SELECT COMMITTEE
INTO PUBLIC OBSTETRIC SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
MONDAY, 26 JUNE 2006

Members

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

Hearing commenced at 11.15 am

TOWLER, DR SIMON
Executive Director, Health Policy and Clinical Reform, Department of Health, examined:

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

Dr Towler: I am as of late the executive director for health policy and clinical reform and in the last week and a half I have been appointed also as the Chief Medical Officer. My working location is 189 Royal Street, although I also have an office in Central Avenue, Subiaco for my new role as the lead of the clinical networks, which are an important part of our new framework for community engagement.

The CHAIRMAN: You will have signed a document entitled "Information of Witnesses". Have you read and understood that document?

Dr Towler: Yes, I have thank you.

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 microphones and try to talk into them and ensure that you do not cover them with papers or make any noise near them. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that premature publication or disclosure of public evidence may constitute contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

Dr Towler: Thank you.

The CHAIRMAN: Would you like to make an opening statement to the committee?

Dr Towler: If you would not mind, I would like to take the opportunity to do so. I thank the members for the opportunity today to talk with the committee on the issue that is before it. I think this is an important issue and I, in my new role, am very pleased to see that it is being debated at this level. I think it is important, from my position as a representative of the health department, to give a little background to the situation in which we now find ourselves in relation to the terms of reference for this committee. Community consultation has been a strong element of the Reid review process and the production of "A Healthy Future for Western Australians" document, the report of the Health Reform Committee. It looked at all services across the health system and it is an extremely comprehensive review of services delivered at every level. There has been a focus recently on discussions about the inpatient care phase of maternity care. I think it is important to remind the committee - I am aware of your focus on the holistic care issues - that care during pregnancy begins before conception, through the whole antenatal period and involves the delivery and postnatal periods; and in seeking to address the issues of the Reid report, the broader aspects of the care of the mother are taken into account.

Recent focus on the clinical services framework looks very strongly at the inpatient component of that service. There was a strong community consultation process built into the process behind the

Reid review, and it sought to look at a number of issues. It endorsed Dr Cohen's "Western Australian Statewide Obstetrics Services Review" of 2003, which emphasised some of the issues of patient safety and the need to look at new models of care. I think it is important that the committee note the environment in which these discussions were held. Western Australia has had a somewhat colourful background of late. The Douglas inquiry was a testing issue for certain people providing obstetric services in this state, and sought to focus very strongly on the issues of safety; and that is appropriate. In terms of the reviews that we have done and the way we are looking at clinical services, all reviews have sought to underpin the properties of good clinical governance, which you will see outlined in the Reid review and which refer to four principal elements of decisions around all care. One is a strong audit; one is an acknowledgement and understanding of clinical risk; another is clearly based on a strong interpretation of consumer values and their inclusion in good policy; and the fourth element is to ensure that there is appropriate professional development and management of clinical services and organisations.

The planning approach that we have looked at in developing services takes into account issues of safety, work force, facility design and planning. We hope also it has given a framework in which patient choice is recognised and honoured. We are looking for information, and the background on the changed demography seeking maternity services has been a driver in ensuring that the safety element is emphasised. We are aware of an ageing primigravid population and the increased risks for people with a first-time pregnancy, but acknowledge the worldwide information that looks at new models of care. I am hoping through this process that we will be able to explore those and look at how we embrace them more wholesomely in the way we go forward.

I will just give you a brief overview of the current processes and I am sure we will come back to further questions. The clinical services framework is strongly focused on just the delivery of facilities, which relates very strongly to inpatient care. The Health Reform Implementation Taskforce and the state health executive forum are looking at the detail of aspects of non-inpatient care service delivery. There has been a metropolitan clinical planning process, which largely engaged directly with clinicians and which formed the framework for some of the decisions about design and facility building. Each area health service has developed a community advisory council and will be taking those discussions to the community advisory council and developing the details for the planning for each facility. We have had recently a review by women's health services, which has produced a paper for us to consider, but the new maternity and neonatal health network will be going forward with a strong consultative program that will look to engage the community at every level of those aspects of maternity care that go beyond the inpatient period, and I look forward to the opportunity to discuss those issues further.

I hope that I can be of use to you today in the report and review that you have in hand. I believe we can demonstrate that there has been substantial community consultation. As a clinician, I am aware that people always say that there is the opportunity for more consultation, but I think the framework in which we move forward gives opportunity for the community to be heard, and we look forward to that opportunity as we move forward.

[11.20 am]

The CHAIRMAN: Can you tell us a little about your background and experience, when you came to the Department of Health, at what stage of the process of the Cohen and Reid reports and the clinical services framework you become involved and what your involvement was?

Dr Towler: I am a clinician and an intensive care specialist by training. I was the head of department and head of the division of critical care at Royal Perth Hospital from 2002 to 2005 before I was invited by Dr Fong to take up the current position. I was also AMA president in 2000-01. I was invited by the honourable member Robert Kucera to be part of the Health Administrative Review Committee, and was invited in the second half of the Reid review to be a member of the clinical reference group for the Reid report. I have in that time also engaged in a number of other

areas of interest. I have been a member of the board of Kaleeya Hospital, so I have had some experience in the private sector. I have been involved in a number of other clinical planning processes at different levels and have a broad background in the health system. I was invited by Dr Fong to take on the new portfolio of health policy and clinical reform, which has a very strong emphasis on the development of what have been called clinical networks. My preference is to call them health networks. We have taken up the requirement from Reid to have a much stronger engagement with the consumer and community, and each of the clinical networks will, as it moves forward, develop a consumer interface that will be part of its executive and part of its routine activity. We have recognised that in clinical planning there is a need for continuous input. I believe I have a substantial amount of experience in those roles as a leading clinician in the Western Australian health system.

The CHAIRMAN: You have talked at length about the consultation processes that have taken place. Can you be explicit and tell us what consultation took place on obstetric services in the process of developing the Reid report?

Dr Towler: In looking at the issue of how consumer participation and consultation was developed as part of the Reid report, the Reid committee called upon the Health Consumers' Council to run a series of community consultations. The process of the Reid report was advertised publicly, and opportunities were given for people to give written submissions either through the Health Consumers' Council or directly to the Reid committee through the Department of Health. The scope of the issues canvassed meant that, on individual issues, it was difficult to identify a specific pathway for consultation. The issues covered in Reid were very comprehensive and addressed all forms of service delivery. A great breadth of material was presented back to the Health Consumers' Council and very few submissions were received, particularly about obstetrics.

The CHAIRMAN: In the Reid report, only about one or two pages are on obstetric services. I cannot remember how many pages, but there were only a few on women's and children's services.

Dr Towler: A number of recommendations in the Reid report relate specifically to women's maternity services. Recommendation 42 specifically pointed to the previously acknowledged Western Australian statewide obstetric services review and endorsed it as an implementation plan. It also recognised the role of King Edward as a tertiary hospital. However, it also pointed to a trend that had been developed when the "Health 2020: A Plan for Metropolitan Perth" document was first tabled by the prior government that sought to acknowledge the fact that a substantial number of maternity services were provided centrally and that opportunities needed to be created to increase the amount of maternity services delivered away from the central city hospital. In fact, the expectation in the "Health 2020" document was that we could move the 37 per cent of women having their babies locally to be as high as 45 per cent over the period to which that document referred. There is substantial concordance between the two plans in the move to increase services, particularly in Joondalup, the Swan districts, Armadale and Rockingham. The Reid committee report endorsed the Cohen review, which followed the Douglas inquiry. It looks to the issues of new models of care and endorses the concept of ensuring that those services that are developed in communities are safe and reliable for women.

The CHAIRMAN: The area that I am struggling with is how much information families had to which they may or may not have been able to respond, such as a consultation process whereby they could make written submissions or something like that. The issues covered by the Reid report were so comprehensive and broad that obstetric services formed a tiny part of its total remit.

Dr Towler: I agree, and I understand the issue before us. As a Royal Perth Hospital clinician, the consequences of the decisions in the Reid report about service delivery in the eastern suburbs have also been a point of substantial discussion. Whenever there is an agenda of reform, the fulsome impact of those changes can be difficult to identify. I have been unable to find questionnaires that specifically relate to obstetric issues in isolation, but it was very clear in the material that I have

been shown on the opportunity for people to submit comments that people were being asked to discuss any issues about health care delivery, particularly in the context of the metropolitan area. Given some of the comments I noted in the *Hansard* report of your discussions leading up to this review, the Reid report has a strong metropolitan emphasis, and although it points to a number of issues with rural service delivery, it does not comprehensively address them.

[11.30 am]

The CHAIRMAN: In general terms, what did the community consultation and submissions reveal from the few responses that you received on obstetrics?

Dr Towler: I had been told about only a couple of submissions. I have not seen the context of those reviews. The report prepared by the Health Consumers' Council expressed the need to cover very large amounts of material. I would need to look at the details to know what was specifically said. It is not something I was directly involved in.

Hon HELEN MORTON: Has the Health Consumers' Council been the main source of community consultation on obstetrics?

Dr Towler: In the Reid process the Health Consumers' Council was engaged as an agency to undertake a particular aspect of the community consultation process. A number of meetings were held across the state in which communities were given an opportunity to raise any issue, although there was a focus around a number of discussion papers that were developed as part of the Reid report. That included the "Options for Clinical Services" paper and a number of other issues that are listed in the contract.

Hon HELEN MORTON: There was no obstetrics paper among them.

Dr Towler: There was no specific obstetrics paper, but nor was there a specific paper on cardiothoracic surgical services, trauma or emergency. They were largely encompassed in the principles of the options of the clinical services review.

Hon HELEN MORTON: I reiterate that the committee is trying to focus its consideration on obstetrics and the extent to which the community was consulted. To what extent, if any, did the community consultation influence the recommendations of the Reid report and the subsequent WA clinical services framework?

Dr Towler: It is probably difficult to ascertain exactly how the consumer and community input is represented in the documents. Not only is community opinion captured by what is collected through a formal process, the processes around the consultation in the preparation of the Reid report and discussions held by Dr Cohen and his committee included a substantial number of persons who relate directly to patients and their families. There was also intent through the Cohen review to ensure opinions could be heard wherever possible. The way that influenced the details of the clinical services framework is driven from the endorsement by Reid of the underlying principles of the Cohen report. In the Cohen report there was a clear commitment around the need for an ongoing process of examining models of care and encouraging a future process of further consultation with the community. It comes back to the issue that maternity care is much more than simply the inpatient period of stay.

Hon LOUISE PRATT: In relation to the nature of community consultation that you undertook, I understand that, in large part, the decisions were about how the clinical services framework would deliver services in a management sense, and that once those structures were in place new processes and structures would be implemented within which to develop policy and consider models of care across any clinical pathway. It is my understanding that, within what is being considered for obstetrics and maternity services, models of care etc are still very much open for discussion.

Dr Towler: Absolutely.

Hon LOUISE PRATT: How is community consultation played out when it comes to the separation of issues within the management framework so that we can improve consultation in the future? You said earlier that these new structures were implemented to provide better community consultation in the future.

Dr Towler: I reiterate that, firstly, the clinical services framework is very focused around what is essentially a hospital building program. It has a clear focus on developing future facilities and the realignment of health facilities in Perth to move away from a cbd-centric view. It seeks to ensure that, on the whole, the facilities we provide in the community are much closer to where people live. The discussions to date around planning have begun now to move into the details of models of care. In maternity services the discussions are about pathways of care. We want to move away from the focus being solely on the facilities themselves, to the care of a patient during pregnancy to care from the earliest period of the pregnancy until after the baby has been successfully delivered. The women's health service has developed the state obstetric services unit, which has been engaged in meeting service providers in not only the metropolitan area, but also the rural sector. It is beginning to get greater feedback on the options for diversity of models of care. In the discussion paper we have put together, we are looking at the range of models of care, such as those outlined in the Victorian document and that have been looked at in detail in New South Wales. At the moment we are beginning a process that will ensure comprehensive community consultation around what represents good models of care in future, and considering those four principles of good clinical governance in creating opportunities in the community to address them. That will include the roles of general practitioners and midwives, and the opportunity to give women greater accountability and greater opportunity to influence the care they receive and to ensure that we address the issues of clinical safety and clinical governance around professional standards. The maternity and neonatal clinical network, which will fall under my jurisdiction, will take responsibility for that process. At the moment we are engaged in establishing a series of questions and getting information on models of care. We are also checking with the professional groups and the Health Consumers' Council to ensure that we are framing the questions appropriately. We will then undertake extensive community consultation so that, as we move to develop facilities, the options around an ambulatory care interface, recognising the needs of the different professionals involved in maternity care, are addressed so that we can make the two statements around giving choice while ensuring clinical safety. The point you have raised that we are at the beginning of a process is a fair statement. We have recognised the need for much greater community consultation in getting now to the details of care from preconception through delivery and into the postnatal period.

During the recent estimates hearings in the lower house we were asked about Western Australia's higher percentage of babies of lower birth weights with five-minute APGAR recordings that are too high. Therefore, substantial challenges face us in addressing those things prior to delivery to ensure a safer period for a woman during delivery of the baby. It is important to acknowledge that maternal and neonatal outcomes in Western Australia are some of the best in the world. The challenge is to create a clinical governance framework with which people can be confident, and which continue to ensure those higher levels of safety and good outcomes and provides the opportunity for women to have a much greater role in the care. I think comments in the Cohen report in particular, and in the Reid report and the Douglas inquiry about the need to meet women's expectations better is something we have accepted as a challenge that we need to address.

Hon ANTHONY FELS: Were there time constraints on when the HCC had to report to you and when the Health Reform Committee had to complete its final report? What was that process? Were there financial resource constraints on the HCC completing that on time?

Dr Towler: There were more issues around time constraints than around resource constraints, as I understand from the report that we received back from the Health Consumers' Council. It was given a substantial task in underpinning across the state how opportunities could be created for consumer participation. The HCC's concern was that within that time frame it would be difficult to

encompass all issues. I think it would be difficult to encompass all issues in a substantive review of the health system of the scale that the Health Reform Committee undertook, without there being some concerns about whether it would be a full overview. That is why it is critical that the Reid report itself pointed to the need for ongoing substantive consultation with both professionals and the community.

[11.40 am.]

It has embedded a responsibility around the area of health services to develop community and citizen advisory committees, which are now almost in place. In the rural sector the development of the district health advisory councils has progressed, and in fact is probably more advanced than it is in the metropolitan area. The health networks themselves will pick up the process. I think, yes, the health consumers' process was fairly short. They were given a task to do and they conducted their meetings. Their own material says that if we look at the percentage of the population that was directly encountered, it was quite small. I think that is acknowledged.

Hon ANTHONY FELS: Did the health report reform committee have sufficient time to consider the Health Consumers' Council report from when it was lodged until the Reid committee had to complete its final draft report?

Dr Towler: I was not a member of the committee at the time. The consumer consultation process happened in, basically, the second half of the year of the Health Reform Committee. It was partly around framing. As you will remember, I said before that a number of discussion documents were developed by the committee, having met with a very substantial range of people. Those discussion documents formed the framework for the consumer consultation, and the clinical consultation for that matter. My impression is - that is all it can be - that the feedback that came from the consumer reviews was not discordant with the information that had emerged out of the discussion documents. On the scale of the Reid report, people could have always taken more time to consider a lot of other input. I go back to the point that the Reid report clearly points to a strong ongoing process of consultation. I think that is how the report sought to address the need for that to be taken up. I think the point that has already been made - that the models of care will continue to be discussion - really points to the issue that the Reid committee created basically a foundation for a way forward. It sought to bed into the system a much greater consciousness around community consultation and it pointed to a series of mechanisms to do that. The Cohen report also sought for there to be substantial community consultation around models of care. That process, I believe, has perhaps been a little slower than ideal, but what has become clear is that there are some difficult issues in the community consultation around maternity care. You will be aware that only last year the Cochran review suggested difficulties about entirely midwifery services in terms of mortality outcomes. I think we are at a point at which we wish to embrace all models of care and look to what forms the foundation for high quality and high safety that underpins patient choice. That is the commitment we have going forward. I do not believe that any of the decisions made to date in any way at this point in time limit the options that are available in the models of care that I have seen outlined.

Hon ANTHONY FELS: Did the committee give any further considerations to your obstetric services from the time of its draft report to the final report?

Dr Towler: I could not answer that question. I would have to find out.

Hon ANTHONY FELS: Could you get that information and also find out if any meetings were held between the time the HCC lodged its report and the date of the final draft report, which I think was 31 January 2004?

Dr Towler: Yes.

Hon SALLY TALBOT: I am very interested, as I am sure are my colleagues on the committee, in your references to the community advisory councils. Of course, anybody in public life is acutely

aware of the general level of cynicism out there. We have read comments in other reports that have been done in other states about people being reluctant to provide community input to reviews, because they are not sure whether their views can make any difference. Noting the Chair's reminder to all of us that we are focusing on obstetric services, I wonder whether you could just comment on the way that the consumer interface operates - the other side of the coin from the review that sits there receiving the input - and the extent to which people making that input get feedback about how their input has been received and what is likely to happen as a result of it?

Dr Towler: I think those are excellent questions that go to the whole process of the way in which not only do we engage consumer and community input, but also clinical advice, about which the same thing could often be said. The Reid report clearly points to the fact that the prior processes for consumer and community engagement were not sufficiently robust. How to address that is a challenge for us going forward. I recently had the privilege of addressing the district health advisory councils, where there has been a very substantial commitment in the rural sector to ensuring those district health advisory councils provide two opportunities: one is to ensure that members are well informed and the other is to provide them with resource around teaching them to undertake the role and ensure that they are essentially empowered to be aware of the way in which their contribution can be fed back. At the moment, I would say that the rural sector is, in one sense, a step ahead of us. My own background includes being a member of the Clinical Senate, having also been a member, prior to that, of the Medical Council of Western Australia. These are clinical advisory bodies that have worked through the Department of Health. I, in fact, wrote the terms of reference for the Clinical Senate as part of my contribution to the HARC - Health Administration Review Committee - report. We in this state have built on a substantial history of engaging with consumers at two levels in that clinical process. One is engaging the Health Consumers' Council, recognising the need to use the resource that is available to people who are expert at providing consumer advice, where they feel that they can make a contribution; in fact, they are fairly direct about ensuring that that contribution is taken into account. The other is that through the Clinical Senate we explored the role of what were called citizen juries. We have used both methods of consumer engagement now over a period of nearly five years. We have had substantial learning from those processes. In both cases we have found that that open approach has led to a substantial level of endorsement for those particular groups.

The Clinical Senate meets around a specific issue and then invites a consumer citizen jury and the Health Consumers' Council to meet in advance of Clinical Senate meetings. I believe we are now in a position to understand how to ensure that consumers' input is given greater credence and taken into greater account. We have learnt from the Clinical Senate process about ensuring feedback around what is endorsed. I would say to you, though, the challenge of demonstrating the extent to which clinical advice, consumer advice or community advice is actually built into a process as complex as the health system can be very difficult. Clinicians, as well as consumers, have said to me, "Can you demonstrate that what we have done has made a difference?" Often the differences take time and often the issue is about ensuring that there is a consistent message and a consistent voice. It is a little bit like moving the *Titanic*: it takes time and it takes effort. I have no doubt from my experience of the Clinical Senate that the ongoing commitment to consumer engagement, and consumer engagement in that process, has had an influence on the policy that was developed. I have no doubt that the Clinical Senate has influenced the clarity around some of the health decisions that are made. As we go forward to a process of looking at new models of care, I believe this is critical. With all respect to my colleagues in the maternity disciplines, one of the reasons I think we are sitting here is that there is not a concordant voice among the health professionals who provide maternity services as to what is the way forward. What is required, and what we are committing to in the process that we will be conducting in the maternity health network, is to ensure that we have heard very clearly what the consumer wants and what the community wants, because I believe we will have to influence the models of care positively, not just accept whatever is stated currently by

clinicians. It is a difficult environment. As I said, the Cochran review has not necessarily supported some of the models of care, but it is about creating the right clinical governance to ensure that those options are provided. Many of the issues in maternity care do not relate specifically to inpatient stay. We know that in Western Australia the inpatient stay period is reducing; it is actually shorter in private than in public -

The CHAIRMAN: Are you talking about maternity?

[11.50 am]

Dr Towler: Yes, maternity inpatient stay. It goes back to the issue that we want to look at the whole episode of care, not just the inpatient stay and the delivery period.

The CHAIRMAN: You touched on a point that I wanted to raise about the discordance. Leading from the Cohen report to the Reid report, was that awareness embedded in the Reid report?

Dr Towler: I only joined the clinical reference group halfway through but my recollections of its discussions on obstetrics acknowledged that these issues were present. The environment at the time was difficult. We had just come out of the Douglas inquiry. In the transcript of your prior discussions there was a recognition of the problems in obstetrics, consequent upon the medical indemnity crisis in Australia. Only now is the impact of that beginning to settle down. The federal government solutions around financial support for premiums, for procedural and general practice and obstetrics have been focused on critical illness and providing some stability on the work force issues. My recollections of those discussions was that there was a clear view that we needed to go on with the discussion but the environment was a very difficult one in which to conduct it. There was substantial community awareness of difficulties during periods in labour ward delivery and a series of adverse outcomes. Douglas was an extremely comprehensive report. It unquestionably focused on tertiary care, but the principles around clinical governance basically resonate through the issues of how we provide care at the time of delivery. I think the Reid committee was aware of this, but I also think it harked back to what is said in the Cohen report about the need for ongoing consumer consultation and a discussion on what is the optimum configuration.

One of my officers in the clinical networks comes from the UK where midwife-led independent delivery suites have been developed, but the level to which the community has endorsed them has been limited. I think Cohen sets up a framework around having an important discussion with the community, in partnership with the various clinicians, to ensure that we create a framework for a way forward. I believe the Reid committee was aware of the fact that it was difficult to get resolution of that at that time. That is all I can say.

The CHAIRMAN: I will move to another section now which is more specific to what you referred to as the capital, or buildings etc. Can you explain what the basis or impetus was for the reconfiguration? I think you have covered some of that. Even right now I do not understand specifically why a model of maternity services could not continue at hospitals such as Osborne Park, Bentley and Kalamunda. I have a better understanding of the Woodside-Kaleeya issue.

Dr Towler: All I can reflect on is the background to Reid and how it references to Cohen. It also goes back to the discussions that emerged in both the "Health 2020" discussion paper and in the final report for "Health 2020: A Plan for Metropolitan Health", which recognised that Western Australia had remained very dependent upon obstetric services delivered largely through King Edward and sought to create a model of improving the opportunities in the community sector to develop obstetric services. The model that was developed by Cohen referred to maintaining a tertiary service, which was obviously at King Edward and then four community-based centres. Consistent with the 2020 document, and Cohen's later report - although in Cohen there was a discussion on this but not a specific result - the end review was that the four community-based hospital providers at Joondalup, Swan District, Armadale and Rockingham should move out from the current environment to a wider ring.

There is also a clear focus in Reid on the role of that inner ring of hospitals. It is a very interesting discussion at the moment, because we are engaged in a very extensive discussion on particularly aged care. Western Australia has a very poorly developed sub-acute sector. One of the principles of the Reid recommendations is that that ring of hospitals, Osborne Park and Bentley in particular, have a very important role in some of the non-acute services, particularly extended aged care, mental health and rehabilitation. Those are being further developed at the moment. It is also a substantial part of the future role for Fremantle.

One of the issues comes back to the substantial discussion on the work force. The work force providing obstetric care is limited at the moment. The committee has rightfully acknowledged the issue of extending that work force by looking at new models of care. However, as we move forward, it is important to ensure that there is a safe environment supported by a traditional hospital-based model. Hopefully, it will form a partnership with the development of new options. The positioning of the options in those four less centric hospitals is designed to create a platform to provide a greater range of services. The three major population blooms in Perth are in Joondalup, Ellenbrook and Rockingham. In all three cases, the services which have been identified are very closely related to those of the Joondalup Health Campus, the new facility at Midland and the development of the Rockingham hospital.

The CHAIRMAN: My question is not specifically about whether those four hospitals should or should not have a substantial secondary level of maternity service. They already have them, but they need to develop more. I do not disagree with anything you said about those four hospitals. I cannot understand why you would not continue the GP-midwifery service that the other three have when it has already been identified as one of the valid models of obstetric services to be provided in the metropolitan area. I am still struggling with that.

Dr Towler: I go back to the comment about the environment in which the discussions took place. There is no doubt that in reading through the Cohen report and the material from the King Edward inquiry, there was a substantial focus on the number of deliveries and the relationship to a safe working environment. Currently we have ongoing problems in the provision of things such as anaesthesia services. There are difficulties in paediatric support for neonatal assessment. One of the main drivers behind this is not any comment that the services where they exist have not been safe, but the process of moving forward and looking at what the drivers are to create a safe environment. With concerns emerging about increasing age and first-time pregnancy, and the increased complication rate that goes with it, and some of the discussions that arose out of the Douglas inquiry, we were not in a position to ensure that we could maintain multiple sites going forward. In the time up to Cohen, there was a more than 20 per cent reduction in the number of general practitioners who had undertaken substantial obstetric training. The view was that the situation was likely to get worse, particularly in the environment around the medical indemnity crisis. Those factors are what made those decisions and they are reasonably well outlined in the decision making process behind it.

The CHAIRMAN: Were safety issues a consideration in the decision to cease obstetric services at Kalamunda, Osborne Park and Bentley?

Dr Towler: They were issues in terms of an image that it was a risk in the longer term. There is a comment in Cohen that points to the fact that the current standard of services was not the issue.

[11:59 am]

It was about realigning the system for the long term to create an environment in which the numbers of deliveries would underpin, on a sustainable basis, both a training environment, which was becoming an increasing issue, and the maintenance of services, particularly the number of specific disciplines, not necessarily the person undertaking the delivery, but certainly the support services of anaesthesia and paediatric assessment, would be at risk.

The CHAIRMAN: I understand that you are referring primarily to training for midwives and obstetricians. Why does training have to come to a central point rather than trainees going to where the services are provided?

Dr Towler: It is not an all-or-nothing discussion. The question of training is one of the major issues facing the organisation as a whole. There is substantial investment in training in most of the larger institutions. There is clear recognition by clinicians about taking on a training role. At the moment, we are looking at models that would provide trainees with the opportunity to go out from the traditional tertiary sector and secondary sector environment to work in smaller hospitals and the private sector. We are meeting substantial resistance to that -

The CHAIRMAN: From whom?

Dr Towler: From clinicians who would be called upon to actually provide the training role. The same thing happens in general practice, where creating an environment for training can be quite difficult. It is an imposition of time. We get messages from the private sector about reduced productivity. It will need substantial additional investment, and at some point we are going to have to face these issues. Training issues in the health system are one of our biggest challenges. In the area of maternity services, we are discussing changes in some of the models of care and options that are available. That also means looking at necessary changes in the training environment. The concept is that larger centres are far better able to adapt and to provide the resource, particularly if a multiple training model is being considered. I do not think that those debates have been expanded to their full extent. I am sure you are aware of the discussions about training for surgical practitioners. The state made a commitment to resource it, but the college said, no, the environment is not suitable. Training issues are a problem. We are aware that, historically, it is easier to do it in an environment in which there are more facilities. There is clearly some resistance to training support from the private sector and from smaller institutions, but we are looking to develop approaches to deal with that.

The CHAIRMAN: My final question on this section is about the evidence that sat behind the reconfiguration decisions. We are talking about the evidence coming into the Cohen report as well as the Reid report, particularly the extent to which relevant research and examination of models of care practiced elsewhere in Australia and overseas were considered and assessed as part of the decision making process. Can you provide us with some background on the range of evidence gathered, any conflicting evidence and the extent to which the position arrived at was based on evidence applicable to Western Australia?

Dr Towler: I will make a few comments about that to put it into context. If evidence to do with the question of a model of care is sought, Cohen went to substantial effort to look at the evidence that was available at the time, emerging from other states and internationally, relevant to the configuration of an obstetric service. He made a series of recommendations. Those recommendations are very much based around evidence on facility performance. The point I have been trying to make this morning is that I do not believe that any model of care - rather than a facility - has been in any way dismissed by what is going on. There is a strong view associated with the configuration we are proposing of providing greater opportunity to train general practitioner obstetrics. I think this is an issue, because we are moving into an area of appropriate credentialing and standards. The facilities decisions were based on a set of facilities-based evidence. I do not believe any model of care has been dismissed. Cohen goes on to cover that in the issues of community consultation and looking for a way forward. I think Hon Helen Morton's own comments in *Hansard* about the challenges facing us in the rural sector are particularly pertinent. The Denmark model, which has a strong midwifery-driven role, is something we need to explore to underpin the safe provision of service.

In the metropolitan area, where we are looking at a much broader context, there are lessons we have yet to learn. The facilities decision is to do with the evidence that favoured volume and outcome,

and looked towards the evidence that was available to Cohen at the time. I do not believe we have dismissed any model of care. In fact, I think we have actually brought into greater relief the issues of embracing broader models of care going forward, and that is the process we wish to undertake now, taking into account evidence like the Cochrane review, which raised questions about mortality outcomes. The idea is to ensure we create an environment in which that goes well. The evidence clearly shows that for uncomplicated deliveries, there are substantial options available. The difficulty is the prediction factor, and in creating an environment in which that can be appropriately addressed.

Hon LOUISE PRATT: I have a question about workplace planning, but I think you have touched on that to some degree. I also have a question that hangs, in part, from a number of things you have said; one of them is the prediction factor. Earlier you referred to the nature of services that might be viable in different locations. You mentioned how the need of different types of surgery or palliative care might be suited to different types of hospitals, and the necessity to locate them closer to the community. Why, in view of the decisions that have been made, is it not viable to keep maternity services at hospitals such as Osborne Park Hospital and Kalamunda District Community Hospital? I think I understand the logic, but I would like some expansion on that for the record.

Dr Towler: There is no question that there is a theme running through the decisions that have been made, which is about creating a set of nodes. It is the four. Kaleeya Hospital is now working well and may well be preserved into the future. However, options are available in the location of services to underpin the guarantee of a safe environment and of a training environment, and to underpin a review of models of care throughout pregnancy that can be supported. I have focused on the issue of facilities planning issues. Most of the episodic care for a woman who falls pregnant, has a successful pregnancy and delivers a live baby, is not "in-patient" anything; it is, in fact, care for a patient, or for a mother - let us not call her a patient. There is nothing about the current configuration that does not allow the examination of general practice or midwifery-led community-based service models, right through the period before conception and through pregnancy and afterwards. The model we have underpins the beliefs about safe practice and an appropriate training environment.

A number of substantial challenges surround the issues of workforce and resourcing. Care of the mother at the time of birth necessarily requires that there be emergency support for three clinical areas. The first is for the mother in delivery; the second is the potential need for an anaesthetist; the third is the potential need for someone to resuscitate the baby.

[12.10 pm]

We believe that this is a basic requirement. The extent to which that is needed when most of the deliveries are uncomplicated is clearly less. In fact, that actually produces another set of challenges. For the whole health system at the moment, it is becoming increasingly difficult to provide the appropriate work force for those acute care issues. The issue exists in general surgery. It exists in plastic surgery. It exists in orthopaedics. The basics for picking the number of sites and the volume of the sites are a work force model that is sustainable, and that creates a environment to support that.

There is also the issue that the more sites we run, the more call rosters we have to run. Although we could reasonably and appropriately expect that the person actually delivering the baby, and the environment in which that may occur, will vary, there is a clear responsibility for what happens if something goes wrong. That is not an excuse. It is a responsibility. The model that we have seeks to create an environment that gives a strong training base, gives us the opportunity to explore the way to support other models of care, and creates a training environment in which we can teach a variety of models of care. One of the difficulties in what we are seeing is that there is likely to be an endorsement of some change. We will need to create an environment in partnership with the universities and the community for how we train people for those roles. That in itself is a challenge.

The greatest work force challenge that we face in the Western Australian health system is not doctors; it is nurses. Most midwives come from a nursing background. We predict that within 25 years, unless there is a substantial change in the development of the nursing work force, the shortages that we are seeing now will pale into insignificance. The challenges faced by Australia in all levels of providing for a work force in health are substantial. Currently an additional 175 000 people join the work force each year in Australia. If we take out those who leave and add those who join, within 15 years that number will be down to 12 500. We will be competing with other professions and disciplines to attract people to work in health. That is a very substantial challenge. To underpin that, we need to create training environments in which people feel supported and supervised and in which we can create opportunities for diversity, and also help to address people's requirements for credentialling and training. It would appear to me from my reading on these issues and looking back at the Cohen report and at the thrust that came from the Reid review that there was a very strong emphasis on those decisions.

Hon ANTHONY FELS: This is a comment as well as a question. If you are closing these smaller community-based hospitals and concentrating on the secondary and tertiary hospitals, are you not reducing the availability of a work force to work in those hospitals? For example, in the hills where you might have GP obstetricians and specialists, they might be more inclined to retire early than have to drive all the way to King Edward to operate. The same thing applies to nursing staff. If you are able to draw them from the local community, would it not make it easier to attract them? Someone who wants to start a career does not want to have a catch a train and travel for 40 minutes to go to wherever they have to go to do their training.

Dr Towler: Sure. I re-emphasise two things. The first is that the amount of service that will be provided away from King Edward will be greater, not less. However, we are moving some of the nodes around. The same challenges are faced by the work force that will be displaced by the decision to close Royal Perth Hospital. There are very substantial challenges in work force realignment. It would not be my expectation that general practice obstetricians from Kalamunda would ever consider working at King Edward, but one would hope they would be interested in working at Swan District Hospital.

The CHAIRMAN: Is that possible at the moment?

Dr Towler: My understanding is that is the commitment. I want to go and check this out, because I picked up something from reading the *Hansard* report last night that I want to find out some more detail about. The Cohen report very clearly pointed to responsibilities for the organisation to continue to maintain and support the development of general practice obstetrics. That is critical. There no specialist obstetric work force in many rural centres. In fact, we are having great difficulty at the moment attracting obstetricians even to the major hub centres. It is therefore critical that we continue to provide an environment in which GPs can be trained in obstetrics. Cohen talks about the importance of a relationship with the Western Australian General Practice Education and Training Ltd. I am involved with that group at the moment in a program called community residencies. We are looking for opportunities to improve training options for general practice. Just as with the decision to change Royal Perth's future - the work force will need to realign - one of the advantages of a program like this, which seeks to identify a number of years in advance what the changes will be, is that it creates an opportunity for people to consider how they will participate. We have the same issue with decisions that will be made by some orthopaedic surgeons, and some other surgeons who are later in their careers, due to the fact that the change for them is disruptive and they will not go with the change. It is an issue for us. The transition management is actually particularly difficult. We want to create clarity on what the long-term view is so that practitioners can make plans for the future that take into account where they will have a long-term relationship. If you look at the outcome, more obstetric services will be provided away from the centre. The models of care that are linked to them can be variable. That is the discussion we need to have now. This will, I believe, create a much better environment in which to educate

practitioners, both nursing and medical, for roles in the rural sector, and for the provision of services away from the major central issues in town.

Western Australia has an extraordinary history of an environment in maternal care that has been able to identify the bulk of high-risk deliveries. It is an extraordinary statement of what goes on in this state that our outcomes match the best outcomes in the world, given that our people are spread out to the four winds. We have been expert at identifying high-risk deliveries. I am sure that one of the reasons that the outcomes in some of these centres away from the tertiary hospitals are so good is that we have a very strong culture of identification of high-risk delivery. That needs to be maintained. However, there is no doubt in my mind that the fundamental realignment that is proposed seeks to build a stronger community-based obstetric sector and provide the resources to that to develop other models of care. That will be much more difficult if we remain centred on King Edward as the principal provider. One of the great challenges for us is to ensure that the leadership and direction on these decisions is not determined by tertiary hospital practitioners alone. That is one of the reasons for the proposed very strong community-based consultation and the need to engage with exactly the sorts of practitioners whom you have focused on. I agree with you. A GP currently working in Kalamunda may tell me where to get off and decide he has had enough because we have taken his hospital away. However, the broad view is better community-based services and a longevity, taking into account the substantial risks with the work force and the need to develop appropriate training environments in which people can feel supervised. Young practitioners today are much more demanding about the supervision they get and the environment in which they learn than they were in the past. The model that says you throw someone in at the deep end and let them find out by trial and error is not acceptable. It is critical for us to create training environments in which we know that supervision is of high quality. The model that is proposed based on the Cohen report seeks to ensure that those sorts of environments exist much closer to the community than they have in the past, with substantial volumes of people and substantial expertise to create a sustainable work force that can then underpin a range of models of care based in the community.

The CHAIRMAN: It is after 12.15 pm, and we still have another set of questions that we want to go through with you. Just to finish off on that, have you received submissions about the Cohen report and the evidence that was the basis of that report and how that was dealt with?

[12.20 pm]

Dr Towler: Not that I am aware of; I will have to check.

The CHAIRMAN: Okay. Were any alternative options considered when the Cohen option was being put together?

Dr Towler: The Cohen report pre-dates the Reid report. I am sure you are aware that substantial sections of the Reid report recognised that the opportunity to do a comprehensive review of, for example, mental health, did not exist because that would require a substantial amount of additional work. My understanding is that the Cohen report was considered to be meritorious and that it was supported. As I said, it is a model of facilities, and it points to a process going forward.

The CHAIRMAN: We will start to look forward from here. We have touched on some of that.

Dr Towler: I think we have touched on it quite a lot.

The CHAIRMAN: One of the things we started to talk about was the Women's and Children's Health Service metropolitan clinical master plan. I do not think we are aware of that plan's terms of reference. Are those terms of reference available to the public?

Dr Towler: The Women's and Children's Health Service was engaged in what was called the metropolitan clinical planning process, which was a series of consultations with clinical groups across the metropolitan area. As such, I do not know whether it had formal terms of reference. It was seen as part of a continuum. It was the first phase of a planning process concerning the

development of clinical facilities in both the north and south metro. Therefore, it also included women's and children's services. Consultation with over 40 clinical disciplines was conducted by the Department of Health and representatives of north metro. We posed a series of questions around models of care and how a facility should underpin community-based services. The report basically tries to encourage clinicians and the organisation to ensure that the planning for our future facilities takes into account the changes that we consider will be important. In that sense it was a very focused first look. It clearly points to a process of planning - again, largely focused on facilities - to ensure that options for changes in models of care are supported by whatever we develop within the fabric of hospitals and community-based services. It was seen as an opportunity to derive two sets of information. The first was specific to areas, and the second posed questions of global planning. The reality is that the planning structure of the Western Australian health system is very similar to that of New South Wales. I suppose that is not particularly surprising. The Reid report strongly endorses the role of area health services, which take a population view, and, therefore, a lot of local planning becomes area based. However, the responsibility for more global principles of planning lie with the department and essentially with the division for which I now have responsibility. We are looking through the 40-plus submissions that were received. Some of them were extremely comprehensive. That underpins our process to go to a much broader consultation.

The CHAIRMAN: They were submissions from clinical people.

Dr Towler: They were clinical people. No provision was given in that first round to consumer engagement. It was an internal planning process to start the development of business cases for sites. We have recognised from the outset - much of my own commentary has been along these lines - that this is not a health networking model. It is my responsibility to ensure through the health networks that we not only consult with consumers, but also that they become embedded in our whole structure. Two or three networks are functioning and we have consumer representatives on the executives. They are a key element of what we are doing.

The CHAIRMAN: You mentioned that consultation in obstetrics was not robust leading up to the Reid report -

Dr Towler: It was not specific to obstetrics.

The CHAIRMAN: And that this process has not had any consumer involvement to date. I take it that the clinical services consultation and the clinical services framework was very clinically orientated. The point I am making is that a lot of the work is being determined before the community is given an opportunity to say what it would like. By the time the community is consulted, it is almost a fait accompli. The community will be involved by either supporting or not supporting it. It may be involved with education. How do you feel about the community - mums and dads - wanting a say in how they will have their babies in that process?

Dr Towler: The process up to now has focused on what has gone before. The process that has been going on within the organisation of WA health over the past 12 months has focused on setting up a series of business planning cases. As I said before, I do not believe that any model of care has been dismissed or adversely influenced by the process that we have at hand. The Reid report was released early 2004. It gave reasonably clear direction on the thinking of where the facilities would be placed. It is clearly my responsibility - and the whole organisation's responsibility - to ensure that consumer engagement is not just occasional; rather, it must be a fabric of our planning structures. I can assure you that in terms of a discussion on models of maternity care, we do not have a position in terms of, "This is the position we are taking to the community". Over the past few months we have been looking at the models of care across the world. They became very evident. In fact, one of the aspects of the metropolitan clinical services planning process was the extraordinary effort that was made to get evidence-based information for the discussions that were being held. That whole information program package will be made available through the health

networks in an ongoing discussion with the community. I have been tasked with leading and conducting discussions with the community and consumers on maternity care. We have just inherited that responsibility.

The CHAIRMAN: When did you inherit it?

Dr Towler: It came about largely as a consequence of Cohen, and the view that there was a link to the women's health service provider. In the first instance we sought, shall we say expert assistance, in developing the original framework. That was partly taken up in the metropolitan clinical services planning process, which led to the report that is before you. We have recognised that having the consumer consultation so closely linked to the statewide obstetrics services unit and to King Edward Memorial Hospital for Women is, with respect, probably not the optimum way to go forward. It is much more consistent with the role that I have in the development of health networks, which have a clear responsibility to engage not only consumers, but also the community and carers, who are often forgotten in these processes. We are putting together the community consumer carer consultation framework. In the first instance - given the tension among the professionals involved in maternity care - that will ensure that we have covered the scope. We are engaging the Health Consumers' Council for commentary around the way those questions are being framed. They are not directive. In fact, the whole aim is to be inclusive and to seek opportunities on discussions and alternate models of care in a comprehensive way. We must look fundamentally at what the community is seeking and we must try to marry that with what we understand to be the best evidence on safe outcomes. We clearly have a responsibility having the evidence on safety. At the same time, we have a clear responsibility to ensure that voices are heard so that we know what consumers, the community and mothers would like. We will seek to put the two issues together in a way that, if it is affordable, we will do what we can.

[12.30 pm]

I am hoping that the full community engagement process, which we are trying to define at the moment, will be very comprehensive and will take some time. We are committing substantial resources to this process. However, I do not believe the outcomes of that will be disadvantaged at this point by the decisions that have been made on facilities planning. I think, in fact, the opportunity exists through this process to start to make changes long before we have bricks and mortar in place.

The CHAIRMAN: Is it cast in stone that any of the current facilities planning, facilities-based evidence, or whatever you call it, the facilities planning issues or decisions that have been made, are able to be re-made on the basis of discussions and consumer involvement etc?

Dr Towler: I would like to be specific about what the questions are that you are asking.

The CHAIRMAN: Okay, then, be quite specific. Do you want me to be more specific in my questioning?

Dr Towler: I believe that the facilities framework has been outlined and my impression is that those decisions about facilities have been made.

The CHAIRMAN: And cannot be revisited as a basis of anything that comes from here on in?

Dr Towler: No. I think it is clear from what has happened in the discussions on the future of Princess Margaret Hospital that the things that were written in the Reid report and its outcomes are never necessarily written in stone.

The CHAIRMAN: So it is possible, for example, that Osborne Park might, through whatever involvement and whatever decision making process takes place here -

Dr Towler: I would say to you that I would think it was unlikely, given that there are plans to do other things with the site that meet other community needs and which are, in fact, substantially beneficial. There are real issues, as I am sure you are aware, concerning how much you can do in

any one location. Fundamentally, some of the directions taken from the Reid report are being refined and revisited, because when we have looked again there has been reason found to reconsider, and a lot of the reconsideration is actually going on around that ring of hospitals that includes Osborne Park, Bentley and Fremantle. We are beginning to understand that the subacute sector interface issues are particularly challenging and the mental health issues have resulted in very substantial planning on all those sites to improve certainly intermediate care facilities and post acute-stay facilities. A facilities review will go on all the time on the best evidence that is available; I have no doubt about that.

Hon LOUISE PRATT: I just have a brief question about something you have already touched on and I am just trying to get it on the record in a more succinct way. You talked about redirecting traffic from places such as Kalamunda to a centre such as Swan District to make the nodes there more viable around which to base training and a range of other workforce development issues.

Dr Towler: Yes.

Hon LOUISE PRATT: So if you have a smaller place like Kalamunda, is it that you are then not creating something that is big enough and close enough to the people to compete with King Edward or is it that you really need to redirect that traffic to those outer regional areas? I am just trying to work through the logic of that picture.

Dr Towler: Sure. It is a balance. Kalamunda is almost a unique case. Delivery numbers are around 500 deliveries a year. It falls in the middle range of deliveries. When you start from a commitment seeking to move services away from the centre and to identify a number of nodes so that we can support a strong work force group around those centres, there is a clear sense of just how many places in which you can do that. I think we acknowledge the quality of services that has been delivered at Kalamunda. The view, though, is to the future and to sustainability in terms of workforce, access and training. As I believe the models of care that we adopt are likely to change over time - I do not think there is any doubt about that - then the more centres in which you are trying to do that, the more difficult it becomes, particularly as you increase a community-based service. So the views here are about trying to strike a balance. I completely understand how people in Kalamunda would feel. I do not think there is any doubt about that. However, also as a Royal Perth clinician, I was a little rude to Professor Reid the first time I read the draft of the document, because it was very challenging to Western Australia's largest health service provider with a very strong history. However, the realignment of the health system to clearly meet the needs of the south metropolitan area, which has been inadequately addressed for a long time, leads to a series of corollaries. I suppose what I am trying to say as gently as I possibly can is that the corollary here is that Kalamunda is probably the outstanding example of where the pain is substantial.

Hon SALLY TALBOT: You have obviously had an extensive range of professional experience in terms of community consultation. I do not want to put words into your mouth, because you have given us a very succinct and eloquent exposition of the situation this morning. However, you have described a kind of polarity of opinion within the obstetric profession, the medical profession. Would it be fair to say that it is equally true to say that the community does not speak with one voice over the right outcome? Can you detect a reflection of that polarity in the community?

Dr Towler: As my clinical area is not obstetrics, I do not believe that I am as well connected to that discussion as I probably would want to be to make a reflection on it. In my reading, particularly as you can imagine in the last week, I have been going back to the comment I made earlier: clinicians, in fact, represent not only their own opinion but also that of the people they care for. I would say without a doubt that there are differences of opinion within the community. That is not different from anything; we have the same discussion on the delivery of cardio-thoracic surgical services and a number of other clinical disciplines as to what is the right view. A lot of it is about the balance between sustainability and safety with volume, and access closer to home. That is a very tricky balance and my impression from reading some of the material and certainly a little bit

from my own personal experience is that - and I think it comes through in Cohen very nicely - in a lot of ways a lot of the issues in the community are not just about the way services are configured, but the way in which people have been treated and managed and their experience. It is not just related fundamentally to the nature of the service; it has also been partly related to their experience of that service, and that experience can often vary widely. That is very challenging because we can all find examples of people who have had a bad experience, even in a very good institution. You can often find then many people have had a very good experience. So those sorts of community differentials are set up all the time. I have a number of friends whose families have had adverse experiences of Royal Perth Hospital and would not go there if you wanted them to. I equally know many, many people who believe it is a great institution and would choose to go there all the time. I think what I am seeing and my impression has been that you have that same diversity in community experience, because often it depends on a single episode of care. So I think the counsel of women who have had a number of babies and who have, I think, learnt to express their opinion with greater confidence are sending messages around the experiences they have had that need to be heard. I think it is very important that we capture those messages, but I do not believe to any extent that the community has a clear voice. The point I was making about women who have had a number of births is that the challenges are even more substantial for women before their first birth because the experience is largely unknown. Confidence and safety in those situations must be foremost in their mind, and we need to create an environment in which they can be confident about themselves.

[12.40 pm]

The CHAIRMAN: When will the maternity services framework be released?

Dr Towler: The framework? I think we have recognised that we need a much more comprehensive community consultation than we have had before. We are looking to address the models of care that have been well outlined through the metropolitan clinical services planning process and hinted at by Cohen. I think we will see a discussion document that frames a series of questions. After some recent meetings, we propose to have a discussion about what is called the pathways of care, which seeks to ensure that we look at the experience from prior to conception, right through the pregnancy to the period after pregnancy and which seeks to identify options for an individual if she has an uncomplicated pregnancy but also clearly demonstrates what happens if problems develop. The first process of ensuring that we have set up the questions will take us about another six weeks. We hope to then start a very comprehensive community engagement. I suspect that we will not have the answer until early next year, to be honest.

The CHAIRMAN: Thank you very much.

Hearing concluded at 12.41 pm