# SELECT COMMITTEE
# INTO PUBLIC OBSTETRIC SERVICES

**TRANSCRIPT OF EVIDENCE TAKEN**
**AT PERTH**
**MONDAY, 7 AUGUST 2006**

**SESSION ONE**

**Members**

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

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**Hearing commenced at 11.10 am**

**FORD, MS PRUDENCE, 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?

**Ms Ford**: Yes, I have.

**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 documents you refer to during the course of this hearing and please be aware of the microphones and talk into them. Ensure that you do not cover them with papers or make 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 a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege. Would you like to make an opening statement to the committee?

**Ms Ford**: I will not make an opening statement because I am not really sure what the committee wants to know and it may be more efficient if I am asked questions. I advise the committee that, while I worked in Health for many years, I resigned as a public servant in January this year and I am now a private citizen. Any comments I make cannot be attributed to the Department of Health and I will try to be very careful to only make comments in my capacity as a private individual.

**The CHAIRMAN**: I know you and I know the role that you have played within Health but it may be worthwhile if you provide the rest of the committee with a background about the level of work that you performed at Health so that people know where you come from.

**Ms Ford**: I have been a public servant for 30 years. The first 22 were in the commonwealth, significantly in Health but also in Finance and Attorney-General's, and the last seven to eight in the Western Australian Department of Health with a period of secondment to the Department of the Premier and Cabinet. In the health department, I started off being general manager of the public health division but within 10 months moved to run finance and infrastructure, which looked after the finance area, strategic planning, capital works and a range of other things such as parliamentary liaison and ministerials. After I did that for a couple of years, I was seconded to Premier and Cabinet and worked on the functional review of government. One of the recommendations in the functional review report was that the Department of Health have a separate and specific review to look at priorities and direction setting. At the conclusion of the whole of government functional review, I went back to the Department of Health and a few months later I headed the secretariat for the Reid report. I did that while running my normal job, where I was a senior executive responsible for strategic planning, human resources, capital works and a few other things. Following the Reid report, I was seconded back to Premier and Cabinet to work on the shared service centre, which had been another recommendation of the functional review. I spent about 12 months doing that. The current Director General of Health asked me to be part of his senior executive team to run the health system and to implement the report. I came back to the department and for the first six months was responsible for policy planning, finance, capital works etc until we got the department more

structured and organised and got a chief finance officer and a clinical policy head. I did that until I resigned in January this year.

**The CHAIRMAN**: Is it correct that you have acted as the Commissioner of Health in WA?

**Ms Ford**: Yes, I have acted as Commissioner of Health for periods.

**The CHAIRMAN**: I wanted people to understand the senior role you had in the department. Looking more specifically at the Reid review in your role as a public servant, can you provide the committee with a brief outline of your role with the Health Reform Committee? Could you describe what that role entailed?

**Ms Ford**: Officially I headed the secretariat. As you will be aware, the committee was chaired by Professor Reid, who came from New South Wales. The Under Treasurer represented the minister's office and there was a representative of the Premier, who was somebody from Premier and Cabinet. They were all very senior people. Professor Reid tried to come over weekly or every 10 days. He would spend a few days here at a time. Under that kind of environment, committees generally work very closely together. It was a very intense period. It was a very short space of time to do such a major review. My role was to work with that group very closely, to organise all the support that they needed, and to participate. I participated in all their discussions and provided a link between the health system in the broad, the department, the area health services and the members of the committee. I played a technical role in providing information support, data, making sure it was analysed properly and prepared in a way they could deal with and understand it. I had a team of people working with me. I played a role in the process which was perhaps more involved than that might suggest.

**The CHAIRMAN**: The Health Reform Committee recommended that the Cohen report recommendations be supported and implemented but the Reid report does not provide details about the committee's deliberations or the process undertaken in making this decision. I have a series of questions that I would like to ask specifically about that. How did the committee reach its decision to adopt Cohen's recommendations? Did the committee review and assess each recommendation? How did the committee decide to adopt Cohen's recommendations?

[11.15 am]

**Ms Ford**: The whole operation of the committee and the total report was an evolving process, if you like. The committee was very concerned that it should present a blueprint for the future and that that blueprint should be internally consistent. It tried to take a holistic view of the system to make sure that each recommendation fitted in to some totally consistent package. When it came to looking, for instance, at Harry Cohen's report on obstetrics as part of what the system does and what the blueprint should be for the future, consideration was both specific and general in terms of where does obstetrics fit with our view of what a twenty-first century health service should look like. This is from reading Harry Cohen's report and some notes he made on consultations he had with people and looking at other bits of feedback we had.

Please stop me if I am going on too much. It is a dilemma when a person has worked in a system for so long that she might talk about things that people are not actually interested in! I am still passionate about health.

When we looked at the system, we said that we have to balance a range of things. We are obviously trying to provide the best possible care, safety and quality and accessibility with efficiency. A growth rate of nine per cent per annum is not sustainable for the state in terms of cost. When we were balancing those things, it got us to look at whether a better role delineation for our hospitals would help with training, safety and quality issues etc, but also with efficiency. When we got to that point, we had to start looking at what happens in a health system and what needs a physical building, as opposed to what is done in the community. How do we organise the needs of a hospital? We got to that end of the spectrum. We needed to get a package of services that made

sense to deliver. In looking, for instance, at a range of services, including obstetrics, at the high-cost end of the spectrum and to provide a good quality service, we need not only highly trained staff, but also teams. We need obstetricians, nurses, radiographers, sonographers and all those areas. We need equipment and anaesthetists. Anaesthetists are an issue in this state, or at least they were at the time. Specialists in general tend to be difficult for us to get and have to be planned carefully. So when you start to say that you need that sort of team mix, you look at what other services need that team mix and how do we get the best anaesthetic equipment. Those staff do anaesthetic work for other specialties so we have to ask: are we starting to package together? We looked at the specifics. Obstetrics affects huge parts of the population - that is, women and their partners.

Safety and quality was a key thing of the report. I hope that comes out when people read it. Obviously, that is a critical issue in obstetrics. WA has a very good reputation, but, obviously, it is a critical part of the system. Clinical governance is being talked about more and more. People now say "Yeah, sure" about clinical governance. Even two or three years ago when the committee did the work, we would go to meetings and people would ask what we actually meant by clinical governance. It was still an evolving and new concept for some people. It was critical to us to get adequate clinical governance across the board. The committee looked at obstetrics. As part of my support to the committee, we found every document we could and every other piece of work that had been done recently across the board. Obviously, Harry Cohen's report was critical there. The committee read all of that material and factored all that into its thinking. As we moved in the last eight weeks, we tried to put it together. As I said, we tried to map the total system that was coherent. All that then came back in in a more general way in terms of role delineation. They came back and said that what he said in that report makes a lot of sense in terms of what we think ought to happen in the system more generally in getting a better role definition for our hospitals.

The other thing that the committee looked at a bit was that Harry Cohen's report had been out for consultation. I am relying on memory here. I think it was shortly before the reform committee went out for its public consultation. The report had been out in the public arena. We had all been surprised at the relatively good public acceptance of it. As a very senior bureaucrat in the system, I thought that Harry Cohen's report would spark a lot of attention and outcry. I imagined some of our media outlets would jump on it with glee and use it to create a lot of debate. We did not see a lot of that reaction. There had been our lot of public comment, but not all of it by any means stated that it was the most wonderful thing since sliced bread. A lot of it picked up issues about Woodside, and Kalamunda and Osborne Park to a lesser extent. On the whole, in terms of health issues, there had not been a critically negative response. There had been quite a lot of positive comment about the directions. The committee noted that and said that that was great; it could now put that in its picture. That is how the committee dealt with it in a descriptive way.

**The CHAIRMAN**: I am interested in the area you are talking about with the level of public consultation around the Cohen report. I am not familiar with that public consultation. I know that there was a huge amount of clinical consultation. The report talks quite specifically about the level of clinical consultation that took place. Are you able to remember what the public consultation process consisted of?

**Ms Ford**: I sort of can, although I cannot remember the details. I can remember the broad-based approach because it also influenced the committee in how we consulted for the Health Reform Committee's broader work. The public consultation consisted of Harry Cohen doing a couple of media interviews to announce that his report was on an Internet site. He invited people to make comment. He did those media interviews. Obviously, the people who picked it up most were those who were directly interested; it rang an immediate bell. They were people who were obviously closely involved with obstetrics in some way. It did attract letters and submissions from individuals who had no connection with the health system other than having had a child or some patient relationship with the system. From memory, there were not a lot of those. I was not involved in

that aspect; it was handled by Harry Cohen and his team. When we sought feedback from that aspect, he was very clear that he had some of that reaction, but not a lot. As I said, the reason I can recall that much was because it influenced what the Health Reform Committee decided to do in asking the Health Consumers' Council - which is the approach we took - to try to organise more broad brush consultations. We had discussion papers written. We put them on the web site. We tried to engage the media in some discussion of that. Based on some of Harry's experience, we thought that it was not going to produce a lot of consumer comment, although it would produce a lot of clinical comment.

[11.30 am]

**The CHAIRMAN**: You also mentioned that the committee sought further information and reviews of other documents and reports on obstetrics. Did I get that right?

**Ms Ford**: Yes. Generally, we tried to find whatever we could. As I said, I had a secretariat team that tried to pull whatever it could of recent documents.

**The CHAIRMAN**: I understand that Harry's work was very much related to the UK health system. I wonder whether you obtained other Australian documents and models, and considered approaches or recent research from New Zealand?

**Ms Ford**: We did in general but not in the specific. In its report, and earlier in the process, the Health Reform Committee said to itself that it could not possibly do the detailed work in the time available to actually plan every service stream. A lot of that work has subsequently been done with the work on bed numbers and what have you. Therefore, we looked at the organisation of health systems and the delineation work in other states, particularly in New South Wales and Victoria. We considered how they generally organised services with splits between community-based and hospital-based services, if you like. Obstetrics was mentioned in lots of those areas because of the community-based obstetrics push across the country. The midwives are very active across the country, and particularly in Western Australia, in presenting a view that the system should be skewed more to the community-based midwifery end than is currently the case across the country. However, we did not write for the committee volumes and volumes on obstetrics because we did not write volumes and volumes on surgery or anything else; we reported more in the context of the general organisation of health service delivery.

**The CHAIRMAN**: You have talked about the service planning model you came up with requiring things like anaesthetists, appropriate equipment, resources and teams to be based - I am assuming now - at fewer hospitals to ensure that those things were affordable and obtainable. There is an understanding that the low-risk delivery program or services can feed into those hospitals that have back-up or referral centres, or whatever you want to call them. That seems to be well accepted as a model in rural WA. Why was it not also considered a model suitable for metropolitan WA?

**Ms Ford**: I do not think the Health Reform Committee would have said it was not considered a suitable model for metropolitan WA. Much of the report - as the committee was trying to get a holistic and packaged approach, if you like - focuses on trying to beef up both the health information and health promotion end of the spectrum through to community-based services. That would include, for instance, homebirths with community-based midwifery at the less intensive interventionist end of the spectrum right through to the other end. The committee said that that was a push in the report - I hope it comes out quite strongly. The committee intended that to be a theme of its report. It talked about trying to shift resources from the most acute areas. For instance, the purpose of the committee's recommending that WA move in the first instance to only two tertiary quaternary hospitals was to ensure, firstly, that both hospitals were big enough to service north and south and have all the facilities needed, and, secondly, to overcome the problem that competition with the three adult tertiary hospitals was inefficient and causing resources to be dragged into that tertiary quaternary end of the spectrum when they could hopefully be used more appropriately at the secondary or community end. As I said, the theme throughout the whole report was that that shift

was needed. The committee probably felt that obstetric services were in that same continuum and needed more detailed planning.

**The CHAIRMAN**: The current report was based on metropolitan-wide changes based on every hospital performing 1 000 or 1 500 deliveries. Consequently, the option for some of those hospitals to continue to provide a low-risk, GP-midwife-led obstetric service that fed into these referral centres was decimated in that process. Why was it considered an acceptable model of care in a regional part of Perth, but, for whatever reason, not considered an acceptable model to continue to operate in metropolitan Perth? That is the crux of it: I want to understand why it was not considered acceptable in Perth, whereas it is acceptable in the country.

**Ms Ford**: This is where you get to a lot of competing things. In coming up with its total report, the committee had to grapple with many competing issues; for instance, the shortage of doctors overall, from general practice through to highly specialist services, and the need for safety and quality. The committee was convinced that individual doctors could be very safe and have excellent records, but the evidence from overseas and emerging in Australia is that every specialty, whether it be obstetrics, cardiothoracic or any of the others that have been slightly controversial, has certain numbers, ways of operating and team configurations needed in order to deliver the best across-the-board outcomes. The committee attempted to look at ways that our training could be a little more flexible, both basic training for nurses and doctors right through to ongoing education and training. To do that, the committee felt we needed a critical mass in certain spots to be able to cope. Training is a very intensive resource usage. Unless you have got a critical mass of people, you cannot be flexible enough to do some of that work. Thus, there is a whole training-education component that the committee looked at. There is the whole question of equipment etc. In fact, it is a whole question of community expectation. Fifty years ago people were very happy to have their babies in wards of 10 patients. Now, if you said to a woman, "That is the obstetrics ward; it has got 10 beds and the toilets are down the corridor," she would say, "This is Third World. Western Australian should be able to do better." Of course, by and large, we do a lot better than that now. However, when you have community expectation of a certain standard, it must be dealt with. A whole range of such issues apply across the spectrum; it is not just obstetrics. This led the committee to say that it really needs to try to reorganise our system in the metropolitan area. The committee was not only trying to get critical mass for large secondary hospitals at a big level in that it believed that 300 beds were needed in each one to really do that and to give them the total capacity they needed to operate as very large humming entities, but it was also trying to free up space for some of the other hospitals - that is, not the four secondaries but the others in the metropolitan area - to specialise in mental health, aged care rehabilitation etc. The committee felt that the two areas in particular of mental health and aged care rehabilitation were growth areas with baby boomers aging etc. We needed as a system to have more capacity. Mental health has always been an issue in terms of capacity for in-patient and community facilities. We could use some of this existing infrastructure to provide that and to specialise, and, again, to create teams and centres of excellence and all such things. The committee tried in its blue print to say that mental health and aged care rehabilitation could be specialised in centres north and south of the river in the metropolitan area using some existing facilities if some space was freed up in those facilities, but they did not need to be in a major secondary hospital. However, with obstetrics, for example, once you need the major secondary hospital, you probably need anaesthetists and all the other resources that come with being in a large facility; therefore, that was going to be an efficient use of resources. I am talking about not just dollars, but also people, machinery etc. This would provide a big enough critical mass for ongoing training, development, quality assurance and all those sorts of things. It was not that the committee at any stage said to itself that it would push all obstetrics into huge secondary hospitals. It did what it did for the works; that is, to say that as a general principle, we need to beef up the community base of almost any discipline. We recommended there should be a resource shift out to the community. However, when you get to this resource-hungry sector - the hospital sector is very

resource intensive - we think you need to reorganise it to meet all these competing objectives and to get what we could see was the best possible arrangement. That was the tenor of discussions at the committee over months.

**The CHAIRMAN**: The consultation process that was undertaken by the Health Consumers' Council focussed on a number of discussion papers that you have referred to, although none of them was quite specific to obstetrics.

**Ms Ford**: No.

**The CHAIRMAN**: Do you believe that the community understood or had an opportunity to understand the changes that were being considered for obstetrics in WA?

**Ms Ford**: I would make a more general comment here. In WA and across the rest of Australia, we do not have what I would call "informed consumers" regarding their health system in general. That makes it very difficult for the community to make any decisions on obstetrics, cardiothoracic surgery or any other issues, and engage at the speed with which they need to engage in order to actively participate. I am speaking as a private individual now; I am making a personal comment. The future of health in this country needs much more community debate premised on creating a much more informed community. There is a five to 10-year piece of work to get the community that is able to understand some of these competing issues; therefore, when faced with changes - for example, the obstetrics configuration or the tertiary quaternary hospitals north and south - the community can say it has a good enough grounding in health and can engage over three or six months in a proper and very constructive discussion and really let their views be known. The problem now in obstetrics is the same as with any of these other issues. When you sit down with a group of consumers - I have done this many times in my career - who say we ought to have a hospital capable of doing surgery in York, for example, consumers must understand that we have had terrible trouble getting general practice coverage and the cost of providing a hospital capable of doing surgery.

[11.45 am]

**Ms Ford**: If we have had trouble getting general practice coverage, and none of these centres can get an anaesthetist, how would we be able to get an anaesthetist? Issues like that are gone through before the community starts to say, "Okay, we can see that is not working. How, then, are we going to manage, given that we need surgery?" The community begins to engage in a much broader discussion about how it wants health services to be organised, and therefore what the real issues are for them. It is a long answer to your question, but as a private individual, I think the community probably does not feel involved, consulted or heard on a range of health issues. That is probably true. It is not because people have not made an attempt to consult, but each time one of these issues come up there is, I think, a lack of general understanding out there upon which to build. My view is that we need to do that, because the health system needs that. I am fond of saying to people in my community that as long as the community opts for tax cuts at each election it is probably not going to get much in the way of health services. The community has to understand those basic trade-offs before it can ask how it wants resources, people, equipment, dollars or buildings to be packaged together to deliver health services, given the range of competing objectives, interest groups, health conditions etc.

**Hon LOUISE PRATT**: With respect to the comments you have made about community consultation, now that there is planning taking place within the clinical services framework, we might drill down a bit further into the different community areas you mentioned. Do you think there is a role for greater community consultation that will provide a better fit within those discrete areas, now that there is a framework to go with it?

**Ms Ford**: When a quarter of the state budget is being spent, and people's lives are being touched on a daily, weekly or monthly basis - we are all either there ourselves or have friends or relatives

touching the system - the consultation has to be significant. I know that I was terribly frustrated during my 20-year career in health at commonwealth and state level, particularly at state level, with people who criticised us for being out of touch and not consulting, when we felt that we were trying to consult. There is obviously a mismatch there. I can speak freely because I am no long in the bureaucracy. I attribute that mismatch to a number of things. As I have harped on already, one reason is the basic level of informed community. Better information and general discussion in the community is necessary, not discussion initiated on the front page of *The West Australian*; I am not interested in that sort of discussion, having been a bureaucrat for many years. I am interested in good discussion - the pros and cons to the community of issues etc. There is also intense pressure - I suspect that, as politicians, the committee will feel this even more intensely than I did as a bureaucrat - to balance a range of competing objectives. It is very easy for an interest group like the National Fibromyalgia Association, or a particular community like York, to be very consumed with their needs, and rightly so. As a bureaucrat, I had to balance those objectives, and not everybody could get what they needed. It was always a problem trying to explain that in a fast-moving system. The politics of health is another area in which there is a potential mismatch between what appears to happen and what people want to happen. It is sometimes very difficult, for a range of reasons. Sometimes decisions are made very quickly; sometimes they are not made very quickly at all, and that annoys the community. Sometimes decisions are made in an environment in which consultation is not a high priority in resolving an issue, and that causes anxiety. I think there is a fair bit going on in the system. I am no longer involved, but I know that community advisory groups have been set up, and that there have been attempts at discussion about, for instance, the role of the new tertiary hospital down south, and the impact it will have. People are trying to engage the community. There is a mismatch between the community's expectations of how it will be engaged and the influence it can have, and what actually happens.

**Hon LOUISE PRATT**: Do you think the government does itself a disservice by not consulting the community? You mentioned the case of York; that when people have been taken on a journey and have had the reasons behind a decision explained to them, some people can come to an understanding of why the decision was made. In the case of Kalamunda District Community Hospital, for example, there has been quite a lot of local community angst without a lot of understanding of the new services that have been introduced. There is an offset between what is required locally and what is better placed elsewhere. The government made those decisions without providing any local community education. Can those things be better handled? Can the community be taken on a journey? There will be some dissatisfaction in any case. Is there a best practice model for identifying sensitive areas and being a bit more on the front foot?

**Ms Ford**: Yes and no. Obviously my answer is going to be biased by the fact that I spent 30 years trying to do this - clearly, from a community perspective, unsatisfactorily. There are obviously best practice models for community consultation in which communities have achieved great things and have been far more satisfied with their services than any issues we can point to here. Kalamunda hospital and the Western Australian Association for Mental Health's housing issues have also caused great community concern. Some communities have been demonstrably able to deal more satisfactorily with those issues because they have had a better consultation program. However, there are many things involved in getting all of that right. When the consultation is about one particular issue, it does not tend to work. If the consultation is about building step-down facilities for people with mental health issues, and it is the first time that the community has been aware that the health department owns the block of land, it will be an uphill battle to secure a successful outcome. There is also the "not in my backyard" mentality. "Yes, we understand that they need housing, but . . ." Conversely, the reaction from the community to obstetric services is, "We understand that you have to rationalise, but not in our community, because we are special in some way." That is why I have returned to the notion of the need for a much better general - rather than issue-based - discussion about the realities of the health system. That means that it will not take six

months to explain to the community that it is not a matter of the government spending another $500 000 to prop up that service in the hospital; it is a much broader issue, and it needs to be dealt with in a broader context.

There are so many pressures on the health system to deliver acute health care. If people were asked what health issues appear in *The West Australian*, they would say waiting lists, or something like that. The push to get resources into frontline health care, whether it be community midwives or King Edward Memorial Hospital, means that resources that are seen to be not frontline; that is, people who can talk, consult and listen are not really valued, and people do not want to spend money on them. The community reaction is frequently, "While you were spending six months consulting your community, we paid your costs of $50 000, including travel expenses. We could have had a midwife in the community, delivering a service; look at the midwife waiting lists." Consequently, those sorts of resources are not forthcoming. As I private citizen, I can say that clinicians are often not the best communicators. The skill mix needed to consult is perhaps slightly different. If I were about to have a baby or have an operation, I would rather that the obstetrician or the surgeon was highly qualified in the relevant area. If that meant that I had to actually ask them questions to get the information, I would be prepared to put up with that. However, they are not necessarily the best people to send out to engage the community in a discussion, because they have a particular focus and particular training. There are a range of reasons we do not do it as well. There can be great models, but I arrived at a point in my career where I would say to people, "Do not come to me with a pilot program on anything." There are lots of models out there. Unless we can figure out how to embed it in the system systemically, we will be doing a brilliant job for one community and have another hundred communities feeling pissed off, annoyed and disenfranchised. The question is how to apply the systemic approach across the system and how to have it valued beyond the rhetoric of, "We believe in consultation."

**The CHAIRMAN**: Since the changes at Kalamunda hospital, the general practitioner obstetricians that were providing services there do not currently have access to a hospital in which they can provide services. That has decreased the availability of people providing services. I understand that Kalamunda hospital has a safety and quality record that was world class according to the various scores that are used, and that it had the highest patient satisfaction score of any hospital in Perth on the basis of community expectations. It would seem, at least across a couple of the parameters of reasons for consolidating services into some areas, that it is an example of a move working against community and system requirements. Was there ever any consideration that services like obstetrics at Kalamunda could continue to operate as a general practitioner-midwife-run service? The savings, apparently, have been costed at less than $500 000. Did the committee take that level of detail into consideration?

**Ms Ford**: The Health Reform Committee did not do any of that work. One of its recommendations was that detailed work needed to be done across the board. That was subsequently done in the bed numbers work that was carried out last year. The committee did not go down to that level for anything except a very small number of specialties where it came up, and obstetrics was not one of those. The Health Reform Committee did not do detailed bed number costing or workforce planning for any facility in the state or for any region or area. It did not have time, and it was quite clear. The committee did a lot of work on projections - for instance, by diagnostic related group - over the next 20 years. Most people realised that the growth in mental health would be very significant, and that over the 20-year period the growth in the need for aged care rehabilitation would also be significant.

The growth among some specialties such as cardiothoracic was negative, as it was for a range of others, and for obstetrics it was flat etc. The Health Reform Committee did a lot of that work. However, in apportioning individual facilities it tried to take a broader approach, which, as I said, painted the picture of two tertiary quaternaries so it stopped fighting and dragging in so many resources, made big secondary hospitals so that they could do all the work a big secondary would

do in other places that most of our secondaries could not do because they were not big and did not have the equipment, the numbers of staff etc, and a range of specialist-type facilities to deliver mental health etc. Below that, the committee said that someone must knuckle down and do the detailed planning. The issue about the safety record is exemplified in the country, for instance, in areas other than obstetrics. In some of our small hospitals in the country GPs are doing particular surgical procedures. Some of those GPs doing some of those procedures have an impeccable safety and quality outcomes record over 20 years. Some do not and the evidence shows that a really good outcome is less likely if the package needed is not provided, such as nursing, equipment, 24-hour care - whatever is needed for that particular procedure. It has always been a dilemma. The whole time I worked at the department it was always at great pains to say, "When we say that these procedures cannot be done in hospitals that look like this, it is not because we are saying that GP X has a bad safety record; quite the contrary, GP X might be good and we might be happy to say he has an excellent outcomes record." However, as a system, the evidence suggests that a good outcome from a hospital of that configuration doing that procedure is less likely than it is at a hospital of a larger configuration with more specialists and equipment. Therefore, as a system, we have a responsibility to say where we think things should happen to deliver the best chances of a safe and high-quality outcome. It does not guarantee it, because we get human error and other things. We constantly tried to explain that to people and to use broader evidence, not individual-doctor evidence, to make system-based decisions.

It is also fair to say that as bureaucrats we were confronted more times than we liked with coroners' reports that said, for instance, if the department had provided ultrasound equipment to this hospital, this person might not have died because the doctor says he would have ordered an ultrasound and that would have picked up the condition and the person would have been transferred or lived or whatever. Unfortunately, it takes only one or two cases like that in a coroner's court to influence the system to say, "Hang on. If we're going to get criticised like that, we can't allow those things to happen there." In general, there are moves towards greater role delineation and more specific information about who can do what where.

I cannot comment on the issue of the GPs at Kalamunda and whether they have access. When I was in the department, I understood that discussions were occurring with them to give them admitting rights and to welcome them to Swan District Hospital. I cannot comment on that; I am out of the system and it is an area health service matter anyway, broader than a departmental matter.

**The CHAIRMAN**: We have reached the end of our questions. Thank you very much.

**Hearing concluded at 12.10 pm**