SELECT COMMITTEE
INTO PUBLIC OBSTETRIC SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
MONDAY, 7 AUGUST 2006

SESSION TWO

Members

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

Hearing commenced at 12.12 pm

BOETCHER, MS MARGOT

Member, Health Consumers' Council, examined:

DRAKE, MS MAXINE
Advocate, Health Consumers' Council, examined:

The CHAIRMAN: On behalf of the committee I welcome you to the meeting. 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 recorded by Hansard. A transcript of your evidence will be provided to you. To assist the committee and Hansard please quote the full title of any document you refer to during the course of this hearing for the record and please be aware of the microphones and try to talk into them. Please ensure that you do not cover them with papers or make noise near them and please try to speak in turn.

I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement 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.

Would you like to make an opening statement?

Ms Boetcher: Thank you for asking the Health Consumers' Council to appear before this inquiry. I am a long-term member of the Health Consumers' Council, and I was chairperson from 2000 to 2003. I have a strong interest in and commitment to women's health. The Health Consumers' Council is an independent community-based organisation that represents the consumer's voice in health policy, planning, research and service delivery. The council advocates on behalf of consumers to government, doctors, other health professionals, hospitals and the wider health system. To find out more, you can check our web site www.hcc-waglobal.net.au.

[12.15 pm]

Funded by the Western Australian Department of Health, the council provides a statewide service and has three principal activities. The first is individual and system-wide advocacy. The second is consumer-patient representative recruitment, training and support. The third is policy initiation and review. I would like to make some general observations about the subject of this inquiry. The Health Consumers' Council was closely involved with promoting the need for an inquiry into obstetric services at King Edward Memorial Hospital for Women. I refer to the Douglas inquiry, which produced its final report in 2001. You will remember that the Australian Medical Association vigorously opposed this inquiry. We have a strong focus on patient safety and quality of care across the whole health system. We note that consultation processes by all governments in Australia leave much to be desired. We recognise that the consultation with patients and their families in the planning of obstetrics services outlined in the statewide obstetric services review

document 2003 - that is, the Cohen report - was woefully inadequate. We are very happy to answer questions.

The CHAIRMAN: Thank you for those comments. Can you outline the consultation process undertaken by the Health Consumers' Council in relation to the Reid report?

Ms DRAKE: The Health Consumers' Council was contracted to provide a formal consultation process to the community for the Reid report. We were given nine months to do that and a certain amount of money. We contracted a project officer who conducted consultations throughout the state. An information pamphlet for health consumers was circulated throughout the state so that they would better understand the health system and better comment on what they thought needed to happen. The response to the consultation in all the areas in which consumers were invited to participate was not as high as we would have liked it to have been. We concluded that that the lead time needed for serious consultation in which the community is invited to make intelligent and informed comments is considerable. We did not have the time we would have liked to get a better response from people and to feed them enough information to extract some good comments. Consultation of the order that was needed would have taken a couple of years because of logistics - that is, how long it takes to get information out and back in, and how long it takes to get people out to country areas to undertake the consultation and to spend time attracting people to a topic that largely is fairly dry, unless it is well packaged and people are exposed to it a fair bit. Of course, consultation processes have high expectations and are often disappointing. Although we were very pleased and proud of everybody who participated, we would have liked a far greater volume of people so that we could have gained a greater sense of some representativeness. The other consequence is that you get a fairly vanilla population reply - that is, the people who respond may not represent the full diversity of the Western Australian population. Greater effort is needed to reach those people and again that takes time.

The CHAIRMAN: Knowing the subject that is of interest to the committee, can you indicate how broad the consumer consultation was and, secondly, how specific it was, especially with respect to the changes that were being considered to obstetrics?

Ms DRAKE: It was broad consultation so it did not necessarily go down to the level of detail to address services such as obstetrics services. Certain populations are very difficult to consult when it comes to health service planning. One of those is the people who are the consumers of obstetric services. When a woman is pregnant, she is focused on her pregnancy. After a woman has had her child, she is more likely to be focused on the services that relate to the child's age and period of development. The Health Consumers' Council has always been mindful that expressing any view in the public arena about obstetrics, childbirth and maternity services has to be viewed in the context of the fact that we mainly hear from self-appointed representatives of that consumer population. I refer to midwifery groups or groups that are a combination of midwives and consumers who are interested in various aspects of maternity services. It is extremely difficult to gain a clear sense of the views of consumer populations when it comes to maternity services. I am not aware of any dedicated effort to reach that population. Our view is that the Cohen report was fundamentally a survey of services from the provider perspective and that the level of information that would have been gained from the consumer perspective would have been negligible. One of the difficulties with the response to the Cohen inquiry was that it was a forceful view from a service provider resource perspective. There was no evidence from the consumer perspective. As the Health Consumers' Council needs to make a deliberate effort to access certain populations for particular questions, we had not been asked so we were not in a position to give a forceful consumer view in reply.

The CHAIRMAN: Has your view changed with regards to the current arrangements that are taking place with the reconfiguration of obstetrics services in relation to consumer consultation or people's informed consideration of that at the community level?

Ms DRAKE: As Margot said in her introduction, the council's first principle is safety and quality of health care services. In a situation in which we do not have a definitive view of a consumer perspective on a particular issue, we have to take the higher order principle of safety and quality as the first point of reference - unless, of course, we were to ask women in rural areas, "Given the service resources available in your area, are you prepared to trade off some units of safety and quality for accessibility and proximity to your family during birthing?" We do not know the answer to that question. We have to take an academic approach. Is it reasonable to expect people to trade off safety and quality for accessibility? If we do not have an answer to that question, we would have to say that safety and quality is the primary issue unless we have evidence that there is sufficient resources to support accessibility. I do not know whether that is too long-winded an answer. In relation to obstetric services in Perth, we have to say that, as a first principle, safety and quality is a primary issue. The strongest argument that was put forward by the authors of the obstetric services inquiry was that unless there is a sufficient throughput, particularly in birthing units, you cannot guarantee safety and quality. If a senior clinician is making that statement and you are not aware of the evidence that they are bringing to bear, you have to be brash, arrogant or well informed to argue against it. In a way, the Health Consumers' Council's response had to stop at an impasse after that report was issued because the argument from the clinicians was that unless we have a certain number of births in certain units, they are unsafe. The council could not go forward and say that it supports fewer births in certain units knowing that it might be less safe for consumers. Would you support that, Margot?

Ms Boetcher: Yes, I would. What happened in the 1990s and late 1980s when they were changing the birthing process right around the state was interesting. At that time we were told that it was all about numbers. Small country hospitals were closed and women were told that they could not give birth in them. In Northampton in the late 1980s, I was part of that process. We fought tooth and nail to keep our hospital as a hospital, not a health centre. We lost. The district hammered members of Parliament. Kim Snowball, who was the director of health at the time, was involved, yet we got nowhere because the decision was taken away from the community. At that time I was getting calls from women in Exmouth, Carnarvon and other remote areas who were absolutely horrified by the thought that they would have to leave their families and travel to a bigger centre to give birth. That process kept happening. The smaller centres have pulled back and have been demoted. Women are told that they have to move and people have adjusted. However, I do not think that that is what people in the country want. I lived in the country for 30 years. I know that they do not want that, except if they are told that they may experience problems during the birth. In those circumstances, they are happy to go to a specialist service in Perth. However, if they are going to give birth normally, they do not want that. Women experience different levels of problems.

[12.30 pm]

If they are going to have a normal birth, why can they not have it in their normal small hospital? We were asking those questions and we were given statistics, as Maxine quoted. I think it is the case worldwide that the greater the number of births in a centre, the less mortality in both mother and baby. It is about those statistics; it is not necessarily about what women in the community want. As far as I know, nobody has done a survey in Australia about what pregnant women want. We are told what we want, which is about statistics and what is safe. People just fit in with that because they have to.

The CHAIRMAN: What were the barriers or problems you had with the consultation process on the Reid report?

Ms DRAKE: Why are we discussing the Reid report?

The CHAIRMAN: The Reid report picked up the Cohen report without any alterations and immediately adopted it. I understand that the Health Consumers' Council was contracted to

undertake the community consultation for the Reid report, not the Cohen report. My question is: were there any barriers or problems with the consultation process and, if so, what were they?

Ms DRAKE: Would you like me to focus my comments on obstetric services?

The CHAIRMAN: Yes.

Ms DRAKE: We were never given a specific brief to look at obstetric services as a particular issue. Had there been a weighting in the contract to look at particular issues to a certain depth we could have proceeded to perhaps consult on those issues, but there was never any specific reference to consult on obstetric services, and that would have taken a very deliberate approach. As I said before, accessing that population is extremely complex.

The other issue is that the organisation of health services generally occurs in a manner that reflects where the power rests. In relation to obstetric and birthing services, the power rests with the established medical authority and the established medical system. The organisation of obstetric services has followed a path that has become specialist and tertiary-focused and moved away from birthing in the community and settings that are closer to the ground and closer to the community than a lot of advocates for birthing services would like. In the early period of the Health Consumers' Council there was a source of funds available for women to access what was in a sense a proxy Medicare fund for birthing in the community with the assistance of independent midwives. That fund was never able to be accessed by women because the protocols were not put in place to allow the women who might birth in the community to have access to the hospitals. The obstetric practitioners blocked access for those women to enter hospital if they had a crisis. No woman could enter that program if they did not have a high-risk plan and option in place to move into a tertiary facility.

What we have always seen in this state is that the obstetric practitioners will dictate the access to any alternative form of birthing practice and that will contain services and create an almost irresistible pull towards tertiary facilities. The Cohen report was delivered in the period after the Douglas inquiry. There was almost a process of going through the motions, with the greatest respect to the people who participated in that process. It was the wrong time and it was asking the wrong questions and it was not going from the right base. If there is going to be a serious examination of obstetric services in this state, this might be the time to start with a blank slate approach and genuinely approach the population of Western Australia for the next two years perhaps to talk about what birthing services could look like in this state if we all approached it with an open mind. There are people in this state - migrants from other countries - who have seen extraordinarily different approaches to birthing, but we do suffer from an isolationist "can't see the wood for the trees" mentality in Western Australia about birthing. It takes a single statement from senior practitioner in an article about alternative birthing practices that says anybody who thinks that birthing outside a hospital is low risk really does not care about the safety of the baby and the mother. We could pull those single statements out from article after article, demonstrating how powerful that profession is. It stops the debate in its tracks and from going any further in Western Australia. That is the circumstance we are in at the moment.

The CHAIRMAN: Do you believe that the general community or even a subset of the general community that is interested in birthing was aware of what was being proposed by either the Cohen report or the Reid report in reconfiguring obstetric services?

Ms Boetcher: I would say not.

Ms DRAKE: One of the problems with reports is that they create a fait accompli decision-making process. The announcement is made that Kalamunda and Osborne Park - the peripheral hospital services - will be shut and the community thinks, "What's the use of arguing, because it's already been decided?" The purpose of consultation is to float those ideas before decisions are made. When the Cohen report came out and the media workover was done in that period to get the

message out, the community would not have seen that there was any option, because the power of the bureaucratic machinery had already made up its mind.

The CHAIRMAN: Is there anything that the Health Consumers' Council said or did to alert the general community to the potential changes in obstetrics?

Ms DRAKE: We have not taken a high profile in the media on this issue because we have not had the consumer authority to do so. As a matter of principle, the council talked about consumer choice and consumer focus in decisions or services so that at least we were talking to our constituency, which is health consumers, about their entitlement to have some choice and some say.

The CHAIRMAN: Was there any feedback or follow up from the community about obstetrics in any of the feedback that you received?

Ms DRAKE: I could not answer that question with enough authority.

The CHAIRMAN: When you provided your information to the Health Reform Committee, did you receive feedback from it about how your information was dealt with?

Ms DRAKE: Not that I am aware of.

Hon LOUISE PRATT: Clearly, the Reid report asked to have certain clinical areas rationalised according to different locations based on throughput. You have already passed comment on that. What was your general view about how the clinical services areas were rationalised in terms of the locations at which they could be provided? How do you provide consultation on big issues like that, particularly as you have said you have to make clinical safety a priority? What was the general view put forward by the Health Consumers' Council on that?

Ms DRAKE: With regard to the conclusions of Reid about rationalisation of services?

Hon LOUISE PRATT: Yes, and where they are located.

Ms DRAKE: The Health Consumers' Council was pleased to be involved in the Reid report consultation process over the period of the year that Mick Reid was in the state because it was a good sign of recognition of the role of consumer participation to have our organisation involved. Professor Reid himself appreciated having an organisation on the ground that could do this. The Health Consumers' Council followed the report process and gave general in-principle agreement to the bulk of the recommendations within Reid. The reason for that was that we had been a party to the discussions and it was generally in congruence with the comments being made, given that the comments being made by consumers in a consultation process like that are not of great specificity. People fundamentally supported services closer to home. It is profoundly illogical to have four major hospitals within three clicks of the GPO when most people live much further away. The reorganisation of services to bring services closer to home and to have hospitals of a size that could support diverse service delivery made a lot of sense. One area of possible disagreement was the closure of Royal Perth Hospital, given that very few cities in the world would not have a major hospital right in their centre.

Generally, the Health Consumers' Council supported the thrust of Reid. Another reason for that was that community and health services are suffering change and reform fatigue. Unless there was a concerted effort to get behind at least a blueprint that represented a way forward, we could have ended up sniping endlessly over details and having decisions made on an arbitrary basis that did not follow a plan. Part of our commitment was also to keep government to the plan. When there was variation away from it, like a sudden decision to put a heart-lung transplant unit in Royal Perth when it was not in the Reid report, we made public comment about that. We took it as part of our role to monitor that at least the plan got followed, because why invest all of this energy in a plan if we are not going to follow it?

Hon LOUISE PRATT: In the case of the Kalamunda District Community Hospital, where maternity services have been moved further away from where people live in exchange for services

that the system thought was better to have closer to people's homes, such as palliative care, certain types of surgery and mental health, I can see that you would not necessarily seek to make specific comment about that level of trade-off.

Ms DRAKE: We would be more likely to comment when there is a clear position to push. In the case of Kalamunda, when the numbers of deliveries are not necessarily occurring there and there is no certainty of general practitioner support and general practitioner service delivery to that hospital, we might be pushing for something that is unattainable anyway. Sometimes there is a difficulty that we have to suspend comment or not comment on if we are not certain about what we are making a statement about.

Hon LOUISE PRATT: Now that there are a range of clinical services areas, I assume that the Health Consumers' Council is involved in the future framework for community consultation. Do you have any comments to pass with regards to how that is coming together and how within, say, the Women's and Children's Health Service there might be a framework for community consultation that would pick up on putting together proper consultation in relation to maternity services? In the area of maternity services, despite the fact that clinical location decisions have been made, the reform process might still see a reasonable amount of flexibility in relation to reconfiguring the levels of care. There are probably two questions there. One is the comment about the general framework for consultation in the clinical service areas, and specifically how obstetric services and maternity services could and should be consulted on.

[12.45 pm]

Ms DRAKE: Are you happy for me to comment?

Ms Boetcher: Yes, I will add if I have to.

Ms DRAKE: The Health Reform Implementation Taskforce has always expressed commitment to consumer participation and consumer involvement. It meets regularly with the Health Consumers Council's executive director to talk about those issues. Consumer representatives are placed on all the clinical networks through either our organisation or any other source that those representatives can source. There is consumer involvement in the implementation process. The quality, the penetration and the effect of that consumer involvement is a very big question. It is a big question across the whole health system. How much influence does consumer participation actually have? The other question is - if we remove it, are we worse off? I would say, be in there; participate and rally and say what needs to be said even if one is not sure whether there will be an effect. There is consumer involvement, which is probably to a good level in Western Australia. We are fortunate enough to have a health consumer organisation that those people can be trained through and sourced. What was the other question about?

Hon LOUISE PRATT: Maternity services, specifically. I think you have already answered the question in part. It is not about a broad scale sense of how we ideally involve the community in models of care and what kind of service they want to receive. If you were to run an ideal community consultation around maternity services, what would it look like?

Ms DRAKE: It would be a fantastic thing to frame a consultation process around maternity services, but you would have to go right back to basics because people do not know what is possible in Western Australia - they do not know what is possible. There would need to be two or three years of talking to the community about what is possible in birthing; that is, what birthing can look like and what it does look like in other places around the world where alternative models are proposed. If, for example, in the Kalamunda hospital situation there had been a commitment to establish midwifery-led care in a clinic in Kalamunda, it would have changed completely everybody's perspective on the Kalamunda issue. If we are just going to continue to scale down a service that already does not meet people's needs very well, what is there to fight for? If there were an opportunity to fight for a different model of care in those services, the community would have

come behind it. People were told more or less of the same. That is what we are fighting for. That is still not meeting people's needs for all the antenatal delivery and postnatal services that are needed for women to be delivered by a familiar face, for lots of information, for plans that are going to be followed and for practitioners who will be there. It would be a beautiful thing for Western Australia to commit in the next few years to a consultation process for the community on what maternity services should look like in this state.

Hon ANTHONY FELS: You made earlier submissions to the Reid report. The interim report then came out. Did you then make another submission prior to the final report? How much time was there in that period for them to consider your submissions and address those issues?

Ms DRAKE: I am sorry; I cannot give you specifics.

Hon ANTHONY FELS: Did you feel that there was sufficient time in that period to go through your -

Ms DRAKE: We were sufficiently involved throughout the whole process to feel confident that any comments we needed to make would be taken into account. Whether, in fact, they are included is another matter. Both the consultation process that we undertook in a formal contracted way went in for consideration as well as the comments that the council had to make. We followed the process of the report, interim and final. We were very involved all the way along. We felt confident that our views were taken into account.

Hon ANTHONY FELS: Did you feel that a lot of those views were addressed in the final report?

Ms DRAKE: I would be comfortable in saying yes. We were confident they were taken into account.

Ms Boetcher: I agree with that.

Hon ANTHONY FELS: Do you believe there will be an improvement in the efficiency of obstetric services in the state with the move towards concentration in tertiary hospitals? That is apart from how user friendly services are and all that sort of thing. What about the efficiency of the resources available and the specialists and everything along those lines?

Ms Boetcher: I imagine with efficiency of resources that one would assume the answer is yes. Apart from that, I would not like to say.

Ms DRAKE: Are you saying that resources do not necessarily reflect consumer satisfaction?

Ms Boetcher: Yes, I do not necessarily think there is any link at all. There is provider satisfaction, which is not the same as consumer satisfaction. I think one of the interesting things about the Cohen report was how much they identified their struggle to provide services. That is probably surprising to some consumers but not to others who are seeking those services because there seemed to be an inference in the Cohen report that they may have to recruit overseas or that they are recruiting overseas. There is difficulty in getting providers where they are needed.

Ms DRAKE: I have to say as well that the Health Consumers' Council was, in a sense, an antagonist for the Douglas inquiry, which meant that we were set in some way in opposition to King Edward Memorial Hospital during that period, which was extremely difficult. All credit to King Edward: we were involved as well on the implementation committee for the King Edward inquiry recommendations. All along the Health Consumers' Council has looked for evidence of change in the culture at King Edward that might reflect some effect from those recommendations. It is looking, desperate to find that change, but not necessarily seeing it. To see a report that then re-establishes King Edward as the centre for obstetric services in Western Australia was very disappointing because we did not feel that the multimillion dollar inquiry, in fact, led to any change. The people who presided over King Edward up to the period of the inquiry and during the period of inquiry continue to preside now. They were even involved in the formulation of the report for the future of obstetric services in Western Australia. Given the effort that we put in, it was probably a

point of exhaustion to wait to see what forces other than our involvement might lead to some change in the King Edward and maternity services issue. The Health Consumers' Council approached support for King Edward with the view that, in a sense, it is a sacred site because many generations of Western Australians were born at King Edward. Lots of people hold it in fond regard. Other people avoid Subiaco because of the experiences they have had, which is fair enough. We expected to hear a groundswell of support from the community for the retention of King Edward. We have heard a deafening silence. I do not think that King Edward has reinstated itself in the community's confidence as a result of anything that it has done since the inquiry. I think that we are in a holding pattern regarding obstetric and birthing services in Western Australia until something comes along to shift the situation we are in at present. Perhaps this process might lead to that shift. Nothing from within King Edward is driving for change. No force from outside it at the moment is driving for change. We are just holding the situation as it stands. Given some of the complaints we have had about services at King Edward, we would not be confident that there has been significant change in the situations and the conditions that led to the Douglas inquiry in the first instance.

The CHAIRMAN: And consequently to the Cohen report.

Ms DRAKE: And consequently to the Cohen report.

The CHAIRMAN: My sense of it is that the Douglas inquiry came first, then the Cohen report, which was fully adopted by the Reid report. That was then incorporated into the clinical services plan framework. In that respect, the health department web site states that given the breadth of the consultation during the Reid process - understanding what Reid said previously about the consultation with the community during the Cohen report being woeful and that the consultation with the community about the Reid report did not have sufficient lead time and was non-specific to obstetrics anyway - and the purpose of the clinical services consultation for the clinical services plan, the Health Consumers' Council advised that consultation would be best directed to clinicians with ongoing information provided to the community. This is the difficulty. Why did the Health Consumers' Council think that consumer consultation was not appropriate or necessary at that stage of the process?

Ms DRAKE: Are you talking about the development of the clinical networks as part of the implementation of the Reid report?

The CHAIRMAN: No, the work that was undertaken immediately after the Reid report, which was the clinical services framework. That was then translated into the clinical services plan.

Ms DRAKE: There would have been no way to have meaningful consultation with consumers about that complex area of service development. We attended all the clinical service network meetings - all the meetings on all the clinical areas - leading up to the clinical services plan. The complexity of the information and the detail was overwhelming. It would not have been worthwhile at any point to get consumers involved in that development. Neurology services for acquired brain injury or for tumours, what can we say in terms of a consumer perspective on those issues?

The CHAIRMAN: To what degree do you think that the changes in obstetric services reflect the government's desire to militate against potential litigation?

Ms DRAKE: I think that the government is hostage to the entire community's fear about loss of children and death and the assumptions about the infallibility of medicine. The entire community has a focus on the miracles of birthing and minimising any type of harm during birth. I think that if we had a consultation process for the community on obstetric services it would have to address all of those issues of the reality of birthing. How can you have a stillbirth in a First World country and the birth of a baby in a tree during a flood in a Third World country? What is the mystery of birth that we all need to face? Litigation certainly drives a lot of activity, planning and decision making

to do with birthing probably as much for consumers in terms of thinking about preventing harm and preventing loss as it might for government. We would say that medico-legal defensiveness would form an enormous part of the planning for birthing services, probably based on people's lack of understanding of the complexities of birth and the simplicities of birth. I think that Western Australia generally has a very low level of literacy about birthing and maternity services and that the government would just reflect that in its approach to handling deliveries. Does that make sense to you?

Ms Boetcher: Yes, it does.

Ms DRAKE: We are dealing with birthing in the medical model anyway, which is not necessarily about wellness - it is about illness. We have to start to shift our thinking away from the biomedical-hospital focus model anyway. Until we start to do that and really look at the realities of risk in birthing, we will continue to do what we are doing now.

Ms Boetcher: When various people in the community and some providers, such as midwives, try to suggest there are other models, all we hear is, "Do you want your baby to die; do you mind?" It becomes that sort of emotional blackmail.

Ms DRAKE: It is very hard to sort the propaganda on any side from what might be true. It is very hard to know whether homebirths in Holland might have a high level of risk, and if we reproduce a similar model here, whether that level of risk would be satisfactory to the community. It is hard to know where we stand in Western Australia. We do not have a strong consumer voice in maternity services. As soon as we see a statement about birthing from a midwife, we automatically know we are hearing from a provider and that there may be vested interests and we may be hearing propaganda and we do not know quite what to believe. There is a suspension of belief. That is the situation we are all in.

[12:59pm]

The CHAIRMAN: This is more of a comment than a question. Do you think that, after the event, the record of what has taken place in New Zealand, where nearly 80 per cent of women are now choosing to use midwifery birth rather than engaging a medical practitioner to assist with it, is an example of listening to the vote of the people in some respect?

Ms Boetcher: I think that is true, but I think it is also true that there were certain providers who were part of the process. I do not quite know how the whole thing works, but my understanding is that it was a community plus a provider move towards midwifery in the community. There were a certain number of people within the health provider system driving that, as well as the community. I do not think that that is true here.

Ms DRAKE: We have to remember that it is a marketplace as well. When there is demand for limited services, the supplier can charge more. Obstetricians are in a marketplace. They have a vested interest in keeping services closer to them and being in control. To suggest that they would actively open up the marketplace to competitors - midwives - is kind of farcical given the militancy of the medical population in Western Australia. We have one of the toughest doctors' unions in the country. They are militant about protecting the terms of conditions of their union members, and that involves midwifery as much as it does anything else; that is, keeping certain providers out of the marketplace. I do not think we can ever forget that that is the dynamic we are operating in.

Hon LOUISE PRATT: Do you think that a decent consultation process can help build a mandate to help take on those vested interests?

Ms DRAKE: Absolutely. I have no doubt that a decent consultation process provides the authority to start to do things differently, and to really respond to some of the return propaganda that must be coming from some of those vested interests.

Hon LOUISE PRATT: It has been flagged that the Women's and Children's Health Service will be releasing a consultation paper on maternity services at some point in the future. I think it is already due for release. Has it actually been released yet?

The CHAIRMAN: At the time we were in Parliament, the response was two months. The two months' time frame must nearly be up.

Hon LOUISE PRATT: Have you been approached about being involved in consultations around the release of that paper? I think it is due for public comment in some way. If not, or if so, what kind of resources would be required to undertake a consultation around the issue of maternity services and models of care?

Ms DRAKE: We have not been approached, but to respond to a consultation with another consultation process is probably fairly tokenistic. To be involved in a blank slate - that is, starting and framing a brand-new consultation process across the state on these services - would be a much more productive way to start. Sure, we could receive a consultation paper, and we could send it out to people as we might any other paper, but the richness of that response would be fairly tokenistic.

The CHAIRMAN: Thank you very much. That was very helpful.

Hearing concluded at 1.04 pm