend to be low-risk deliveries.

Hon LOUISE PRATT: So for a homebirth that was taking place in Collie, versus a birth that was taking place at a hospital, you would not characterise the risks any differently, because you do not have access to high-level intervention in any case?

Mr Naughton: Low-risk tends to be determined by the pre-existing condition of the patient, the previous history and a range of other medical conditions. Assuming that the person was a low-risk delivery, I would have thought having the baby at home would be similar to a low-risk delivery at the site.

Mrs Reynolds: The College of Midwives referral guidelines are fairly comprehensive and work well in those models elsewhere in Australia.

The CHAIRMAN: We have heard quite a lot about the differing views about the options and some of the difficulties in trying to pull these options together into a model that will provide choices for women. We have heard also about the conflict that exists between the different groups of people involved in providing obstetric services - not necessarily here; I am talking about as we have been undertaking this inquiry. Would you like to comment on what you think are the potential conflicts among all the different groups of people who are involved in providing these services?

Dr Mulligan: Although I am aware of some tensions that exist from time to time between midwives and obstetricians, particularly GP obstetricians, I am not conscious of any conflict. We have a pretty good incident reporting arrangement in the south west. I can say with some confidence that that has not led to anything that would be a risk to patients - or nothing that has been reported, anyway. We are extremely fortunate in the way in which the specialists practise in this region. Their relationship with general practitioners is as good as I am aware of that exists anywhere. There is no conflict or tension, or even risk of that, between medical obstetricians. As far as tensions with midwives are concerned, I do not think that is anything more than is explained by the frustration of midwives in not being able to practise in a way that some of them might prefer, rather than in a model that is medically dominated, which is inevitably part of a hospital-orientated scheme. That is the only comment I would make. However, I am not at the front-line, as it were. Kate would be in a much better position to comment, as would others who will follow.

Mrs Reynolds: Where it is a consultative process and all the stakeholders are involved, and the policies are well developed and the guidelines are quite clear and there are no grey areas, it seems to work. My experience in the past has been that it works really well, because everyone knows exactly where everyone stands, and there is a mutual relationship of trust. It is about the setting up, the planning and the developing of the model that is to be used. That is crucial to the success and the reduction of tension and conflict.

Hon SALLY TALBOT: Do you feel that you are able to meet the expectations of the women themselves?

Mrs Reynolds: Currently?

Hon SALLY TALBOT: Yes.

Mrs Reynolds: Not in every case.

Hon SALLY TALBOT: Can you elaborate on that?

Mrs Reynolds: It is just that there is no choice for the women. They see a GP and they attend as a public patient in a public hospital, or they see a GP and they are referred to an obstetrician to have their birth in a public hospital, or they choose to deliver in a private hospital. They are the only choices that the women currently have.

Hon SALLY TALBOT: What other choices would the women like to have?

Mrs Reynolds: Shared care options with the GPs and the midwives, or the GPs and the obstetricians; midwifery care within the public health system; access to antenatal visits with the

midwife; and a midwife who they will develop a relationship with and who will care for them during the labour and birth.

[2.40 pm]

Hon LOUISE PRATT: Under that kind of model it would not matter so much if you had rostered GPs and specialist obstetricians, because the continuity of care in that case would come from the midwife.

Mrs Reynolds: Yes, and they would ideally have visits with that particular GP or obstetrician during the pregnancy, so they would not be unfamiliar with them. They would also be screened for risks antenatally and receive at least two visits by the GP or the obstetrician. More often than not, if they needed assistance during the birth it would be that particular GP or obstetrician who would provide that assistance.

Hon LOUISE PRATT: How many women do not get that continuity of care through a relationship with a GP or obstetrician? How many women lack any reasonable level of continuity of care?

Mrs Reynolds: All the women we see have antenatal care with the GP, and the birth is usually attended by that same GP, unless there are complications, but even then the GP would attend, diagnose a complication and make the referral to the obstetrician. More often than not the women may not have met the obstetrician, but certainly the care that is given to them by the GP is by the same person, unless someone is on holiday relief. Usually they have managed to meet the GP, or are well aware that their GP will be away and someone else will cover for that GP.

Mr Naughton: At the district sites there is a similar arrangement, where people work together, and it is usually in partnerships. The next group of people you will be speaking to will be able to provide more information about that. Following on from that, to support what Kate has said, I would like to see more prevention programs to raise awareness of issues associated with pregnancy, and planning to become pregnant, such as smoking and obesity and all the issues that are associated with that, which sometimes result in low birth-weight babies, which can result in a range of other problems. It would be good to be able to target those at-risk groups through people such as midwives, and to incorporate that into the shared-care model.

Hon SALLY TALBOT: The more people you can get into a low-risk group, the more choice there is.

Mr Naughton: Absolutely. That links back to the question you asked before about if we can get more low-risk deliveries happening at the district sites, it would free up the regional sites to provide what they are supposed to be providing, which is the higher-level, secondary-level services. Ideally, we know that if people are aware of the situation, they are able to make choices. If we can help them to make the choices, they will have better outcomes. That is a long-term, big-picture, population approach, which I obviously support.

Hon LOUISE PRATT: In terms of screening both prenatally and postnatally for a range of different health issues, is that being adequately done on a uniform basis? Take, for example, incontinence post birth. There are some programs at Swan District Hospital with physiotherapists, for example. Would a program automatically pick up those women to make sure that they get the appropriate referrals?

Mrs Reynolds: Not necessarily, unless there were issues that were outside the normal in the immediate postnatal period that we might address while the woman was an inpatient in the hospital. However, if it developed or continued, it would be picked up by the GP and managed.

Mr Naughton: The next group of people who will be speaking for the south west are the child health people. They provide a visit to the home to see the mum and baby post delivery. That is when they do the initial screening-type program.

The CHAIRMAN: What is the average length of stay?

Mrs Reynolds: About three days. We have a community midwifery service, so the women can have an early discharge and then be followed up in the home by a midwife.

Mr Naughton: Often those people are discharged to the district sites if they choose to be.

Hon LOUISE PRATT: Do you think women in regional or rural areas currently get greater continuity of care than women in the metropolitan area because they have access to GP obstetricians?

Mrs Reynolds: Compared with King Edward they certainly do. My experience has been that they do.

Hon ANTHONY FELS: It would seem to me that there is probably a higher proportion of GP obstetricians in the south west than there would be in the metropolitan area. If a decision were made to reduce the number of obstetric-service hospitals in the region and concentrate on Bunbury and one or two other regions, what effect would that have on the viability, and therefore the availability, of GP obstetricians in an area such as the south west?

Dr Mulligan: For those who want to practise obstetrics, it is a very important part of their practice. If we were to say to any site where there are currently GP obstetricians that we would not permit them to practise, I suspect they would leave.

Hon ANTHONY FELS: Would you expect them to move toward the centres where you will be concentrating those services, or that they would leave the district altogether?

Dr Mulligan: Not necessarily.

Mr Naughton: The midwives who live in the towns have moved to those locations and have chosen to work there. The vast majority are part-time workers. They are not necessarily willing to travel for an hour to get to work. They have made choices. We do everything we can to maintain the services at the sites we currently have.

Dr Mulligan: It is a major challenge whereby the number of clinicians is small, and the availability of the service 24 hours a day cannot be assured. A judgment must be made on a case-by-case basis when a woman comes into labour whether it is possible to staff the service adequately in that location for that woman to have that baby. We have contingency plans across sites so that if the GP is away, for example, early advice can be given to the woman that she will not be able to have the baby there if that is the case. Increasingly we face the prospect of that happening because no midwives are available.

Mr Naughton: This calendar year has been probably the most challenging year for us as a health service in retaining midwives. Never before have we had such a problem in getting staffing on the wards and getting the numbers up but not getting responses to advertisements, even in towns like Busselton.

Hearing concluded at 2.45 pm