PUBLIC

THE HOUSE OF ASSEMBLY SELECT COMMITTEE ON REPRODUCTIVE, MATERNAL AND PAEDIATRIC HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON WEDNESDAY 26 MARCH 2025

The Committee met at 9.00 a.m.

CHAIR (Ms Haddad) - Good morning. Hello everybody and welcome. Thank you for joining us and giving us your time today at the hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania.

Could I ask each person at the table to state their name and the capacity in which you are appearing before the Committee?

Mrs PETRUSMA - You want me just to introduce them? I don't need to be sworn in.

CHAIR - No, you don't need to be sworn in, but each person just needs to state their name in their role.

Mr WEBSTER - Dale Webster, Secretary of the Department of Health.

Ms STEEDMAN - Trudi Steedman, Nursing Director of Child Health and Parenting Service.

Ms BADCOCK - Sally Badcock, Associate Secretary, Department of Health.

Ms FRENCH - Becky French, Nursing Midwifery Director for Women's and Children's Services at the Royal Hobart Hospital.

CHAIR - Can I confirm everybody has received and read the guide sent by the Committee Secretary? That's great, Thank you.

To remind you of the pertinent parts of that guide, this hearing is covered by what's called parliamentary privilege, which allows individuals to speak with freedom and without fear of being sued or questioned in any court or place outside of parliament. The only exception is that protection isn't accorded to your statements that you make inside these hearings that could be considered defamatory and you repeat them or refer to them outside of this Committee.

It's a public hearing; we don't have any members of the public joining us today I don’t think other than your support team, but there might be people watching online, people might come in and out, including media and we're being broadcast on the web.

If at some point some of the evidence you want to give in private, we can move into an in-camera session. You can request that during the hearing and we have a short deliberative meeting to agree to go into camera and then the broadcast stops. There is still a *Hansard* transcript, but it doesn't get published.

I'll introduce the members of the Committee. We have two apologies today; Cecily Rosol, member for Bass, and Rob Fairs, member for Bass. Anita Dow, member for Braddon, will be

joining us at around 10 a.m. and she apologises that she'll be coming in halfway through the hearing, but she's got a clash she couldn't avoid.

At the table joining us here today we have: Nic Street member for Franklin; I'm Ella Haddad, member for Clark and the Chair of the Committee; and Kristie Johnston, independent member for Clark.

Mr DALE WEBSTER, SECRETARY, **Ms SALLY BADCOCK**, ASSOCIATE SECRETARY, **Ms TRUDI STEEDMAN**, NURSING DIRECTOR OF CHILD HEALTH AND PARENTING SERVICE and **Ms BECKY FRENCH**, NURSING MIDWIFERY DIRECTOR FOR WOMEN'S AND CHILDREN'S SERVICES AT THE ROYAL HOBART HOSPITAL WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you very much, and I know that you're all here supporting the minister, but it's a bit different to Estimates in that you can answer questions - if the minister directs a question to you - directly to the Committee, if that's something you're comfortable with.

Due to the nature of this Committee, we've agreed to read a short sensitive content warning at the beginning of each session. We recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings.

The Committee encourages anybody impacted by the content matter during this hearing to contact services including Lifeline on 13 11 14, or their text line on 0477 131 144, Tresillian Tasmania's Parent's Help Line on 1300 827 282 or PANDA national helpline on 1300 726 306.

That's all of the formalities completed. Minister, would you like to start with an opening statement?

Mrs PETRUSMA - Thank you, Chair and members of the Committee, for the invitation to attend and for the opportunity for myself, the Secretary and other Department of Health staff to contribute to the Committee's critical work today.

Firstly, I want to thank all of you for your hard work and efforts on this very important Committee, as well as to thank and acknowledge every person and every organisation who came forward and made a submission to this Committee. From having read the submissions, I understand just how challenging this must have been for you all, especially for those who provided very personal submissions. I want to acknowledge their bravery in sharing their stories and I assure them today that we have heard your voices.

I, the Tasmanian Government, and the Department of Health are all very committed to supporting meaningful change and ensuring our reproductive, maternal and paediatric health services are accessible, patient-centred and of high quality. To this end, the Department of Health has been working incredibly hard to initiate measures to enhance healthcare services in these areas. Some examples of recent work and reforms, which we welcome the opportunity to expand on today, include the independent investigation of the Royal Hobart Hospital Maternity Services, with all 38 recommendations accepted by the department. A review implementation committee has been established and work is well underway to implement high-priority recommendations by the end of June 2025.

We've also strengthened our workforce. The Department of Health has been working very hard with the University of Tasmania to reintroduce the Diploma of Midwifery in 2026, including a residential program enabling nurses who wish to become midwives to undertake this course here again in Tasmania. We have the establishment of new residential intensive parenting units at St Johns Park in the south and the Launceston Health Hub in the north, to support mothers experiencing postnatal challenges, including support for their mental or psychosocial and physical health needs. We have the successful transition in maternity services in the north west to the public system in December 2023, which is enabling a more connected service and has received positive feedback when it was recently assessed against the National Safety and Quality Health Service Standards.

Today I'm pleased to table for the Committee this document, which outlines in more detail these and other examples of the department's recent progress to better meet the needs of Tasmanian parents, families, and children.

As a mum of four myself, I believe bringing a baby into the world should be a moment filled with care, support and joy. Unfortunately, as we've heard, this is not always the case. I'd like to extend my sincere sympathy to any mothers, fathers and loved ones who have experienced distress and grief during such a significant time in their lives. I know we all share a common goal of wanting to ensure that Tasmanian mothers, babies, parents, children and their families have the best high-quality hospital care to meet their needs throughout the pregnancy journey, from conception to birth and beyond.

I want to assure those who have made submissions to this Committee, and those who may be listening to this hearing today, that your voices have strengthened our resolve to ensure that the necessary improvements are made so that our services offer safe, high-quality, and timely care.

Thank you, Chair. If it's now okay with the Committee, I'd like to ask the Secretary, Dale Webster, for further comments.

CHAIR - Did you have an opening statement as well, Secretary, that you'd like to make?

Mr WEBSTER - Thank you, Chair, and thank you minister. On behalf of the department, firstly, obviously we shall give our sympathy for parents and families who have lost children through stillbirth across our hospital system. Importantly, we learn from every incident that occurs in our hospitals. We have a learning culture that is particularly prevalent in our midwifery areas.

We're very pleased that, having brought the maternity service in the north west back into the public system from the private system that, on independent review, we met the quality and safety standards required of a maternity service. That was an important first step in making sure that right around the state we have quality services.

Yes, things go wrong, but it's important that they are reported and that we have a reporting culture, and then we assess what went wrong and how we can fix that. That's an important role of our leadership in midwifery, represented today by Becky French, who's our nursing director. Becky can talk to the Safety Reporting Learning System (SRLS), and how we actually learn

from everything that's reported to us going forward. I just wanted to emphasise that learning culture.

We've recently done a review of the maternity service at the Royal [Hobart Hospital] [RHH], following some statements made by the ANMF [Australian Nursing and Midwifery Federation]. I wanted to assure the Committee that, having looked at that in great detail independently with a nurse, a lawyer, a midwife, a consumer representative, and a doctor, that we found no evidence of that allegation. That is an important thing to say because that went to our reporting processes and did they work? Having looked behind the reporting processes, we could not find any evidence that occurred.

The final point I'd like to make is we take each of the reviews we are required to do by the Parliament quite seriously. We set up implementation committees for that. Again, with the maternity review at the RHH, there are 38 recommendations. We have an implementation plan for those being led by our chief nurse, but, importantly, being led from within the RHH to make sure that the RHH learns from that report. The chief nurse role is to make sure the system learns from that report. Thank you.

CHAIR - Great. Did anybody else have an opening statement or do you want to move into Committee? Thank you. First of all, thank you all for your time. As a Committee, and I have said this on the record at other hearings, we are very grateful that you were on this Committee until the day before you became Health minister. The reason I mentioned that is, without trying to put words into your mouth, we know that women's health is a priority for you. It is helpful you have read all the submissions. You have read them all before I had, as Chair. I have read them all now, I assure you.

That is really meaningful. I wanted to start by acknowledging that since the terms of reference were created for this Committee and the parliamentary motion to establish the Committee went through the Parliament, quite a lot has changed. There are a few things that specifically have changed that I'd like to ask you about - including the midwifery course that you have been negotiating with UTAS, because that is something we have heard a lot from witnesses.

Yes, also to acknowledge we have heard really amazing evidence from individuals across Tasmania. A lot of really traumatic experiences that people have had, but also some really positive experiences. Mostly, we have heard evidence on maternal services, less so on paediatric and reproductive health, but we have heard some - again, really positive and negative feedback on those. I think that is the value of parliamentary committees, that we can actually hear a really strong evidence base and make recommendations to the Parliament and the Government on that.

We might start with those 38 recommendations of the review, because obviously this Committee is kind of happening concurrently. Well, that review is completed, but that was established and completed while the Committee's been doing its work. It might be helpful for us to have, as a Committee, some evidence into our transcripts on what recommendations are underway, which ones might already have been completed and which ones there is a plan to complete and by what time, so we are not duplicating the work of that review in the recommendations we make.

Mrs PETRUSMA - Thanks, Chair. I welcome the release of the final report of the independent investigation of the Royal Hobart Hospital Maternity Services. I want to acknowledge the members of the Department of Health who are alongside me today because they were - when the allegations were first raised - it was taken with the utmost of all seriousness. We were determined to do a thorough investigation. The independent panel's findings have provided a strong opportunity for learning and for positive change, to make sure we are doing everything possible to provide safe and high-quality care to women during pregnancy and birth, and to families following the birth of their child. We did release the report publicly, only a couple of days after I first received it. The Department of Health has accepted all 38 recommendations made by the independent panel and is working to implement them in full.

The recommendations cover a range of important matters to improve service delivery, including: to enhance staffing models, recruitment processes, leadership and culture; breastfeeding support processes relating to the induction of labour as well as consumer engagement. The implementation committee comprises staff from all regions of Tasmania to share best practice and, importantly, it is to implement solutions statewide, where possible. The committee is reporting to the Department of Health Secretary and its membership includes a consumer representative, which we felt was very important to make sure the consumer's voice was on the committee, as well as a direct care midwife. I wish to express my sincere thanks again to all the health consumers and staff who contributed to this investigation.

And importantly, I want to acknowledge the dedication, skill and resilience of the staff who contributed to the investigation and those working within maternity services. Ongoing feedback is being provided to the implementation committee through the forums that are established. I can table for the Committee the timeline for all the recommendations. I can indicate that most of the major recommendations - you'll see that they are to be completed by quarter two 2025.

I'll ask the Secretary to provide comment because, as he outlined in his opening statements, importantly, some of the allegations that had been made, Ms Amanda Singleton did not find evidence of. So, I'll get the Secretary to outline more of that for the record.

Mr WEBSTER - The way we did the review was, in fact, to set up a panel under the *Tasmanian Health Services Act 2018*, which gives the panel the ability to effectively do exactly what the Secretary can do. So, look at all of the records, call staff in to talk to them, meet with staff to look at what's happening. It overcomes any privacy provisions, et cetera, because they're acting on my behalf under the Act. We felt it was important that we give them that full power to look at our records, et cetera, and bring that independent eye in because these were fairly significant allegations.

Having worked their way through, as I said, under the hood, behind our systems, they couldn't find any lack of report; so, any records that indicate that someone didn't report something. That was important because, obviously, the first place we went to was our Safety Learning and Reporting System (SLRS) to see whether there was anything in there that was reported that was missed as being a SAC1 [Severity Assessment Code 1]. Sorry, that's a category of level, if it's a SAC1, it's the highest level of safety concern. Importantly, I should also say that that level of safety concern, the moment it's entered into SLRS is actually flagged with myself and other senior executives. We get a text message as well as an email telling us that there's a SAC1 so that we can go in immediately and have a look. None of us had any

memory of it. We then went to the system to see whether we'd missed it, and then we asked Amanda's [Singleton] panel to go beyond that and look at records from the relevant period. The person that made the allegation has not passed on any further detail, so we're unable to actually tie it to a particular record or thing, but I can assure you that the panel were determined if it was there, they would find it.

Under the implementation process and, as you'll see from the report that the minister has tabled, there is activity underway. The first major milestone is a report to me in April of this year. So we're not quite there to get that report, but we thought it was important to table the timelines of what we're doing.

The two senior staff who are working on it are the chief nurses, as I said earlier, and the second person is the Executive Director Of Nursing And Midwifery at the Royal Hobart Hospital south, working their way through those recommendations. I think the other thing is that whilst there are 38 recommendations, they do bundle together into certain things like the staffing, et cetera.

Important for us is increasing that midwifery workforce. There is a shortage again Australia-wide, worldwide of nurses and midwives, so it is actually attracting and keeping that workforce in Tasmania as much as we can. On that track, we already have agreements in place with Charles Darwin University and Charles Sturt University - I think that's the right names - where the people do their intensive on-campus, you know, as residential blocks through the year, but do their placements with us and that then flows through to a graduate program with us. Now we're entering into an agreement with UTAS to try to onshore some of that activity. We will try to balance, to keep three agreements going because we think it's important that universities do offer midwifery. We don't want to see a situation where our cohort pulling out of Charles Sturt means that their program becomes unviable. We need to balance that as well.

CHAIR - Do you know how many Tasmanian students are studying through those two interstate universities?

Mr WEBSTER - There're six through Charles Sturt University. I'll have to check Charles Darwin University because it's not in my head at the moment. Probably about the same number. As I said, if we can get an onshore cohort, the second part of that is making sure that we offer that through Calvary [Lenah Valley Hospital] as the other provider. It's not just for our staff; it's actually broadly across -

CHAIR - The midwifery workforce.

Mr WEBSTER - midwifery. In fact, any RN [registered nurse], it wouldn't necessarily be Calvary. There might be RNs in Healthscope or in general practice who wish to do midwifery. We want to pick them up as well. The best way to do, we think, is to have an onshore element.

CHAIR - That's definitely in line with evidence that the Committee has heard directly from midwives, but also from their representative bodies.

The Committee has also heard about the barriers to direct-entry midwifery university courses. I just want to explore the negotiations you're having with UTAS because I'm really glad to hear that those are going on. It would have formed one of our recommendations and it

may still form one. Could you tell us a bit more about the timelines with UTAS, if they're known at this time, whether there will be an option for direct-entry midwifery, or if it will be through that nursing pathway, and what you'd like the Committee to know about those negotiations?

Mrs PETRUSMA - For the diploma, we're looking at early 2026. That's probably - working with UTAS in regards to direct-entry of midwives - that won't be - that will still continue through the other pathways at this stage because we need to get the diploma up and running first of all and make sure that that's viable. That's part of the reason why we need to ensure that there are other options as well.

The other options do allow nurses to do online, too, which may suit them. We also offer, where you can be a student midwife and still work for us - you can work part-time for us while being a student midwife. We also offer different scholarships to encourage people to become midwives. That all sort of feeds into the package. If people want to do a direct midwifery course that is online, they can get a scholarship towards doing that. We do pay for placements in different universities to enable that.

Mr WEBSTER - Just to add to that, our discussions with UTAS about a direct-entry course are much earlier stage than a graduate diploma. We prioritise the graduate diploma. We're on a timeline of discussion with them. They know that we're looking for 2027 to be our first year. Obviously, that's a five-year solution rather than a one-year solution that comes with a graduate diploma. That's why we've prioritised one over the other, but it is early stages and, obviously, they have to go through an accreditation process and things like that, plus their internal processes, but we've asked them to work with us on a 2027 entry.

CHAIR - If students are doing direct-entry midwifery interstate, can they do their practical placements in Tasmania?

WITNESSES - Yes.

CHAIR - Great, excellent. I don't want to hog all the questions. We'll open it up to the rest of the Committee. Kristie, did you want to go in any particular direction?

Ms JOHNSTON - Yes, I might head in the paediatric direction - a little bit different. As Ella has said, we've had a lot of evidence about maternal services and a little less about paediatric services. What we've heard particularly is concern from a number of people about accessing paediatric services in a timely manner and the long waiting lists to do that.

Can you perhaps expand on what the department is doing to try and reduce those waiting lists for paediatric services, recognising that they are often accessed through the public system rather than the private system in Tasmania?

Mrs PETRUSMA - I'll talk for a start in regard to paediatric outpatient waiting lists. We definitely believe that timely access to outpatient services is very important for supporting the health and wellbeing of Tasmanian children. In 2023-24 the Tasmanian Health Service provided more than 36,200 outpatient occasions of service under the specialities of paediatric medicine and paediatric surgery. However, we do acknowledge that some families have experienced long wait times for specialised medical care. The department is working towards improving these times to access out patients' clinics through the Transforming Outpatient

Services Strategy, which provides the foundations for delivering sustainable change and transformation of outpatient care.

More broadly, the department is analysing current service configuration arrangements, utilisation patterns and demand pressures across the system, to try to identify where system changes and investment decisions may be needed to meet the future health needs of children and young people. I just want to assure the community that we're continuing to work towards ensuring our youngest Tasmanians are able to access the services they need, when and where they need them. I'll ask the Secretary to outline more about the Transforming Outpatient Services Strategy.

Mr WEBSTER - Thanks, minister. The Transforming Outpatient Services Strategy, firstly, is maximising the number of occasions of appointments. As you'd appreciate with young children coming into outpatients, we have a lot of occasions that are cancelled at the last minute because the child wakes up with a heavy cold or those sorts of things, so there's always something there. The first thing we're doing is trying to backfill those appointments as quickly as possible so that we reduce our 'do not arrives' - DNAs. It is incredibly important there that across the board we were seeing about 11 per cent. We've got it across the board to about 7 per cent. Paediatrics sits in the 20s, though. They're missed appointments. We have doctors, nurses, allied health available, but not able to get them into the clinic. Transformation is about having centralised staff who can quickly ring someone up and say, are you available to backfill that particular spot, or quickly rebook the person that has pulled out into - because we have that constant churn, as you'd appreciate, with that number. That's the first part of it.

The clinical side is to do things like, do we bring in GPs with a special interest to increase the number of appointments? If we have a particular need in a region, is there a difference to our staffing profile? For instance, in the north west, we actually have a paediatric psychiatrist attached to the North West Regional, rather than to CYMHS (Child and Youth Mental Health Services), and that person is running outpatients clinics at both the Burnie campus as well as doing some in the Smithton District Hospital. A particular need in that region, where we match, from the Outpatient Transformation, the resources to the need. GPwSI [General Practitoner with Special Interest] is another way of employing because, there again - I'll probably say this 50 times in a day - but worldwide shortages of all specialities. Where we can - if we have a GP that's working part-time as a GP but has particular skills in paediatrics, then it's a good idea if we can get them, even a day a week, to do some clinics for us. Then we can increase our numbers. Again, the north west is particularly successful in doing that, the GPwSI program at the Mersey [Community Hospital] in particular, so those sorts of things.

The other thing we're trying to do is modernise how we contact people. Until a couple of years ago we were very paper based, so sending out SMS reminders the day before and getting someone to actually reply with a 'Y', for instance, means that if they reply with an 'N', we have a few extra hours to fill that spot. Those sorts of modernisations behind the scenes as well to our systems, to make sure that we can maximise the number of appointments.

The other thing I'd say is the work of CHaPS (Child Health and Parenting Service) to back up paediatric medicine, you know, universal screening, but also risk assessment about what follow-ups should be done until a child starts school. We're just about to introduce the 18-month literacy check. All of those are about picking up the children earlier so that we can get them on to the waitlist. But, again, we acknowledge that we have to work to actually get that waitlist down.

The final thing about the transformation is getting the pathways right. We're working with Primary Health Tasmania to have GP pathways quite defined, with certain gateways that lead you to the particular type of referral you should be doing. In the past, what we have had with a number of GPs who are uncertain about who the specialist is, they'll do four, five or six referrals just to see which one comes up first. We're trying to be more direct about how you get there.

The final thing we've worked on is eReferral. Most of our referrals from GPs are now computerised, which allows us to - we still have some work to do - a lot of GP practices are tied to their fax machines - but we're working with Primary Health Tasmania to try to uplift the skill set within general practices so they can use the system to make the referral. That way the gateways are built in to the referral process. Instead of having to think about it as you're filling out a form, the system will stop you and say, 'have you considered this?'

Ms JOHNSTON - That would certainly be useful, because one of the things we have heard quite strongly is the difficulty finding the pathways. It's hard enough for GPs who have some medical knowledge, let alone a parent who's trying to find the right access point for an issue they have with their child.

In the document you've just tabled, you talked about introducing appropriate training to staff to prescribe medications for up to three years for children with ADHD [Attention Deficit/ Hyperactivity Disorder]. This is one of those issues that touches across two committees that we're both on. I'm interested to understand, because that is actually a pathway issue that we've heard through this Committee, and other committees as well, around getting treatment. The first step is finding the right pathway - who do you talk to first? Then diagnosis and treatment. Can you expand briefly on that one, please, in terms of what that entails?

CHAIR - It's a referral into TADS (Tasmanian Autism Diagnostic Service) that we've heard about on this Committee.

Mrs PETRUSMA - The actual referral to TADS itself?

CHAIR - Well, getting in there. The early intervention message is really strong, and I think everyone in the community really understands and appreciates the need for early intervention. However, we've heard on this Committee, and as Kristie said on the other Committee that's looking specifically at ADHD, but we have heard in the paediatric space in this Committee as well just how difficult it is. Students are already school age, even though they might have been picked up early by a psychologist or a paediatrician as having neurodiversity, they're well into their school journey by the time they can get into TADS specifically. There might be more complexities to it that -

Mr WEBSTER - Again, TADS is overwhelmed with numbers. We are growing that service but, importantly at the moment, if there are high-risk children, we have a program in place where we are actually referring out to the private sector to make sure we can get through the higher-risk patients.

The appropriate training dot-point there is that generally, throughout Health, scripts are things like, you have a script with five repeats and it's about a six-month period and those sorts of things. What we're trying to do is re-educate our entire Health force to say there are some

situations - and ADHD is an example - where you do a treatment plan and then the prescriptions can follow that treatment plan for a period of time. It doesn't follow the usual pathways that we're used to in Health.

It's not just our staff, but all health professionals, about the differences now that we're moving towards these longer-term treatment pathways, so that you're not coming back constantly for the purpose of just getting a script, and those sorts of things. It's not just in this space, it is more broadly, but particularly in this space we do need to do it. This is one where there is a shortage of paediatricians and psychiatrists who are specialising in ADHD. That means that when you get one and you get a treatment plan, you don't want to waste that opportunity by someone in the chain saying, 'It's been nine months since you last saw your specialist. I won't be able to do anything until you've gone back to the specialist.' We need that knowledge of how treatment plans work being across the whole workforce. That's what that program is about, is educating health professionals in this new way, or relatively new way - I should not call it a new way - but certainly, understanding treatment plans.

CHAIR - While we are in the paediatric space, I just wanted to ask one of the things that we had heard is that there was a bit of - obviously understandable ceasing of CHaPS services during COVID in terms of those regular checks and that there might still be a bit of a COVID lag of those early childhood checks. I just wondered if there is anything you can share with us about that, if that lag is still present.

Mrs PETRUSMA - I believe that you have overcome the COVID lag now and are now back on track. I will ask the statewide nursing director of the Child Health and Parenting Service to provide comment, but I believe we are over the lag.

Ms STEEDMAN - Thank you, minister. Yes, we have recovered very well from COVID. There was a period where the staff had to go and help with the COVID response. Since then, we actually have had really high engagements. In fact, in 2024, from the two-week check, we are at a 99 per cent engagement rate and at the eight-week check, we are at 95 per cent. Then, it progresses on. Even for our four-year healthy kids' check, we are currently at 53 per cent, which is quite high, considering there are other opportunities for the families to have those healthy kids' checks as well through school nursing and things like that. Yes, we have definitely overcome it and back to full capacity and back to full service delivery of all the child health assessments, but also, support and parental guidance that we give.

CHAIR - Are the parenting groups coming back as a regular part of CHaPS work as well?

Ms STEEDMAN - Yes. We have new parent groups that have been running for about the last 12 months, if not longer than that. Some of them are CHaPS stand-alone new parent groups; for some others, we are working collaboratively with the Department for Education, Children and Young People through the CFLCs, Child and Family Learning Centres, and working collaboratively to deliver them, particularly in the regional areas.

CHAIR - Did you want to share anything about the new 18-months check that is being introduced?

Ms STEEDMAN - Yes, CHaPS will be introducing a new 18-month check in July. At the start of July, it will start to be operational. That is through some of the funding that we have

received from DPAC. It is around the lifting literacy funding. It is actually going to be called 18 Months Kids Love to Learn Check and it is around role modelling, behaviour around literacy, reading and it will also do some developmental checks as well. Then there will be referrals that could be made if the child health nurse picks up on any delays or development issues that they can see. A lot of it is really around role modelling and we have worked with Brand Tasmania, with Little Tasmanian. Initially for the first 12 months, every child will receive a book and the child health nurse will sit and role model some of that behaviour as well.

CHAIR - While we are still in paediatrics, I just wanted to ask a little bit more about the GP with special interest program, and the Secretary touched on it - in that outpatient space, being able to, may be, rely on some of that assistance. I know there is also a GP with special interest program running at the Royal that includes paediatrics and beyond. Just wondering if you can update us about that program and also, as the Secretary alluded to, other opportunities to lean on those GP resources in the ADHD space, with TADS or other ways?

Mrs PETRUSMA - We, the Tasmanian Government, have our commitment in regards to - in the 2024-25 state Budget, we allocated $2.5 million to establish a new service that will give families across Tasmania faster access to GPs with special interests who can diagnose and manage children with ADHD. Staff in this service will have the appropriate training to be authorised to prescribe medications for up to three years, an increase from the previous two-year period. The new GP specialised service for children will help ensure that Tasmanian children with behavioural or neurodevelopmental concerns are able to get the care they need in a timely and accessible manner. As part of the planning for the new GP specialist service for children, the Department of Health is preparing to pilot a dedicated multidisciplinary ADHD model in southern Tasmania to address the significant service demand and waitlists for specialist assessment in this region. This model will combine the resources of the paediatric neurodevelopmental clinic in the THS with staffing from both the women's and children's services, paediatric services and Child and Youth Mental Health services.

Planning for this model is based on the GP with a Special Interest (GPwSI) model and it is anticipated that once piloted it will be considered and reviewed by the Women's and Children's Clinical Network with potential for statewide rollout across Women's Adolescents and Children's Service (WACS) and the Child and Youth Mental Health Service areas. Planning includes liaison with Primary Health Tasmania, GPs, and the Department for Education, Children and Young People to ensure cross-sectoral and cross-agency collaboration and efficiency of utilisation of resources.

That's also on top of our kids care clinics for vulnerable children which are also run in the community as well with GPs and other specialists.

CHAIR - Thank you, minister. What you just read about a program being piloted then considered, is that the one that is already in its pilot stage now or is that something new?

Mrs PETRUSMA - This is a new program, a new model, especially to be able to prescribe medications for up to three years. It is an increase from the previous two-year period which is going to definitely assist more parents and families.

CHAIR - Would they be working through an outpatient clinic at the hospitals or through TADS or through other community settings?

Mrs PETRUSMA - I think, it's broadly, isn't it?

Mr WEBSTER - Yes. The idea is that they work alongside TADS outpatients, et cetera. It is that additional resource. It's one of those things with - GPs are increasingly expressing a desire to work part-time as GPs but still want to do other work in particular specialist areas. The rural generalist pathways that are opening up through universities, et cetera, are increasing the numbers that are available in that category.

It's important that we balance that because we know the primary care is short of GPs. It's not about attracting GPs to do something else. It's about attracting part-time GPs who might actually be excited to do the additional work. We already have a GPs with a special interest program through our outpatients transformation. We also have it as -

CHAIR - Is that the one that's being piloted? I feel like I'm mixing up programs.

Mr WEBSTER - That one's a pilot as well. There are two pilot programs, but we're doing one that's specific to ADHD starting next financial year. In the north west we have GPs with a special interest as part of our regular offering at the Mersey. GPs with a special interest are almost becoming part of our workforce generally. We call them different names. Some of them call them rural generalists, some are called GPwSIs, some are just called GPs. What it's about is using the skills of the generalist workforce to do specific work.

CHAIR - Can I just drill down a little bit more on both those pilot programs? First of all, the specific ADHD one: will there be an expression of interest process or are there people already working with the THS who identified to do that work? Do you anticipate roughly how many GPs with a special interest - I didn't know the GPwSIs was their acronym - how many GPs with a special interest there might be, anticipated to work in that ADHD space?

Mr WEBSTER - Through you, minister. Again, in raw numbers, as many as we can get, but in FTE terms, we're probably looking at about up to two FTEs in that space.

CHAIR - Per region or statewide?

Mr WEBSTER - This is a pilot in the south that we'll roll out once we've proven the model. It's important that we do actually prove that these models work.

For instance, our current pilot has been really successful with some special interest areas, but not in others. That, again, will come down to, 'Can we find the staff that have the special interest?', and those sorts of things, or, indeed, the type of patient. Again, a GP with a special interest is not a replacement for a specialist for a high-risk category for instance. If your list is full of high-risk patients, then you really do want specialists seeing those high-risk patients. Sometimes the GP with a special interest is not successful simply because the case mix isn't right to have some that are seen by GPs and some seen by specialists. We're working through - the pilot has targeted a number of different specialties. We're now doing the evaluation of that -

CHAIR - Oh, that's the other one, that's currently -

Mr WEBSTER - The first one. The ADHD one starts in the next financial year and will be evaluated in 2026-27.

CHAIR - Thank you. Did others have any other questions in the paediatric space? We can jump around and come back.

Ms JOHNSTON - Back to maternity services, what we've heard through our evidence and submissions, and people have come and presented to us, is about the value of homebirth experiences. We've heard lots of positive feedback about that, but also some of the challenges that consumers face, and that midwives face in terms of liaising with hospitals, particularly about admitting rights and recognising, as we say, the chronic shortage of midwives across the entire workforce. This seems to be an opportunity to work with those privately practising midwives to utilise their services to assist Tasmanians in their birth journey. I was wondering what the department is doing in regards to recognising that resource that we have in the community and working with them around admission rights, particularly to hospitals where there are occasions where they need to be admitted to hospital.

Mrs PETRUSMA - In regards to publicly funded homebirth in Tasmania, we believe it does have the potential to provide the community with greater choice in woman-centred models of care that align with their needs and preferences. I'm absolutely delighted that the Department of Health is currently developing an internal discussion paper to explore options to deliver high-quality, safe public homebirths in Tasmania. This paper will explore the local Tasmanian context and consider relevant research and guidelines across Australia and will be progressed to the Secretary for consideration very, very soon.

Ms JOHNSTON - Excellent.

Mrs PETRUSMA - Subject to the Secretary's endorsement, consultation will occur with women, midwives, medical practitioners, administrators and, importantly, women seeking to choose this model of care. The consultation process will assist to determined agreed model-of-care requirements for planning and implementation.

Our long-term health workforce strategy, Health Workforce 2040, emphasises the need for Tasmania's health system to expand with midwifery continuity of care models and to strengthen workforce recruitment. That will be at the heart of the strategy. We believe that developing a publicly funded homebirth program supports our strategy to strengthen midwifery continuity of care models and allows Tasmania to be more competitive in recruiting midwives, as well as supporting them to practise to their full scope.

Ms JOHNSTON - Fantastic. That paper would be completed shortly - what's the time frame for in terms of the next steps after that, I suppose?

Mr WEBSTER - The paper being developed through our office of Chief Nurse and Midwife - the minister said 'soon' because I wasn't able to contact Francine to say, 'what's the timeline?'

CHAIR - We understand she's on holiday.

Ms JOHNSTON - That's alright.

CHAIR - I'm glad she's not joining us remotely from holidays.

Mrs PETRUSMA - It says here, 'early 2025'.

CHAIR - The right to disconnect laws apply in Tassie, I'm glad she's having her holiday.

Mr WEBSTER - 'Early' is the next few days.

Mrs PETRUSMA - That's what I was going to say, it must be soon.

Mr WEBSTER - If you like, we can get back to you - I'll let you know when I've got it, basically.

Ms JOHNSTON - The next step, if I understand correctly, would be further consultation, engagement with stakeholders in terms of that.

Mr WEBSTER - Yes. Because it's internal, we would then take it out to midwives, to the obstetricians, to AMA [Australian Medical Association] and ANMF, et cetera, to make sure -

Ms JOHNSTON - Consumer groups.

Mrs PETRUSMA - Consumers.

Mr WEBSTER - The birthing centre in Launceston, et cetera.

Mrs PETRUSMA - And women seeking to choose this model of care. We definitely want consumers to be part of this process.

Ms JOHNSTON - Is that potentially seen as part of the solution to the reduction of services through Healthscope as well? Is this another component that enhances the service delivery? Minister, you talked about the importance of continuity of care. This is absolutely an opportunity to enhance continuity of care, but is this also perhaps a way to respond to the loss of Healthscope maternal services, to be able to provide an additional avenue or care model as well? Not done because of that, but -

Mrs PETRUSMA - It's not really as such to replace Healthscope, we've got other measures in place to address that. It's more about us providing the community with greater choice in women-centred models of care that align with their needs and preference.

Speaking for myself, my first child was born at the Launceston Birth Centre and I was fine to go home a couple of hours after she was born. By the time I had my fourth, I didn't want to leave hospital. You might want a different model of care depending on where you are in your journey. This is about offering greater choice.

We also want to recruit midwives from around Australia and internationally, but also develop our own home-grown midwives through offering the diploma through the University of Tasmania. Most of them want to practise to their full scope. If they want to make that choice of being a midwife and providing public homebirth services in Tasmania, then we want them to have that option so they feel they are operating to their full scope of practice.

Ms JOHNSTON - That's fantastic, thank you.

CHAIR - That's really good. We've had so much evidence from people where it is about that choice and you're absolutely right. There're people who want a hospital pathway, there are people who want a birth house pathway, there are people who would like to see birthing on country models, for example. I think that was while you were still on the Committee we heard from the TAC. A hospital option is the preferred option for many women and I think that people will be really glad to know that that work is happening in your department.

We were fortunate as a Committee to tour the Launceston Birth Centre. I didn't realise your first baby was born there. It's so lovely. What was really important for us to learn is Jaimee [Smith], the midwife who runs that, has very strong links into the LGH [Launceston General Hospital], which is obviously right across the road, and really strong relationships with midwives there as well as with obstetricians. From the homebirth midwives the Committee has heard from, it's been made very clear to us they absolutely understand that within their scope of practice they know when to transfer and that's made very clear to their patients before they take them on as patients.

Obviously Launceston is the only one - it's a great facility - but I just wondered in that work that your department's doing, is there anything you can share about potentially having birth centres like the Launceston Birth Centre in the south. I don't know where it's up to, but I know there were some midwives who were trying to put together a project plan for a Hobart birth house. I don't know whether there are any plans in the north-west, but obviously homebirths don't always mean at somebody's own residence, it can mean in a birth house like that. I'm just wondering if the department has any engagement with those people who were trying to put together a Hobart birth house plan and if that's part of your scoping paper's thinking.

Mrs PETRUSMA - I can say that since I've been minister that nobody has approached me as yet, but I will ask the Secretary if he's heard anything.

Mr WEBSTER - Not having seen the paper yet, I can't really comment on what's in it but Becky may know if we've got any activity in that area.

Ms FRENCH - At the RHH, we have made a pathway around the admitting rights for the privately practising midwives. We've moved forward with that as a flow for them to be comfortable and actually bringing their women in to be cared for in the hospital. But as per, I guess, the birth house model, we're aware of it within the Hospital. There hasn't actually been any conversation with us around that shared moment.

CHAIR - It might happen as part of the consultation on the paper.

That would be good.

While we're in the maternal health area, one of the things we have heard consistently from people who have had a traumatic experience is access to mental health services, prenatally, during their hospital stay and in that postnatal period of care, and the understanding or lack of understanding around psychological birth trauma as opposed to physical birth trauma. Obviously, physical birth trauma experiences often can and do lead to psychological birth trauma as well. That's probably been one of the most consistent and compelling issues

that's been raised with us by individual witnesses who have written to or appeared before the Committee.

Can you extend a little bit on any expansions you're planning on that maternal mental health work?

Mrs PETRUSMA - I'll make some statements, but if it's to do with mental health, it is under Mr Jaensch [Minister for Mental Health and Wellbeing]. I'll make a few comments. The Secretary might be able to provide the Committee with a bit more, but Mr Jaensch is the responsible minister. From reading the submissions, I want to acknowledge the birth trauma experienced by some women in Tasmania, including physical injury, psychological distress or both, and the long-lasting impacts that this can have for individuals and their families. I want to thank everyone who shared their experiences of birth trauma with the Select Committee.

The Tasmanian Health Service manages both physical and psychological birth trauma through various services including maternity and women's health services, perinatal and infant mental health services and the child health and parenting services. This multidisciplinary support team can support the mother through many different avenues, whether it is psychiatrists, psychologists, social workers or nurses. More intensive care and support is available for mothers experiencing mental health concerns such as post-natal depression and anxiety, whether it is at the mother and baby unit or also through Gidget House with the Peacock Centre in Hobart, because that is a new perinatal mental health centre open in Hobart in mid-2024 as part of the Federal Government commitment. That provides face-to-face and telehealth-based psychological support services for expectant and new parents.

There are also other services that can be offered by the Perinatal and Infant Mental Health Service (PIMHS) and I will allow the Secretary, if he wants, to provide a bit more information.

Mr WEBSTER - Thanks, minister. The Perinatal and Infant Mental Health Service is well established in the south of the state, as you probably know, Chair. Over the last three years, we have had funding from the Federal Government to expand that across the north and north west with a high degree of success. The important thing is the integration of that mental health service, particularly with our CHaPS service, but also with our maternal services, so that the referral pathways become seamless, identifying, at the hospital level, that someone is not coping and referring to perinatal before the birth or even a post-birth trauma. The Gidget House model is about that sort of continuity. It is part of a Federal Government initiative to have 12 perinatal infant mental health services rolled out across the country.

One of those is based here in Hobart and as part of the relationship that we have with the Federal Government under our bilateral, Gidget House is actually co-located in our integration hub in North Hobart. They actually deliver their services out of the state Government facility there. There is that better integration with us, so if they do believe that the person, the consumer, has progressed beyond their model, there is referral into the more intensive model, which is PIMHS. This is similar to the parenting services that CHaPS runs, which again, are across the state. They are psychosocial, but also about breastfeeding, all of those things that young mothers might not be coping with, the parenting services are there. Again, it is the referral pathway out of CHaPS back into perinatal mental health. That is what we have strengthened, particularly in the north and north west with the model - including, the second Gidget House opening in Launceston alongside the new intensive residential parenting unit there, which will be run by Tresillian in the north.

CHAIR - Gidget will be co-located with Tresillian?

Mr WEBSTER - Yes. That's right.

CHAIR - OK, great.

Mr WEBSTER - What we are trying to do with our mental health services is have them integrated even though they sit as a separate element of the system. Again, it is also assuring we also are very aware that with acuity level with mental ill health, there is a need to actually balance the parenting element with the dealing with the mental ill health of the consumer as well. There will be occasions where clinicians will recommend separation of the [parent and child] - because of the acuity level as well and that's when adult mental health services kicks in alongside the perinatal mental health services.

CHAIR - Can I ask you another question about the federal funding that you have under that bilateral agreement, specifically around the north west? The numbers in your written submission are quite high numbers - high engagement of consumers in the north-west. I know it's an Australian Government issue, but has that federal funding continued for the PIMHS service in the north west, and is the service going to continue to be provided by THS mental health nursing staff, or is there going to be a hybrid community and THS model like Gidget in the north west?

Mr WEBSTER - We're doing the evaluation at the moment. Whether or not we secure ongoing funding will come out of that evaluation. But, given the numbers we had already, before the Federal Government pilot, we'd already started to expand PIMHS into the north and north-west. I don't see it being withdrawn, but the model needs to come out of the evaluation.

CHAIR - What are the staffing numbers in the north west at the moment for PIMHS?

Mrs PETRUSMA - If it's perinatal and mental health services, it's Mr Jaensch.

CHAIR - I'm sorry, of course it is.

Mr WEBSTER - Off the top of my head, and it's sort of integrated with the north because there are some staff who travel across, I think there are three or four, and I'm looking at Trudi because some of them work out of CHaPS as well to get that level of integration.

CHAIR - But CHaPS only provides postnatal support, doesn't it, not anything prenatal?

Mr WEBSTER - That's right, but identifying postnatal that there is someone is important, but, yes, the rest is prenatal.

CHAIR - I'm sorry, I do keep forgetting about the ministerial split, but on a departmental level and operational level, that ministerial responsibility doesn't really affect day-to-day work, does it? In terms of patients moving between -

Mrs PETRUSMA - No, it's all seamless. That's really to do with which acts come under which minister, but behind the scenes it's one health system. It's very much offering different models of care, seamless small handovers and, yes, they're very much -

Mr WEBSTER - It's just making sure we have multiple referral pathways so that we're not waiting for them to get to a particular point before we get the referral. In fact, it can start from the very first visit to the GP to find out that the mother is pregnant - that might trigger the GP to refer in. So, there is a continuum of referrals and we have to make sure all of those pathways are switched on.

CHAIR - Can we go to the mother-baby unit as well? I know we've discussed that recently, minister. The plans for St Johns Park, will that be entirely under your administration as Minister for Health and through a CHaPS pathway, or is that -

Mrs PETRUSMA - But with in-reach from Perinatal Infant Mental Health Service and -

CHAIR - Into the residential facility, okay.

Mrs PETRUSMA - But, yes, it's all - Perinatal Infant Mental Health Service will definitely be closely connected, as will the psychiatrists and other mental health care professionals. It's part of what we want to see as a step care delivery model, so that people can move in and out of the intensive residential parenting unit. So, CHaPS are the nice, warm umbrella overall, but if they need more intensive mental health support, then they'll be referred to the right place. It's all going to be based on clinical decision making. I think the team is formalising the full model of care next week, which is a different team of experts and specialists are coming together to determine the final model of care, including some of the most passionate advocates for having the model of care community-based because the hospital is definitely not the right setting, especially if they need intensive parenting support. So, a woman's mental health needs will be looked after just as well as her physical health needs, and the baby's needs as well.

CHAIR - I realise the model of care is still being discussed, so feel free to park this question if it's too early to be asking it. When you talked about the residential facility being able to refer out if there are particular mental health concerns for the mum who's been admitted, do you mean PIMHS staff or other mental health nursing staff coming into the residential facility, or those mums being referred out of the CHaPS-run mental health -

Mrs PETRUSMA - Existing staff at the mother-baby unit can work in the new unit. Most women with mental health concerns can be looked after by the new service. It's only when they tip over to where the baby's life, or the mother's life might be at risk, then they need to have an even higher level of acute care because you can't have a mother who's going to be unsafe for herself or her baby. That's when they tip over. The Secretary can offer more information.

CHAIR - I know - and this might be useful for your answer, too - that that used to happen with the private service at St Helen's [Private Hospital]. They had a referral into the psychiatric ward if needed.

Mrs PETRUSMA - Definitely. It still happens now.

CHAIR - I know it was really rare, too. Midwives and nurses we've spoken to who maybe once in five years might've seen one of those referrals for really acute psychosis or someone

referred into the psychiatric ward at the THS. By and large, most mental health concerns were dealt with in St Helen's. Is that kind of the model that's intended?

Mrs PETRUSMA - That's the intention here because the whole point about having CHaPS there, and Trudi and I have had a good conversation about this, is that they identify women who have anxiety or depression at a very early stage. It's those women who we intend on wrapping holistic supports around so they don't progress to having acute mental illness where they then tip over into needing to go into the Royal Hobart Hospital. It is only on very rare occasions that they do tip over to where we do, for the baby's sake or for the mother's sake, need to actually separate a mother and child. The intention is to keep the mother and baby together as long as we possibly can because we appreciate that dyad bond where they need to be together to get much better outcomes for both the child and for the mother as well.

Mr WEBSTER - I'll just comment that it was probably a mistake on our point of view, that because the mother and baby unit sat in a mental health unit within Healthscope [at St Helen's Private Hospital], when it moved across to us, we parked it and put it on the mental health services. It was never a pure mental health services. The staff there are a mixture of CHaPS, mental health, midwives - because it needs all those inputs.

The reason we've acknowledged it should sit under CHaPS comes from the CHaPS name. They're the parenting service part of the department. We think it's important that it is integrated rather than sitting out. Mental health don't usually do psychosocial. They're an acute service. They don't do midwifery. So, the skill sets don't generally sit within mental health, whereas they do within a CHaPS team.

CHAIR - I do understand that. By the way, we've heard glowing reports about CHaPS staff throughout this Committee, other than everybody would like more.

Correct me if I'm wrong, but my understanding of the staff mix at St Helen's, when it was being run there, was, yes, a mixture of midwifery trained staff, nursing staff, child health specialist nurses, et cetera, but they all had some mental health components to their qualifications and training either through a formal qualification, a diploma of mental health, perinatal or prenatal mental health, or through years of experience of working in - recognising that a mother-baby unit, while it's dealing with new parents, is more than a parenting service. It's usually where things - severe maternal exhaustion or a very disrupted baby - that means they need more support than what the regular kind of parenting assistance can provide. Is that the intention for the mixture of staff at the St Johns Park facility?

Mr WEBSTER - Yes, and that's where the intensive work comes in. This is not just our day service or our regular parenting sessions for new mothers. It is the more intensive end. You have to have a mix of skills there. That's the intent. It was our experience with the unit at St Helen's, for instance, that we could very rarely get someone with acute mental ill health admitted to St Helen's, even though we had a contract with them for beds. That was because they didn't have the mental health staff to deal with acute ill health.

CHAIR - Rather than physical access to the bed. That's interesting.

Mr WEBSTER - It was the skill mix the other way, if you like; we're more confident because of our broader skill mix, that we can actually provide that service. A lot of perinatal, a lot of adult mental health, will be in-sourced, rather than sit there in the unit, on a regular

basis. Because of our broader skill base across all of our units, we're probably more confident. Trudi's sitting beside me thinking, 'He's pre-empting my model of care'.

CHAIR - I did preface my question by saying, 'If it's too early to talk about that model', but -

Mr WEBSTER - I'm not pre-empting the model of care, but the concept is it's a multidisciplinary team approach.

CHAIR - Did you want to add anything in, Trudi?

Ms STEEDMAN - Just a couple of notes - the majority of our CHaPS clinicians, approximately 80 per cent, do have a postgraduate certificate in child health and parenting services. In that comes quite extensive training around perinatal mental health - the assessment of, the prevention of, but also the management of that. It's a really good opportunity for the intensive parenting service to be in for that early support. We know that that early intervention can really help stop but also minimise the development of significant mental health concerns. We know that if we can get in there early, particularly for infant sleep and settling - really for CHaPS to be able to provide that wraparound, step down service in the community, going to the residential and then back to the community for more follow-up support - that hopefully that that progression into significant mental health will be minimised. We certainly see that in models across Australia, between the Karitane model and the Tresillian family care model, their percentage of families, or mothers or carers that need that extensive mental health support, is quite low, because it's that early intervention.

CHAIR - That's great, thank you. We're hearing from Karitane later today.

Ms JOHNSTON - I have something about physiotherapy, if I can jump into a different area. Correct me if I'm wrong, but we've heard concerns raised about physiotherapy services offered to mothers immediately post-birth. Ella, you might be able to correct me if I'm wrong from the evidence, but my understanding was that it used to be offered that you would get a visit from a physiotherapist before you left the hospital. Now it is a refer-in to the service, rather than a standardised, 'everyone sees a physiotherapist'. Now you get referred in if there are particular issues that might have come up before you leave hospital. I recognise that everyone gets information about physiotherapy services in their bag of goodies to take home post-birth, including information about accessing physiotherapy services, but obviously, taking new bub home, the last thing you're doing is looking through a bag full of information. You're trying to figure out how to look after a little human.

CHAIR - Or thinking about your own health.

Ms JOHNSTON - Exactly, or thinking about your own health. Are you able to explain to the Committee what the process is for accessing physiotherapy services immediately post-birth, before you leave the hospital and then after?

Mrs PETRUSMA - I will ask Ms French, the Nursing and Midwifery Director of Women's, Adolescent and Children's Services, to reply to that one.

Ms FRENCH - Currently, accessing women's health specialty physiotherapy grouping is a referral-based moment. Acknowledging things around birth trauma is a key indicator

around that referral pathway. Women with a known concern during pregnancy, we also refer in through that process. If there was a previous birth trauma or something like that, we might pick that up through the antenatal period and make those early referrals just to see if we can do any changes to their clinical management during that time. Yes, it is currently by referral process, acknowledging that part of the work that the midwives do around physical management of physical trauma is part of the suite of stuff that would be part of our normal care management and planning and obviously out into the community of physiotherapy pathway as well. That is how it currently works.

Ms JOHNSTON – Is that a change though? Was it that it used to be that you would see a physiotherapist?

Ms FRENCH -I mean, I've been at the Royal for quite a time. Previously, the physios would not actually see each woman and do an assessment or anything like that. There was probably what we would call rounding, where a physio might just pop their head in or say, 'hi', something like that. I wouldn't say that every woman actually went through an assessment, like an in-depth thing about their birth or anything. It was just really a familiarisation of, 'Yes, we exist. If you want to access us, this is the pathway.' It would have been like a flyer-based thing back in that time, but now obviously we have different referral pathways and utilise electronic referrals and things like that.

Ms JOHNSTON - Certainly, one of the concerns that I think we've heard from this Committee is that often women put their needs last in terms of the birth experience. They are so focused on the baby that they often don't realise that these services are available until significant periods of time. It might be the second birth or third birth or 15 years later when they present themselves with an issue that has really arisen from not managing it at the time of birth.

Is there an appetite, then, to look at having that sort of rounding, kind of popping in, 'hello', face-to-face connection with the physiotherapy services rather than just a sort of referral information brochure going home? Just recognising that the importance of being able to communicate in a very difficult time, if you're sending information home, it's not getting picked up, it's not being proactive in terms of trying to nip issues in the bud that can be very expensive and very traumatic later on in the health process and journey. Is there a move to perhaps go back to that system?

Ms FRENCH - Obviously, allied health is having the same sort of workforce challenges as are all other areas of health. Woman's health, particularly, is definitely a very specialised part of physiotherapy. Definitely, workforce broad challenges around accessing allied health. There're no immediate plans to pivot back towards that, recognising all those points you raised. We try to build in through all aspects of our care from the minute someone might book in with their pregnancy, recognising what might have come at a previous birth or any other considerations through that assessment to try to actively move in and refer into that space.

We also have a post-birth referral process. It's referred to as the Oasis Clinic. It's about recognising that post-birth trauma that might be impacting the gynaecological health, which we can then sort of pick up through a gynae, be it six, twelve, five years down the track. We actually have that through what we consider our gynaecology umbrella as far as accessing, and that includes access to a physiotherapy as well as a gynaecologist around urogynae.

Ms JOHNSTON - Fantastic.

CHAIR - While we're on that too - there're so many things we could ask about. With the current referral pathway, is that a referral into a publicly available pelvic floor physio treatment pathway or is it referral into the private system?

Ms FRENCH - This is just my understanding of physiotherapy. Obviously, it sits in a separate area, but my understanding is that our referrals will go through to the physiotherapy department with the specialist women's health physios who have arrangements with different community-based physiotherapy groups.

CHAIR - But it could still be provided through the THS to that woman?

Ms FRENCH - Yes. It might be on site at the Royal Hobart or, I know they do a lot of work through Glenorchy through the women's health specialist service out there just to enhance what they have been doing as sort of a quality improvement exercise to ensure that they can adequately address as many referrals as they can.

CHAIR - Can I ask one more question about the referral? Other than the brochure going home, which Kristie has noted, which happens for, obviously, everybody that gives birth at the THS, those who are referred further, is it just those people who have had significant perineal tears or other birth injuries or could others be referred into that?

Ms FRENCH - Generally speaking, around the perineal trauma, is where the physiotherapy referrals would be, but for some people who might have had difficulties with pelvic instability or, say, a mother of triplets who has had some diastasis that we would consider on a case-by-case basis as far as that referral process would happen.

Mrs PETRUSMA - We do acknowledge that we need more physios in Tasmania, which is why we have been offering allied health scholarships, but we're also working with UTAS because they now do offer the Masters, of course, of Physiotherapy finally here in Tassie again. So, we are very eagerly trying to encourage as many physiotherapists as we can to choose working in the public service instead of private practice. That's why we've recently signed an MOU [Memorandum of Understanding] with UTAS as well in regards to trying to increase onshore workforce here in Tasmania for the future, so it's a lot of work.

I want to provide an update to one of my answers. An email was received from the Hobart Birth House on the 24 February [2025]. My hardworking office met with them on 13 March 2025 and they had been busily seeking further advice from the department regarding the matters raised.

CHAIR - I'm really glad to hear that.

Mrs PETRUSMA - So we'll have more information on that soon.

Mr WEBSTER - To round out the physiotherapy question, CHaPS, as part of their assessments, and obviously they're seeing a child up to five years, will actually have a referral pathway to physiotherapist for the parent as well.

CHAIR - For pelvic floor physios specifically? That's good to know.

Ms JOHNSTON - If I may pick up on another aspect of the answer you gave, Becky, about assessment, when people book in when they first realise they're pregnant, and booking in through THS, what process do you go through to recognise previous birth traumas and to be able to understand someone's previous experiences in terms of a hospital birth or homebirth and triggers that might be for that around what you might need to do managing their care throughout their pregnancy and then also postnatally as well? Can you explain that to me as a complete novice what you might do?

Ms FRENCH - I guess the approach that as midwives and any healthcare providers working within maternity space who are already part of the health service, it's acknowledging that you would go in with a trauma-informed approach to a conversation around that. Part of what we would do prior, when we received the referral, is a triaging process so you would begin to understand - that would include looking at any previous birth and obviously acknowledging there's an ability for the clinician to make some assumptions about a birth and if they'd engage with the service around what might be considered trauma or areas of concern but recognising birth trauma is a very individualised thing as well. Picking up on those cues in that immediate - what we would consider is called a - booking in appointment, would be really part of those key factors in there.

We also do perinatal screening so we do use other tools to sort of get a gauge of where someone might be sitting as far as their mental health. We do other screening - psychosocial screening, family violence screening and other things that are part of that whole suite of the process we do when anyone is booked into our service for maternity care. So it's kind of inclusive as far as our approach to the conversation and really being aware of cues with women, previously looking at their histories and just picking it up through that screening and booking-in process, acknowledging you might pick that up at every assessment or visit that comes through that space as things. As that relationship grows, things might come to light that they might not want to share in that initial visit.

Ms JOHNSTON - Is that initial visit required at the hospital or can that be done remotely or through another service, or do people have to actually physically come in to be able to go through that process?

Ms FRENCH - Part of the triaging is acknowledging the risk factor, potentially. So women who might be high risk, we would definitely bring them in for a face-to-face booking-in process but there is a phone booking-in process as well, acknowledging that women might be at work. They have a lot going on in their lives, potentially, so both pathways are on offer around being able to find what's most suitable.

We also do these visits out in the community as well. We do a lot of satellite antenatal care. So, hopefully we've picked a place to work with women to find a suitable community-based space where we might be seeing them for their care as well.

Ms JOHNSTON - In terms of data collection, do you have data on women who might make the initial booking but then actually don't present for birth? People who've maybe fallen out of the system and they might have gone to the private system or they might have decided to freebirth at home. Do you have any data on those initial contacts and then do you actually see with their bubs?

Ms FRENCH - We do capture and we can capture booking-in bookings. We do look at those every month to see how many women potentially obviously projecting forward about busyness of times and able to see that for birth numbers.

But as far as I guess tracking, which is I guess is the question you're asking, we wouldn't actively check where if someone was booking in with us and then they didn't birth with us. We just sort of acknowledge it from a trends perspective around that.

Ms JOHNSTON - Is that something the department might be interested in collecting? We've certainly heard some evidence on people freebirthing in Tasmania and I'm curious to know whether there are people who have made that decision very early in the piece or with the people who have made that decision later on in their pregnancy journey. Whether it's people who have engaged initially, but then for whatever reason have decided to exit that service, is that able to be collected?

Mr WEBSTER - It may be of interest from a research point of view, but given the low numbers of both homebirth and freebirth at the moment, it's sort of how much effort would we be putting in to track to get those stats when they're so low versus the number who actually end up there. I'd have to talk to our data people about can we do it automatically? But we certainly don't know if someone's freebirthed-

Ms JOHNSTON - Unless they present after birth for whatever reason that might be.

Mr WEBSTER - Exactly.

Ms JOHNSTON - Do you collect that data then at that point in time they have freebirthed at home?

Mrs PETRUSMA - That's really Births, Deaths and Marriages because if you have freebirthed, you still have to register the baby and then it's captured by Medicare. It's captured by other data gathering services. We also have to remember the reasons why sometimes the woman may no longer be giving birth at the RHH is that sometimes they might have booked both private and public. It might be coming down to,'Will I be able to get my private health insurance or do I need to have public health reassurance?' Because it's going to come down to a day apart or something.

But also some women sadly might have lost their babies so for us to ring up and say your baby was due a week ago and then they say to us, I lost my baby at 15 weeks or something, we can re-traumatise parents. We have to be sensitive about the information we're trying to collect when there are other ways of collecting data, which is also through Birth, Deaths and Marriages and Medicare when they have to register a child. There're other ways of looking at data too.

CHAIR - We're nearly at the end of our time.

Mrs PETRUSMA - I do have a big gift; this here is a collection of a lot of the brochures, items that are given out, whether it's the maternity services or by CHaPS and information. Some of it when I was looking at it last night will bring some tears to your eyes. I found it quite emotional because it is about grief and loss.

But just so you understand the full range of resources, well, actually this isn't the full range, this is a sampling of resources we can give parents at different stages of their parenting journey and includes information in regards to informed consent. This is just the sort of documentation that women are given, especially if they're making like a booking at the RHH.

You can see how comprehensive the information to try to assist women to understand consent and their right to consent and their rights during birth. You'll see a lot of that addresses that and some other issues I know came up through the submissions.

CHAIR - That's really useful. Thank you for going to the trouble of putting that together, whoever did that piece of work, everyone involved, thank you. It's been really important for the Committee to hear the evidence you've provided today. Thank you to you and all of your team for making your time available to us.

We discussed as a Committee yesterday whether or not we try to find another date to have Mr Jaensch here or whether we provide written questions to him if he's happy to accept those. If we go away as a Committee and have other questions, are you happy to take written questions from the Committee at a later date?

Mrs PETRUSMA - Definitely. If you need us to reappear to clarify any points, we're happy to come back as well in person if that would be easier for you.

CHAIR - Before we finish, I just need to read another formal statement into the *Hansard* for each of your knowledge. Thank you for your appearance. What you have said to us today is protected by parliamentary privilege. Once you leave the table, you need to be aware that privilege is not attached to any comments you may make to anyone including the media even if you are repeating what you said to us. Do you understand that?

WITNESSES - Yes.

CHAIR - I don't think anything really came close to offending parliamentary privilege, but we need to make sure we're on the record.

Thank you also for agreeing to take any further questions in writing. We are keen to progress the work and get to our report writing stage and present something to parliament. I think if we did seek further information, as Chair, my anticipation is that would be by writing rather than another hearing date, but I can't rule that out. That would be a decision for the whole Committee. Thanks again.

The witnesses withdrew.

The Committee suspended at 10.31 a.m.

The Committee resumed at 10.46 a.m.

CHAIR (Ms Haddad) - Good morning. Thank you and welcome. Thank you for attending today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services. Thank you, too, for your written submission, which we've all received and read. We look forward to exploring with you further. Could you state your name and the role in which you are appearing today?

Ms O'LOUGHLIN - My name is Grainne Ann Faith O'Loughlin. I'm appearing as the CEO of Karitane, but I do wear several hats which I'm happy to explain to the Committee that may be of relevance to the hearing.

CHAIR - Lovely. Thank you very much. Can I confirm you have received and read the guide sent to you by Mary, our Committee Secretary?

Ms O'LOUGHLIN - I can confirm I've read it. Thank you, Mary.

CHAIR - I remind you of the pertinent parts of that document. The hearing is covered by parliamentary privilege. What that means is that you can speak to us freely, share whatever it is that you would like the Committee to hear without any fear of being sued or questioned in a court or any place outside of Parliament. The only exception to that is that protection does not extend to statements that you make that might be considered defamatory if you repeat them or refer to them again outside these proceedings. Does that make sense? Are you happy with that?

Ms O'LOUGHLIN - Yes.

CHAIR - As I said before the broadcast started, this is a public hearing, which means members of the public or media may join us in the room here today. We are being broadcast live and there might be members of the public watching. If at any point you'd like to give evidence to us in private, you can make that request and we will move into an in camera session and we can hear any information you'd like to provide to us privately.

Ms GRAINNE ANN FAITH O'LOUGHLIN, CEO, KARITANE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Great, thank you. I'll just introduce our Committee members. Anita Dow who you just met on screen. Anita is a member for Braddon, which is in the north-west of Tasmania. Nic Street, the member for Franklin, which is kind of metro Hobart, as well as down into the Huon Valley. My name is Ella Haddad. I'm the Chair of the Committee. I'm a member for Clark, which is urban Hobart, metro Hobart. Kristie Johnston, also a member for Clark. We have a couple of apologies from Committee members who can't make it with us today: two members for Bass, Ms Rosol and Mr Fairs.

I'll read our sensitive content information into the *Hansard* for anybody joining us online or accessing these transcripts after today's hearings.

We recognise as a Committee these hearings are discussing highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening

to or participating in these proceedings. We encourage anyone impacted by the content during this hearing to contact services including Lifeline on 13 11 44, Tresillian on 1300 827 282, their Parent's Helpline, or PANDA's national helpline on 1300 726 306. There are other resources on the Committee's website.

Are you happy to start with an opening statement?

Ms O'LOUGHLIN - Thank you so very much for inviting me to address the Committee. It's been a little while obviously, since I submitted the original submission and then a revised submission in September 2024. I would like to acknowledge the great work and progress that's been made in Tasmania since the Inquiry was launched.

Karitane is an organisation that's 100 years old - just turned 101 actually - established in 1923. I've been the CEO there for just over 10 years. The work of Karitane is around the important first 2000 days, early intervention and prevention from child and family health services and also perinatal and infant mental health services.

As I alluded to, just as we opened, my role as well as CEO of Karitane, that may be pertinent, is that I am the Chair of the Australasian Association of Parenting and Child Health (AAPCH), of which the CHaPS service in Tasmania is a member. That's an organisation that brings together the practice wisdom from child and family health across the country and looks at models of care, workforce issues, quality and safety and things of that nature.

Karitane holds a lead agency contract with the Commonwealth Department of Health and Aged Care for the ForWhen perinatal mental health navigation service. We do hold a formal contract with Tasmania Health Service between Karitane and THS for the provision of that service to Tasmania.

I would also like to acknowledge I'm a member of the National Child and Family Hubs Network and some of the conversation that we may talk about today will allude to integrated care, models of care, stepped models of care and really systems transformation and looking at the whole child and family ecosystem. I welcome your questions and look forward to our conversation.

CHAIR - Thank you, I think the Committee is really fortunate to be able to learn from your experience across all of those various hats and thank you for generously giving us your time today. We are really keen to learn from you and learn about where there might be gaps in Tasmania service delivery, where there might be things we can learn from other states and territories.

I'll open it up to the whole Committee but before I do that, could we have a little more information about the Karitane model? You've explained the practice framework in your written submission as a triaging model. Could you tell us a little more about the model of how you triage and refer. Also, if you have data on how often in Tasmania you can't find a service to refer someone who contacts the Karitane line or there might be a service, but there's a long waitlist or other barriers to getting people into those services you need to triage people and refer into.

Ms O'LOUGHLIN - Yes, I think the first question about Karitane as an organisation is there in your papers - a model of care that really describes the continuum of care from

Karitane's care line where we just pick up the calls from parents seeking a little bit of help and support across a number of early intervention and prevention programs all the way up to what we would call intensive support.

Intensive support in the child and family health lens being the inpatient residential unit or that tertiary level of care that we provide across the state in New South Wales, which is under a conversation obviously for Tasmania with inpatient residential beds. Karitane may be a little bit different to some of the child and family health services in Tasmania in that we do have what we call our PICMH service, which is perinatal, infant child and mental health services. We do employ perinatal mental health, infant mental health psychiatrists and clinical psychologists around early intervention, prevention for children with disruptive behaviours.

We have along our stepped model of care from careline and intake, because we've got so many programs that families could really fit that best meets their needs, it's quite important that at that front door we understand what the family's needs are - that we are not over-servicing people by funnelling into scarce, inpatient tertiary beds and that we help families every step of the way.

Karitane would receive about 430 referrals per month. All of those families have to be triaged through our centralised intake system. That's staffed by admin support, but actually trained child and family health nurses. It's a clinical decision-making tool and we have a toolkit called the Karitane Triage Tool we use for all the statewide referrals in New South Wales.

There's probably a series of clinical redesign elements because to deal with that volume and to make sure families are responded to in a [timely] way, there's obviously moves towards AI and algorithms. If a family just needs a call, a webinar or an online resource that we're not really funnelling them to a child and family health nurse interview - a pre-admission interview - which happens which then allows families to be matched to the point of care that best meets their needs.

We receive referrals into that intake team through health professionals, largely what we call the universal child and family health nurses who are in the front line that would do the blue book checks and follow families up to the first six weeks. Then there becomes almost like a tipping point for families where universal services are not able to meet their needs and families are identified of having some other more intensive support needs, whether that be for sleeping, settling, breastfeeding, perinatal mental health, et cetera.

At that point, we would see what the level of referral is - GPs, Child and Family Health Services. Often, if I reflect back to 10 years ago, the referral patterns were, a family goes to a GP and the GP says, 'You just need Karitane.' They didn't know the plethora of models of care, and everybody was getting funnelled into the beds when they didn't really need a tertiary level of care. So, it became looking at what was the gap between universal services and these quite scarce and expensive to run clinical beds, and we adopted more - the rest of the health system, so, we're a public health service affiliated health organisation, so we are a not-for-profit and a charity, but we are mandated by New South Wales health policy directives and policy. We adopted - almost the admission avoidance strategy; what can we do in a preventative way so we're not funnelling families to this point of care?

Also, we were noticing from data that families would come in, that there's been a traditional model across the country of four nights, five days, and we're really testing that with

evidence. How many families stay for four nights, five days? What are the clinical outcomes and impact? How many families discharge early from the program and what's the reason for discharging early? So, parent's sick, baby's sick, they got what they needed after two nights, it wasn't the right program, it didn't match the expectation of what they were getting. There's been a very traditional model that's run for many, many years across the country, in residential beds particularly, and I'm aware that Tasmania didn't have a public residential bed and we had the St Helen's [Private Hospital] model, and I'm very cognisant of the changes that have happened in the system the last 18 months. But, really, with the exception of the Northern Territory, every other state and territory has a residential bed that is a child and family health residential bed -

CHAIR - And publicly.

Ms O'LOUGHLIN - Apart from WA. WA has Ngala and it's just made an announcement actually in the recent election that they will be a publicly funded unit, but it was previously privately only, so I think that's about to shift. There is a distinction between the residential units that are run by child and family services like Karitane and Tresillian. They are not mother-baby units, they are not psychiatric facilities and they are not for parents with moderate to severe psychiatric diagnoses. In New South Wales, in addition to Karitane's residential units and Tresillian's, there are parent-baby units that are centralised for the state, there are two, one at Westmead and one [at the Royal Princ Alfred Hospital]...

The connection across from our intake teams is, first of all doing what we call a PAI, parent assessment intake, a detailed psychosocial screening and mental health screening and domestic family violence screening, and to say, 'Are we the right organisation for this family to come into and do we have a point of care that's going to suit this family's needs? It's not under- or over-servicing.' That intake tool has been shared with AAPCH [Australasian Association of Parenting & Child Health] colleagues across the country, so if there are people who are revising their intake they can have a look at what we do and what they do to look at best practice and benchmarking.

The other pathway that happened during COVID was that, because we were a secondary referral service and we relied on health professionals to find parents who needed that extra hand and to make a referral - that was creating some barriers to care because, one, bulk-billing GPs were disappearing in our sector and it was a barrier for families - one, to get an appointment with a GP and, two, to pay out-of-pocket expenses. We were starting to see that we weren't reaching some of the more vulnerable communities because it was families who could afford to go to GPs and get a pathway, so we were getting culturally and linguistically diverse and First Nation families having less access to these tertiary beds because there were some barriers at the front door.

And, child and family health nurses, when there were shortages in the service system. If you didn't have a local universal child and family health nurse, then you didn't get to an entry point that could identify your issues to get to the secondary service. Shortages and barriers at the front end created problems, I guess, for families.

What we did - and that only heightened during COVID because obviously GPs were, well, everybody was redeployed and focused on COVID and support systems. Families couldn't get to see a child and family health nurse or a GP.

CHAIR - They were also often working on the COVID response.

Ms O'LOUGHLIN - That created quite a shift in New South Wales. We spoke to our colleagues at Tresillian, to Rob [Mills, Tresillian CEO], who I know very well, and we said, 'Look, we are a secondary service, but we are going to have to create a self-referral pathway.' That doesn't mean a family can say, 'Hi, I want to come into your beds,' all it says is, 'I have a mechanism to make myself known to you that I need some support. I may not know what kind of level of support, but I need it.' Self-referrals come into intake, then we go through the process. The source is now, GPs, health professionals, and self-referrals.

CHAIR - What kind of split is it between those three referral pathways?

Ms O'LOUGHLIN - During COVID we were probably sitting around 80 per cent were self-referrals and it stayed quite high. Pre-COVID it was the reverse. About 75-80 per cent were all through health professionals. We went very high during COVID when there were a lot of service closures, obviously. We're probably just settling down, but still well over 50 per cent that are self-referral.

Now, there are some risks with that, in that you get families who just have a universal [service] gap and they're referring to intake and the resources used to triage them, but they may never come to Karitane. In a broader service system, that navigation piece is critical for families. If we adopt the 'no wrong door' and help families to navigate to the right point of care, then that higher order vision is that families get to the service they need to get to. If it's our door or Tresillian's door or a phone call to whoever it is that there's a pathway to say, 'Okay, it's not us, but we're not just going to say its not us, we're going to help you get to where you need to go.'

CHAIR - We know who it is. There's a warm referral into - that's really logical.

Ms O'LOUGHLIN - We're finding that intake and care navigation is becoming a stronger model. For Karitane, if I talk about the broader child and family ecosystem, we have lots of NGOs that are funded by Commonwealth programs for families in more vulnerable communities. We also have our health system, we have our early education, we have emerging foundational supports. In south west Sydney, where Karitane is, we have 52 NGOs that provide some form of child and family support. If we don't know how to navigate that system and what those NGOs do and what the health system does and what the early education does, then our families don't stand a hope.

I guess we've been looking at the role of - a little bit what you're doing now actually - what is happening in our entire service system? Who's providing what against these continuum of care? There is some duplication between state- and federal-funded programs. How do we smooth our scarce resources to make sure that the whole continuum of care from prevention, early intervention, up to intensive and tertiary level support is used efficiently and effectively. That's where the integrated models of care have come along, working in partnership and collaboration.

I feel I might be going off topic or into something else but that's the reason the centralised intake is super important because you'll have many service providers in your system that aren't just sitting in CHaPS and Health, but how do you make it seamless for families to get through to their points of care?

CHAIR - It's that 'no wrong door' approach. I think it is really important.

Ms O'LOUGHLIN - It is. We're really excited. We don't know if Tasmania has been equally excited, but the Child and Family Learning Centres have been running for a very long time. Even though they're funded through Education - the whole of Australia is looking at child and family hubs as a model of care and I feel that there's a real golden egg opportunity.

CHAIR - There is. They're very well frequented in Tasmania where they exist. They're very important parts of our community.

Ms O'LOUGHLIN - Yes, and in our submission there's a child and family hub for Fairfield that we're designing. It's like that. It has all the tentacles of NGOs, family violence, legal, social supports, wraparound supports that a family need. Our role is to bring those partners together. It's not just co-location where you just go in a door and you see them or in a door and you see here, it is actually the family being navigated smoothly to all those providers. They won't know if it's Karitane or Barnardos or Uniting, they don't really -

CHAIR - need to know where the funding source exists.

Ms O'LOUGHLIN - They don't need to know where the funding source is -

CHAIR - That's right, they just need to get the service.

Ms O'LOUGHLIN - as long as they get their housing matters and their social supports and the domestic violence [supports]. It's just a seamless sort of come-in [continuum of care]. That can be anything from -

Mr STREET - The front door is the most important -

Ms O'LOUGHLIN - The front door is so critical.

Mr STREET - that it's identifiable and that it's welcoming as well.

Ms O'LOUGHLIN - Exactly. Our work in doing that has been around authentic - you'll probably hear the word 'co-design' a lot. There's co-design and there's co-design. Community consultation and consumer-led care is really - we're designing a hub at Fairfield, and we're like, 'We could do this, we could do that', and the feedback from our multicultural families particularly is saying, 'Do you know what, we hate the fact that you have sliding doors with black film on them, because it looks unwelcoming and it looks like we're coming to Centrelink. We'd like this, we'd like that, this is what would be amazing for our kids to play with, I want to come in for a cup of tea and meet my peers and not feel like I'm being watched or judged or anything like that'. It is those soft entry points that really build trust for the community, and services that are designed by the community, that go, 'Hey, somebody's listened. We haven't just answered questions'.

CHAIR - It would be nice if Centrelink was also a welcoming environment; that's such a great example.

Ms O'LOUGHLIN - That's right, but Centrelink can come into the hubs and not look like Centrelink. There's different ways to connect up the resources in the system in a more

efficient way for the system, but in a more beneficial way for families. That's what excites me about the opportunities that lie ahead for Tasmania, so we're part of those conversations.

CHAIR - That's great. Maybe just before we open it up, you described really well those experiences in western Sydney, in terms of navigating people in those 50-odd NGOs. Do you have any observations from the work that Karitane does in Tasmania about that service system and where the biggest gaps or, as you said, potential duplications, might be in a Tasmanian NGO context?

Ms O'LOUGHLIN - I have, and I'm happy to share these afterwards if they're useful, a slide deck of some stats and data. I'll look at them but I'll read them out, if that's okay.

Particularly for the ForWhen perinatal navigator service, we've been gathering data. We started that service in February 2022, funded by the Commonwealth Government. To date there have been 486 referrals. Those referrals are pretty constant. They're not really rapidly rising.

CHAIR - Is that just in Tassie or is that nationally?

Ms O'LOUGHLIN - That's just Tassie, sorry. We have over 7000 nationally. I'll refer to Tasmania's context. You represent 7 per cent of the total national cases that have been referred. Seven per cent are from First Nations parents and families, and that is higher than the national average to the program, which is 4 per cent, and 5.5 per cent are male partners or non-birthing partners. We're getting quite good engagements with dads and male partners.

Tasmania has a higher percentage of pregnant parents who referred in the second trimester, compared to other states. There is something there antenatally about engaging the families -

CHAIR - Earlier.

Ms O'LOUGHLIN - Yes, so not focusing only on after the birth and the postnatal period, there are families who are being picked up who are developing anxiety and depression in the pre-birthing phase. We're definitely seeing a higher percentage of that coming through. You can't see it, but I have a location map of where the families are coming. It's not all clustered around Hobart, we have quite a cluster around Hobart and southern Tasmania, but there's a good cluster in central and north-eastern Tasmania, and then quite a few First Nations families, a lot up in the north and eastern corner, and in the centre as well. I'll send you the heat map of where the families are coming from.

The issue for the perinatal navigator here is that our job is again to try to match families to the level of care they need. The navigator program is designed for families and parents experiencing moderate to severe perinatal anxiety and depression and, is it a GP, a Gidget House or an online resource? Our job is to see even if there isn't the optimal service available, where is the next best? And now we start to record. They didn't get the optimal, but they got the next best or the next best because that's all that existed. So doing a gap analysis is really for the Federal Government on some of the PIHM services but also recognising that these families don't singularly have anxiety and depression as a presentation. They often come through our front doors needing breastfeeding support, sleep and settling, and we know if we can get that preventative piece early enough then we can actually avoid some of that escalation. You've probably heard that from our various other colleagues.

But in terms of moderate to severe cases - I'm just looking at our data - 86 per cent in March 2025 were screened and triaged as moderate to severe perinatal infant mental health families and 14 per cent [were mild cases] - the variation there seems to be anywhere from about 67 per cent up to 100 per cent - being moderate to severe. But when you see it, there's a coloured chart and everything that's in orange I'm showing is moderate to severe [and] in the blue [is mild]. So we are definitely getting quite to the target audience.

In Tasmania, 52 per cent of clients are entering a service with a K10 [Kessler Psychological Distress Scale] score of 30-plus, which is severe and that's above the national average which is 47 per cent through our program.

In terms of referrers to the service, there're more referrals, in fact, from your midwives in Tasmania to our navigator. So, as well as self-referrals, again we've got child and family health nurses, GPs, mental health professionals, midwives, other nurses and social workers. So there's a very multicoloured chart which I'll show you about the split of referring.

From August 2023, where a service referral was needed, 88 per cent were able to be referred to the preferred service and 38 per cent were referred to telehealth services, including interstate private NGO psychology services, and the national average for that is 34 per cent.

So I guess it's making sure that Tasmania knows that they don't have to do all the heavy lifting. There are online resources, other pathways and so even if you're on a waiting list for somewhere, we can support that family whilst they're waiting for the preferred service of choice. As I say, those are probably some of the highlights for the Tasmania context.

Mr STREET - How are you funded?

Ms O'LOUGHLIN - How's Karitane funded? We are funded by a myriad of funders, so predominantly, New South Wales Health - New South Wales Government, and the largest contract we have is with the Ministry of Health, with a local health district, which is South Western Sydney Local Health District. So, our operating revenues are about just over $20 million, about $8.5 million of that would come through New South Wales Health.

We also then are commissioned by the Department of Communities and Justice, more the social services, and they fund us for a number of community-led programs for families in disadvantaged and more vulnerable communities. That would be supported play groups and things of that nature, and then we've got some Commonwealth Government funding through DoHAC, which is the national perinatal mental health navigator. They fund Karitane and then we partner with all the states and territories to run that.

Mr STREET - The work that's done in Tasmania is funded through the Commonwealth Government?

Ms O'LOUGHLIN - Yes, so, Karitane doesn't have any statewide contracts with the Tasmania Health Service.

Ms JOHNSTON - You touched on a bit beforehand about virtual, digital and hybrid models of care. How important is that to a state like Tasmania where we're quite regionally diverse and to try to make sure we get access across the regions? Can you elaborate a bit more

on how that works for our people coming in through your intake service in terms of the importance of digital and virtual access?

Ms O'LOUGHLIN - Certainly. New South Wales, similarly, has quite a dispersed rural and regional community. I guess, in about 2017 we made a very deliberate decision around accessibility for families. We actually piloted some studies at that time in partnership with NSW Health and just seed-piloted it by Karitane around virtual home visits for child and family health nurses, really to see if there was consumer demand, appetite impact, efficacy, safety, et cetera. We did a two-year pilot, which was successful, presented data. We've got a partnership with University of New South Wales around academic research and evidence-based practice, quite robust studies. I shouldn't say 'quite', I should say 'very', particularly if the University of New South Wales is listening.

That then turned our attention to actually access for child and family health nursing consults - what else in our suite of continuum of care might be amenable to a virtual model? We got a grant from the mental health branch around managing children with disruptive behaviours. Very huge demand like there is in Tasmania, big waiting lists for paediatricians and diagnostic and early intervention and prevention before children get to school. That's one of our biggest waiting lists. We've got an eight-month waiting list even at Karitane for children with disruptive behaviours for treatment.

We turned our attention to a pilot trial for that and then COVID came. We thought, well, actually we've got some 20 staff trained and there are models of care and evidence, and we closed our doors during COVID to the residential units because of transmission and unvaccinated babies and safety for workforce and also babies and families. In that three weeks we shifted all our residential services to a virtual residential unit again in a pilot testing phase. We've done some publications, which are available, on the efficacy and impact.

One, it was reactive, but the studies actually showed that for accessibility, we were increasing accessibility to rural and regional. We were overcoming some of the rural and regional workforce shortages because even with local secondary services trying to be established, we could see that we could extract and retain child and family health nurses in these remote locations. That left it up to probably mobile services or families travelling into metro areas for care.

Again, we wrote after two years, a business case to the ministry and we were really delighted that the New South Wales Government funded 20 virtual residential parenting services on the basis of our virtual residential unit model. They allocated 10 of those virtual beds to Karitane and 10 to Tresillian. We've been running those for the last four years. There's an independent evaluation which is just about to fall due in April [2025]. I was going to say this month, but very soon.

The occupancy rates have been phenomenal; 95 to 100 per cent occupancy of those 10 beds. We do triage into those because not every family is clinically suitable, but there are a number of families who are and the impact and outcome for those families have been strong for any studies that we did. At six weeks post-follow up, families were actually more confident from the virtual cohort than from the inpatient cohort.

We believe, and we'll do more studies, that it's because families are in situ. They're learning how to sleep and settle in their own home, in their own space not surrounded by child

and family health nurses. When you're in an inpatient setting you feel like - families were nervous going home because 'it all sort of worked beautifully but -

Ms JOHNSTON – what if it all falls apart when you go home.

Ms O'LOUGHLIN - What if it all falls apart when you get home?' Also, partner inclusion. If there's a parent working or whatever that situation or another carer in the family, people could tune in after hours at nights 24/7 on call. It's like having a nurse bell on call.

We are really hopeful that the virtual residential is here to stay. That's certainly one of the conversations we've been having with CHaPS. Out of all those services that are setting up, it's quite easy to set it up if you've got a good centralised intake and triage effected families, but you also don't need a local workforce to do it. They can lean in, partner, and collaborate.

CHAIR - So that's something you're talking to the THS and CHaPS about?

Ms O'LOUGHLIN - Yes, CHaPS and the THS. We put some proposal for that and for the disruptive behaviours for the children waiting on paediatric waiting lists and the high demand for paediatricians. We think there's - I guess our conversation has been about, what do you have in your service system? Where can we help build a capacity or work with you to partner to build capacity across from Karitane or AAPCH colleagues; what will help CHaPS and the service system? Then where is there still a gap that might be useful to partner with someone as a service provider or to transition to getting CHaPS ready to be that service provider ultimately.

What you also spoke about was the integrated and hybrid models of care. In the child and family hubs that we're setting up, they tend to be established in more regional centres with high levels of vulnerability and disadvantage.

You also asked about funding; we've large philanthropic organisations like the Paul Ramsay Foundation and the Investment Dialogue for Australia's Children. There's a real place-based partnering with government movement that is happening, which I think would be exciting for Tasmania to be part of those conversations.

But what we see is setting up these place-based - say it was in New South Wales and it was out in Orange and there might be four service providers, a couple of NGOs, a great GP, but you don't have everything you need to provide all of that wraparound. Then we've been working on a hybrid model of care, so which services could be provided virtually from child family health nurses or paediatricians or whatnot so that you actually develop a hybrid place and wraparound virtual supports with good partnering.

Partnering doesn't come naturally to lots of organisations. There are silos and tussles around funding and there is competition in all of that. We've been working with our partners and have 60 people interested in the Fairfield [Integrated Hub] partnership to be service providers to different organisations on capacity building to work effectively in partnership and what that looks like creating vision, shared governance data, et cetera, et cetera. You don't end up just with co-located models that feel still just as fragmented for families.

I could talk to you about that for a long time, but I won't. The other piece I popped in there was on often we do have mobile services as solutions. Again, sometimes those are

singular service providers and the cost impact of that and the risks and the safety and how we actually integrate mobile services. If there's a mobile bus going from one organisation, can it take five other people with them who do different elements of wraparound support. You get a mobile integrated care hub and if you like -

CHAIR - Mobile, multi -disciplinary I'm thinking of the acronym now.

Ms O'LOUGHLIN - Yes, so we've talked about integrated care hubs, mobile integrated care hubs and virtual and hybrid integrated care hubs. Various organisations can be the lead depending on what relationship they have with the community. It really shouldn't matter.

Mr STREET - We've got to stop with the acronyms. It has been hard for me to pick up as I have come late to this Committee.

CHAIR - I actually used to really hate acronyms and now I'm one of the worst offenders.

Ms O'LOUGHLIN - I would say one more thing on that is on impact evaluation of the services and how important it is to build in outcomes. We've got digital outcome tools that we use, which I think might actually be adopted by Tasmania, certainly South Australia and New South Wales. But anyway, there's Karitane parent confidence scales and other scales that we can then actually create benchmarks on impact and best practice models of care like the Health Roundtable does for other bits of the health system.

Ms JOHNSTON - Regarding the virtual delivery of services, have you found challenges around digital literacy for many of the communities, some of the most disadvantaged you're trying to connect with? Because that's clearly an issue in Tasmania with digital literacy.

How do you overcome those barriers? In terms of families you really want to be connected with who might have a low digital literacy levels, how do you provide a virtual service in that environment?

Ms LOUGHLIN - There is a digital divide and affordability for people to have data and to run things, we actually as part of the outreach for the child mental health services provided dongles and other things to people. Again, we had to look at the whole solution.

Like what was the barrier that we're stopping at? We also kept hearing, our First Nations families don't want to connect through phones and what not. ForWhen has absolutely blasted that out of the water and because we got cultural leads, we got yarning leads, we've got Aboriginal family support workers. It's about that soft entry point. Where's your first touch point that builds enough trust to do that. There were some myths, I guess. We set up an NGO telepractice during COVID and there were a lot of - everybody said, 'it's relationship based and it can't be done virtually and nobody will trust it and nobody will do it' - and there are some families that don't. It's not a one-size-fits-all solution, but it actually increases access for a cohort of families that benefit.

Ms DOW - Thank you very much for presenting to our Committee. It's been really informative. There were a couple of things that I wanted to ask you about. The first is where you speak about CHaPS and the opportunities to work in a strategic partnership with CHaPS, the THS and service providers across Tasmania in the implementation of our Children's, Youth and Wellbeing Strategy in Tasmania, in particular around a program of sustained nursing home

visits across the CHaPS for vulnerable families or families that are at risk. You've spoken a lot about the partnerships that you have formed with other state governments, mainly the New South Wales Government.

Do you perceive there any barriers to working with the THS at the moment in Tasmania, obviously not funded by them in any way, shape or form to provide services - that's primarily federal funding. I just thought you might provide a couple of points to the Committee about that and those opportunities that you see and what the benefits to Tasmanian women, families, children and babies would be.

Ms O'LOUGHLIN - We've had a longstanding relationship with CHaPS and the director of CHaPS. What we've noticed is the acting roles and the staff leadership in CHaPS that have created a focus more on operational matters and in the last 18 months, we've seen a turn towards the strategic planning of what a holistic model of care would look like and what CHaPS' capability, scope and vision is.

I think that's a really positive shift and in terms of navigating, this is why this Committee is so welcomed because it really needed that helicopter overview of the service system to really see where the gaps and the opportunities are. I think you've shone a light on that already and I'm sure your findings will continue.

I then think it's around that entire ecosystem - one thing I'm not very clear on is what the procurement mechanism is. You've got a whole range of subject matter experts, partners, NGOs and others, both within the Tasmanian system and outside of the Tasmanian system, just navigating through, to be honest; the department secretaries and the changes and who to speak to was, is difficult.

I'm not saying that any other state or territory has got that completely clear either, but certainly a willingness in other jurisdictions where we've had whole of organisations where health, early education, NGOs and interested partners have been brought together to do strategic planning, and so, I found that a lot of conversations in Tasmania have been on steering committees or certain committees that we may not be able to have a voice into or hear from.

And so, I guess a mechanism for ongoing consultation for the best service solutions and the best systems design would be really welcomed and then looking at what can CHaPS currently deliver and what's their vision, and what they, with a little bit of support from peer groups and others, be able to deliver? And then, what would they consider out of scope where a partnership with another Tasmanian provider or another AAPCH provider might be the solution or might be a temporary solution whilst they get to full enablement?

I think that would be a big enabler, Anita, if that answers your question.

Ms DOW - Is there a specific mechanism or governance body in other states or advisory body in other states or jurisdictions that you would recommend to this Committee to look at; its form and function and how it interacts with government and it provides advice about system design and workforce challenges and the like? That would be of interest to us, I think, to understand what exists in other jurisdictions and what you recommend has been valuable and successful.

Ms O'LOUGHLIN - Yes, certainly. I can speak to probably about three. I mean all the service systems are in various states of reform. That includes the NGO system with out-of-home care and permanency support. It is actually looking across the service system that's very important. I think sometimes in health we look vertically from universal to tertiary and bringing that breadth of service providers in is important.

In New South Wales, there is the First 2000 Days initiative which crosses portfolios of health and education [and social services], and some degree of NGOs. Looking at the strategic plans that come from those service providers and the overarching Brighter Beginnings: The First 2000 Days of Life policy, which you've probably heard about or aware of. In Victoria, there has been a significant amount of work around the early parenting centre development. There were three major service providers in Victoria: Tweddle, QEC [the Queen Elizabeth Centre], and Mercy Health. When I say early parenting centres, these are residential beds, commissioned, I think, another 100 beds from across many health service providers; Monash, Bendigo, there's a number. That was commissioned and then all the partners had to co-design, but what they did was they buddied up an experienced service provider with an emerging service provider so that there was that collaboration and partnership across the service system. No-one had to start from scratch and work it out for themselves. It was a leaning in to create that independent service delivery.

In Queensland they've done a massive amount of a really impressive work through the Queensland Health Department. We were up in Queensland last November with the AAPCH. There's a number of people there I could put you in touch with, again across service redesign but also investment in the child and family ecosystem. You've got Thriving Queensland Kids as an initiative. In Victoria, you've got the Murdoch Centre for Research [Institute].

The good thing about these, they're primarily research-driven initiatives, doing great research, which builds pilots and capability, but they're partnering with service delivery organisations. Having CHaPS or Karitane et cetera, partnering as a service delivery to pilot things that can then rapidly be adopted from knowledge translation, not just to publish a paper, but actually to change models of care and service delivery because they're proof, and evidence-based and helps government really decide where the best bang for buck is.

There are so many places and spaces that government could invest money. Sometimes I think it must seem to government, and I don't blame it, that, ‘are services interchangeable? I've got one care line here and one service provider, don't they do the same as them? Where's the overlap?’ With government making decisions, it's really important that we've got these subject matter experts that say ‘that is not the same as that. You can't replace this with that.’ This is a stepped care model and you need every bit of those to have that wraparound. I'm not sure we're quite there yet in some of the states and territories. Certainly moving towards it in Tasmania is my observation.

CHAIR - I hate to draw our conversation to a close because I think we could keep talking all day with you, but we've gone a little bit over time.

Ms O'LOUGHLIN - Sorry about that.

CHAIR - No, don't be sorry. Thank you very much for appearing today and for giving us a brief kind of insight into your vast experience. If other things come up after the Committee that you think, 'I wish there'd been more time', please write to us again through our Committee

Secretary, Mary, whom I should have introduced at the beginning as well, but I know you've had contact with Mary.

Equally, if you're happy for us to write to you down the track if we need to when we get to report writing stage, we'd appreciate that.

Ms O'LOUGHLIN - I'm very happy to. Thanks so very much for having me and thanks for your questions and time and interest. Have a good afternoon. Good luck with the reporting and the outcome. You must be getting to the end?

CHAIR - Yes, we are.

The witness withdrew.

The Committee suspended at 11.36 a.m.

The Committee resumed at 11.41 a.m.

CHAIR (Ms Haddad) - Good morning and thank you all for joining us. Welcome to today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania and thank you for the written submission you've provided to the Committee. We've all received and read that submission. Could you state your name and the role in which you are appearing before the Committee?

Ms FLANAGAN - I'm Jo Flanagan, CEO of Women's Health Tasmania.

Ms SHANNON - I'm Lucinda Shannon, Deputy CEO of Women's Health Tasmania.

Ms HEARD - I'm Elinor Heard, policy officer at Women's Health Tasmania.

CHAIR - Can I confirm you've each received and read the guide sent to you by our Committee Secretary? Great, thank you. To remind you, the pertinent part of that document is that the hearing is covered by parliamentary privilege. What that means is that you are free to speak to us in any way you wish and share any information you wish without any fear of being sued or questioned in a place outside of these hearings.

The only exception to that is it doesn't extend to any comments you might make if they are considered defamatory and you repeat them outside of this place. You can make them in here, but if you repeat them outside of these proceedings that parliamentary privilege doesn't extend and the hearing is public, which means public and media might come in. We have had people observing previous hearings or watching online.

If at some point you would like to give any oral evidence to us in confidence, you can ask for that. We have a short deliberative meeting to agree to go into what's called an in-camera session and we can do that and then the broadcast stops. There'll still be a *Hansard* transcript, but it won't be a public document.

I'll introduce the remaining members of the Committee. You saw one of our members just had to leave unwell. Joining us online is Anita Dow, member for Braddon in the north west. Nic Street is the member for Franklin, in the south. I'm a member for Clark. My name is Ella Haddad and I am Chair of the Committee.

We've got apologies from Kristie Johnston, member for Clark; Cecily Rosol, member for Bass; and Rob Fairs, member for Bass. They are all unable to join us. But they have your written submission and they'll read today's transcription and be part of the report writing. Mary, our Committee Secretary who you've had contact with, is at the table.

Ms JOSEPHINE FLANAGAN, CEO, **Ms LUCINDA SHANNON**, DEPUTY CEO, and **Ms ELINOR HEARD**, POLICY OFFICER, WOMEN'S HEALTH TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION, AND WERE EXAMINED.

Thank you. We're providing a sensitive content warning at the beginning of each session. As a Committee, we recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians, which may be a trigger for individuals listening to or participating in these proceedings.

The Committee encourages anybody impacted by the content matter during this hearing or afterwards to contact services and supports, including Lifeline on 13 11 14. Tresillian's Parent Help Line on 1300 827 282 or PANDA National Help Line 1300 726 306.

I declare on public record that I'm a former chair of Women's Health Tasmania and was on the board for five years, in case any member considers that to be a conflict of interest. I will do my very best for that not to be the case, but that should be on the public record before we started.

Would you like to start with an opening statement?

Ms FLANAGAN - Yes, we each have an opening statement.

CHAIR - Great.

Ms FLANAGAN - Thank you very much for the opportunity to present. We appreciate the Committee's interest in these areas of health care. Every day we hear stories, good and bad, about reproductive and maternal health services and we see the huge impact that these experiences have on people's lives. Even in a restrained financial environment, it's important to keep working to get things right.

We'd like to use our time with you to highlight some points from our submission and also to raise some other issues we didn't raise in the submission. I'll talk about the part of the submission that addresses reproductive health care, and also about our organisation as part of the reproductive healthcare system.

Lucinda is going to talk to you about some work we've just begun on barriers to access to late gestation abortions in Tasmania, and Elinor is going to talk about issues impacting on the quality of maternal healthcare in Tasmania. We're each planning to talk for about 15 minutes and we hope that will leave plenty of time for questions and discussions.

CHAIR - That's fine, thank you.

Ms FLANAGAN - I want to start with a note about the language we're using today. We work with women and people of diverse gender who are presumed female at birth. We may unintentionally flip between women and people when we talk, but our intention is to include all these clients in our discussion. We'll be using both termination of pregnancy and abortion as terms to describe that medical procedure. Termination of pregnancy is a term that's probably more commonly used in medical settings and abortion is the phrase that's used in the community. Finally, reproductive coercion is a phrase, but it is a bit of jargon. It's the phrase used to describe a form of intimate partner violence that involves controlling a person's reproductive decisions or actions. It might result in forcing someone to have an abortion, or it might result in forcing someone to have a baby.

I'll begin by introducing Women's Health Tasmania. We're a statewide health service delivery organisation and the Tasmanian women's health peak body. We've been a leading voice in shaping gender-responsive healthcare systems and practices in Tasmania for over 35 years. We provide person-centred, trauma-informed reproductive and pregnancy care along with mental health, wellbeing, and health promotion services to meet the diverse needs of women across Australia. We're an important part of the reproductive healthcare system. Our

clients have complex needs. We provide direct support to over 4900 individuals each year, primarily focusing on women from priority health population who present with complex needs.

The key health issues our clients present with are chronic mental health conditions and sexual and reproductive health needs, including pregnancy support and termination access. Many of our clients are dealing with comorbidities. That's the simultaneous presence of multiple health conditions. These can exacerbate the likelihood of hospital admissions and are often combined with trauma, such as domestic and family violence, sexual violence, financial and legal issues, uncertain visa status, and homelessness. For our clients, we provide mental health and wellbeing services, physical health and wellbeing services, health education, and health promotion.

We know we have impact. Our work helps reduce the burden of disease related to mental health, domestic and family violence, and chronic illness, providing much-needed support that might otherwise fall on the acute health system. In addition, we're playing a central role in the health system. We facilitate the medical terminations of pregnancy pathways to support people seeking medical terminations of pregnancy or access to long-acting reversible contraceptives. We do this by partnering with 35 primary healthcare practices around Tasmania and a mainland telehealth provider. We manage $150,000 a year in brokerage funds, and we support patients accessing these services through the provision of counselling, case management, psychosocial supports and information. We support the development of this sector through the delivery of training and the management of the Pregnancy Choices Tasmania website.

We broker around 335 procedures annually. This helps the acute care system because these are people who do not need to go to hospital to have a surgical termination of pregnancy in a theatre setting. This community-based model reduces pressure on the Tasmanian Health Service and provides people with an essential alternative to surgical terminations. Our medical termination work has been described as a critical health service by a minister for Health and is considered an essential response to Tasmania's reproductive health needs.

I want to raise some key points from our submission with regard to reproductive health. The first is that Tasmania has a good foundation in which we could build a good system. We decriminalised abortion in 2013, ahead of other Australian states, with community support for legislation which was nation-leading at the time. Tasmania has provided financial support for surgical and medical termination since 2018, including for people not eligible for Medicare or the PBS. The state has provided financial support for access to long-acting reversible contraceptives since 2019, and there's been public provision of free surgical terminations via regional hospitals since 2021.

Tasmania has services and practitioners that champion reproductive health care. Specialist services such as Family Planning Tasmania and primary health clinics specialising in women's health provide coherent, consistent services. Individual GPs across Tasmania are also highly valued for their support. Patients' stories of good experiences in the system tell us that choice and autonomy in reproductive health decision-making are valued. That includes choices between specialist and non-specialist services.

Women tell us they have experienced non-judgmental, compassionate care and that they value that highly. When consideration is made of privacy and inclusivity in services, it's also highly valued and people tell us they feel safe and comforted.

But there is room for improvement. We also have women and pregnant people seeking reproductive health care report to us that they have encountered stigma and judgment in healthcare settings and that hinders open discussions. Clinicians' dismissive or critical attitudes exacerbate stigma and stress. There are persistent gaps in reproductive health expertise, especially in primary care. Regional women and pregnant people face long-distance travel for services. Regional folk face heightened fears of judgment due to the absence of reproductive healthcare providers. The system is fragmented. People must navigate multiple healthcare settings, GPs, clinics, hospitals for different stages of care.

Often there are aftercare issues after an abortion. There's a lack of follow-up care, causing anxiety and confusion for patients. Patients may encounter conscientious objection. This can be expressed passively through delayed referrals or inappropriate referrals that delay their access to health care and limit their choices. Our abortion law doesn't require GPs to disclose their conscientious objection, leaving patients unaware of their GP stance on reproductive choice.

There are also information gaps. Many patients lack clear information about abortion services and procedures. Some of these barriers to adequate care are due to low levels of reproductive health expertise in healthcare settings. Women tell us they have experienced delayed diagnosis, poor communication and lack of information. We see evidence of low reproductive health literacy and insufficient training in reproductive health, particularly among GPs. In our submission, we have made recommendations on workforce development and health-literacy initiatives.

There are also workforce issues. There's a GP workforce shortage, which is only set to worsen over the next decade. There's a chronic shortage of them, especially female GPs. Rural areas face severe shortages, with bulk-billing GPs nearly impossible to find. Patients face long waits for GP appointments, which has significant consequences for people needing contraception or termination of pregnancy. Overstretched GPs and health workers face burnout, facing high turnover and depletion of reproductive health expertise. There's also a shortage of specialists willing to do medical terminations, IUD insertion or removal, and that's especially true in regional Tasmania. In our submission, we support expanding the roles of other health workers such as nurses, midwives, nurse practitioners and pharmacists to work to their full scope to reduce workforce pressure.

There are also structural problems impacting on people's experiences of contraception and abortion. Access to contraception is impacted by high costs and geographical issues, especially in rural regions, poor access to primary healthcare providers, health literacy issues, this trend away from hormonal contraceptives at the moment because of online misinformation. Community health promotion services need resources to improve community health literacy about contraceptives. Going into communities, co-designing appropriate information and producing resources that aren't text-based is resource intensive.

There are structural issues impacting on abortion access and quality of care. Unlike other states, Tasmania doesn't collect data on how many abortions are happening. The lack of centralised data on abortion referrals hampers effective service planning. Many clients still face high costs, especially those not eligible for the Women's Health Fund.

Family Planning Tasmania's submission called for medical abortions to be funded for all pregnant people requiring them and we support this call. However, we respectfully disagree

with the model for delivering these services that Family Planning [Tasmania] is suggesting. I'm happy to answer questions about that later. There are significant barriers to accessing later gestation abortion. Lucy is going to talk about this.

Reproductive coercion effects around 20 per cent of pregnancies. We need resources to educate the community around this.

There's a scarcity of services in rural areas, with limited abortion providers outside urban centres. In our submission, we made recommendations with regard to financial barriers, workforce development, regional disparity and time-specific barriers to access. I want to give you one case study to show what the impact of these problems has on people. A woman presented to a GP saying she thought she was pregnant and she wanted to terminate the pregnancy. The GP rang Women's Health Tasmania to refer her to us for a termination of pregnancy but we don't provide GP services so it was an inappropriate referral. The health worker let the GP know that. The GP told our health worker that he had advised the woman that she could have a medical termination of pregnancy up to 16 weeks of pregnancy, so he'd obviously checked the legislation, but of course that's not true. For a medical termination, they're only available up to nine weeks.

The health worker let the GP know that medical terminations were available only up to nine weeks and that after that point the woman would need to be referred to the local public hospital for a surgical termination. The GP was also urged to check Tasmanian Health Pathways, which provides clinical pathways for GPs. Our health worker told the GP that the woman would need blood tests and dating scans organised promptly. One week later the GP called back. The woman had made another appointment with him and he was requesting further information. He had not organised blood tests or scans. The health worker advised him to use the Tasmanian Health Pathways to get the clinical information he needed. This time, she also suggested to him that the patient be given our phone number so she could contact us directly.

One week later, the woman and her partner appeared at our gates at our main office, saying the GP had told her to come to us. Our health worker secured an appointment for her, with a GP familiar with abortion healthcare pathways and who could organise their blood tests and scans. The woman was now too late for a medical abortion and would need a surgical abortion.

I want to talk in more depth about the points we've made about our own organisation, which is an important part of the sexual and reproductive health service system. We receive referrals from GPs, hospitals, schools, antenatal clinics and other professional services. Women can also self-refer without a GP referral so we can guarantee wide access.

We offer specialist counselling and case management around pregnancy options and reproductive coercion. This is a service not provided by any other Tasmanian organisation. We provide emotional health counselling to women unable to access public mental health services or affordable mental health plans. We receive positive feedback for reducing distress, avoiding hospitalisation and improving mental health outcomes.

We are regularly requested to deliver training and workshops on gender responsive health promotion, mental health and reproductive coercion to local health teams and community health providers. Our impact is demonstrated through regular evaluation. Clients report improved health and wellbeing from our workshops, programs and psychosocial support

services. They report that they contribute to self-management of chronic conditions and overall wellbeing.

Some recent work and key achievements that are relevant to this Inquiry are that we've developed the Pregnancy Choices Tasmania website. It's a searchable resource for Tasmanians who need reproductive health services and it's utilised by both patients and clinicians. It's the only place you can find out where are the GPs who provide long-acting reversible contraceptives.

We coordinate statewide networks and support including the Sexual and Reproductive Health Collaborative Group, the Tasmanian Women's Mental Health Professionals Network, the Tasmanian Perinatal and Infant Mental Health Professionals Network, and we participate in around 20 policy networks. We support perinatal mental health initiatives such as mother-baby play groups for women with post-natal depression and services like the Migrant Mother and Baby Playgroup.

We've released important research on maternal health and patient experiences accessing terminations of pregnancy along with the termination of pregnancy, a good practice guide for healthcare providers which was the first in Australia to combine the voice of lived experience with clinical guidelines. We deliver workshops and programs around the state on crucial topics including menstrual health, menopause, reproductive coercion and gender-based violence prevention.

Finally, we manage a critical part of the abortion pathways under contract from the Department of Health, ensuring that women in Tasmania have access to safe, timely and respectful care. We do this work with a multidisciplinary team that includes health workers, social workers, a psychologist and a policy expert, all working together to provide holistic care.

There is more demand for our services than we can meet. Our counselling services are in high demand, yet only 34 per cent of women seeking psychosocial support receive an appointment within our contractual benchmark of 10 working days.

General practitioners and community health service providers regularly request our women's health promotion and preventative health workshops. Many of these requests come from regional areas and what they call 'thin markets' with limited healthcare options. We just don't have the resources to meet the high demand for our services.

Over the last three years we have repeatedly warned the Government that our funding is not covering price and wage increases. We operated at a deficit in 2023-24 and we'll have a deficit again this year. To bring the budget back into balance we'll need to make 1.7 FTEs redundant. That is one-third of our staff. We require a $220,000 a year increase in funding to prevent staff redundancy and a reduction in services. The services at risk include sexual and reproductive health services, which, as I said, the Government described as critical. We await the May Budget to see if we will need to cut our services. If the Government doesn't respond to our funding request, there will be a question of whether services identified to be cut will be transferred back to the department or whether they will just disappear from the system.

Now, I'd like to pass to Lucy.

Ms SHANNON - I want to echo what Jo said. Thank you so much for inviting us to speak today.

Part of my role at Women's Health Tasmania is supporting the team that provides pregnancy options, counselling, support, information, referral, advocacy and case management to abortion seekers. I guess some of what I share today is inflected with the stories of Tasmanians who we've supported to access abortions and some is based on the research paper that we've provided called Understanding Late Abortion.

I am going to talk about late abortion in Tasmania, but before we do that it's important to have a detailed picture of what's available to Tasmanians through the termination pathways that are currently operating in Tasmania. The access system we have now is something to be proud of. It shows what can be achieved by our public health system, but it also presents opportunities to make what we have even better, more accessible, and more patient-centred.

In Tasmania there are three ways of having an abortion. A medication abortion, as Jo referred to, which is available up to nine weeks. It's sometimes called early medical abortion. There's surgical abortion that is delivered in hospital settings. There's also medical induction of labour, which is also done in hospital settings. What's available to an abortion seeker depends on the gestation of the pregnancy and where they live. In Tasmania, three public hospitals provide surgical terminations and they provide them to different gestations. The Mersey Community Hospital in Latrobe provides terminations up to 12 weeks, the Launceston General Hospital provides up to 13 weeks, and the Royal Hobart Hospital provides up to 14 weeks. There is also a private provider who takes referrals for surgical terminations up to 16 weeks. This provider is based in Hobart. Currently, patients who are referred to this provider access the Women's Health Fund to cover the costs of the procedure.

Mr STREET - Really sorry to interrupt. The difference between the three hospitals, who makes that decision? Is there an administrator within each hospital that makes that decision?

Ms SHANNON - That's a really good question. I'll come to that. It's essentially based on what we understand, gynaecology departments to be equipped in terms of the skill level and also what I call cultural readiness to provide a termination up to.

CHAIR - Did you say the private provider is up to 19 weeks?

Ms SHANNON - Sixteen.

The gestational limits are applied strictly. What we mean when we say up to 16 weeks is that on the day the termination is done, the pregnant person's gestation is no more than 16 weeks and 0 days. Let me give you an example of what this means. For someone who's based in the north west to be eligible for a surgical procedure at Mersey Community Hospital, which would be their closest hospital, the GP they see needs to send the referral when the person is less than 11 weeks pregnant, so that there is time for the gynaecology clinic to do intake and then the following week book the patient for the procedure. On the day of the procedure, the person must be no more than 12 weeks and 0 days of gestation.

Our understanding is that these gestational limits are based on the clinical skills of gynaecologists and the cultural readiness of gynaecology departments at the hospitals to perform these procedures at these limits. It's also no doubt informed as well by Tasmanian

legislation, which states that women have the right to choose abortion up to 16 weeks, but after 16 weeks the decision is passed over to doctors to determine whether or not the abortion is necessary.

Now that I've given you a picture of what access currently looks like, let's talk about late abortion and what we mean when we say that. The first thing to say is that there is no single medical and legal definition of late abortion. Late abortion is not a precise medical term. Late abortion is a term that is constituted by different medical, legal and social discourses. You can see that when you look at the different jurisdictions around Australia and where they provide abortion up to. When we say late abortion, we really need to ask ourselves: late relative to what?

In our discussion today, we are using the term late abortion to talk about abortions after 16 weeks gestation and how the service system in Tasmania responds to this. The point I really want you to understand is that late abortions, abortions after 16 weeks, they happen and access to them is a necessary part of a fully functioning reproductive healthcare system.

Let us talk about the reasons why late abortions happen. There is a myriad of reasons and there is a complete list available in the Understanding Late Abortion paper, but I want to highlight a few of the reasons that are especially relevant to Tasmania.

- First, access to GP appointments: as we know there can be wait times to see a GP and there can be significant costs.

- Reproductive coercion: this is where a partner uses abuse and control to prevent a person accessing health services.

- Access to transport: we know this can be an issue for all Tasmanians, but it is especially an issue for people on low incomes and those who live in rural and remote Tasmania.

- Childcare availability: because many people who have an abortion already care for children and so they will need childcare in order to access health services. Something that we know about childcare, especially in rural and remote parts of Tasmania, is that it is very challenging. A lot of the smaller population centres tell us that there is a severe lack of childcare providers.

- Inaccurate or incomplete advice: people tell us that their GPs do not always understand or do not communicate clearly about terminations and what they can access. Hospitals likewise tell us that referrals are sometimes done incorrectly, and that can also slow the patient down.

- Conscientious objection: as Jo was talking about, our Act provides that doctors can be conscientious objectors in that they do not have to provide an abortion service, but they still must, under the Act, give the person information about organisations that can help them access abortion. One of the problems, though, is that conscientious objectors do not have to

disclose their status and we have worked with people who believe that their doctor gave them advice or referrals that deliberately delayed their access. For more information - I do not know if this is the right time to table this - but I would like to table this. It is our Talking to People About Terminations of Pregnancy in Tasmania report where there is some information about conscientious objection and how that can show up.

- Another reason that people can present late is because they are late to identify they are even pregnant at all. I want to emphasise that this can happen to anyone at any age, but we know that young people might identify a pregnancy late because of the quality of their sexual or reproductive health education and they also might have really low agency or confidence at navigating all the many stops along the way that you have to do when you decide to have an abortion.

- Foetal abnormalities: this is another reason why late abortions happen. These may only show up in a pregnancy after 16 weeks and different hospitals undertake tests for foetal abnormality at different stages of a pregnancy.

- The last thing I want to talk about, which is really relevant to Tasmania, is service closures at holiday times. At Women's Health Tasmania we have observed that heading into Christmas and the time between Christmas and New Year's, many services shut their doors. This leads to abortion seekers being unable to access services in timely ways. We now deliberately keep our service open so that we can respond to the increased demand for support and information.

Something that I would like you to take away from all of that is that abortions that happen after 16 weeks are not exceptional and they are not anomalies. There are reasons, always complex ones, that mean people are presenting close to 16 weeks or beyond 16 weeks. It is often because people are experiencing disadvantages that then interact with those narrow, time-limited options that are available in the Tasmanian health system. The people who present late for abortions need more support, not less. Creating equitable, accessible, patient-centred abortion access in this state means we need to look at the gestational limits as set by the hospitals and how we can extend them. It also means providing more choice and access for abortions after 16 weeks. I'm going to talk about that now because our current system for late abortion, after 16 weeks, in Tasmania is narrow, one-size-fits-all, and lacks clarity.

What does abortion after 16 weeks look like in Tasmania today? Under the *Reproductive Health (Access to Terminations) Act 2013*, abortions over 16 weeks must be approved by two doctors, one of whom is a specialist in obstetrics or gynaecology. After 16 weeks, pregnant people who are approved for a termination can access a termination by induction of labour. From our conversations with pregnant people, induction of labour is not always an appropriate way to terminate a pregnancy. For example, we've had women seek other options outside the state because they had previously experienced stillbirth and told us that labouring to terminate a pregnancy would be highly distressing and they were concerned about the mental health

impacts. In other states, surgical terminations of pregnancy are available at higher gestations and they don't require going into labour to terminate the pregnancy.

For those in Tassie who are amenable to an induction of labour or who determine that they cannot travel interstate, the situation is also dependent on gestation. Between 16 and 18 weeks the two doctors' sign-off is considered sufficient to provide a lawful grounding for the health professionals involved to proceed. Beyond 18 weeks, the hospital convenes a panel, what's referred to in the literature as a 'hospital termination review committee', to decide whether the abortion should be undertaken. To be very clear, the decision is no longer the pregnant person's decision. Whether or not the abortion will go ahead is now in the hands of medical professionals. I can't speak directly to local panels in Tasmania, but the Australian research on hospital termination review committees conducted by Professor Barbara Baird provides insights into how they can negatively impact the person seeking the abortion.

I'd like to talk about some of those now.

The first thing is that review committees can increase delay. The panel needs to be convened, case reports written, sometimes psychiatric assessments done, and all of this takes time. There's a lack of transparency and accountability. In most jurisdictions, it appears to be the case that a patient has no right of appeal following a committee's determination. Details on who and how are scant, and they're not visible to health consumers. The last point to raise is that termination review committees are also vulnerable to inconsistency and domination by individual practitioners. For example, in medical hierarchies, a nurse's psychosocial assessment will be outweighed by that of a psychiatrist's psychosocial assessment.

Let me give you an example of how we see those ideas from the research showing up in local people's experiences. We know of at least one service denial involving a young person who is being supported by [a] youth health service. The service explained to us that the young person was over 18 weeks pregnant, that they had parental support for the abortion, and that they also appeared to be competent to make their own decisions. Yet, they had been denied an abortion at the Royal [Hobart Hospital]. The health service worker and the young person couldn't ascertain the reason for the service denial or how to appeal it. From our third-party point of view, we advised about options in Melbourne because it seemed like a more straightforward pathway for this young person to take.

I want to be very clear that we're not critiquing the intentions or clinical practice of the professionals who are on these committees. We know that these professionals are champions of reproductive rights and that actually without them our access system doesn't exist. However, they're working to do their best within a legal framework and a system that has inherent flaws. It's also clear that other jurisdictions aren't hampered by review committee processes and this is partly because their laws don't treat abortion after 16 weeks as exceptional, or problematic, or more ethically challenging, and partly because they've been through the cultural change and planning processes to embed choice of procedure after 16 weeks. We also cannot underestimate the role that leadership at all levels of government plays in normalising access to abortion.

What I really want you to take away is that, if we plan for and support our three public hospitals to extend their gestational limits, we will make a very real tangible difference to the experience of Tasmanians. We can increase the provision of surgical terminations at higher gestations, but to do this, we will need to increase the skills, support and cultural readiness of gynaecology department workforces. We can also create a pathway for surgical terminations

in Tasmania available to the public at least up to 18 weeks. This then means people can choose between an induction of labour or a surgical termination, depending on their individual circumstances.

The value of a transparent pathway means that we can ensure it is fair, accessible and available. We think that committing to and embedding these pathways is important groundwork before looking at legislative change. In 2013, abortion in Tasmania was decriminalised, but the follow-up work to build the capacity of the health system to support people's rights under the legislation was not done. Despite decriminalisation, Tasmanians had some of the worst access in the country.

Legislation on its own is not enough to guarantee that people can take up their reproductive rights, so we think that planning for, committing to and investing in transparent and equitable pathways are the steps that underpin and bolster any further legislative changes. We think we have an opportunity to build on the incredible work that has already happened in our public hospitals and ensure that Tasmanians have the same choices that people across the Bass Strait are offered. Thanks.

CHAIR - Thank you very much, Elinor.

Ms HEARD - Thanks. Lucy, if you do not mind me doing so I wanted to add that, looking nationally, I think the next earliest gestational limit in law is at 22 weeks in New South Wales and then beyond that in other states and there are a couple of jurisdictions that do not have a gestational limit, just in terms of understanding -

CHAIR - The national context.

Ms HEARD - Yes, the national context. Thanks very much for having me. Rather than repeat what is in our submission in relation to maternal health, I am going to speak to a few broader points around the provision of services in Tasmania at the moment. I will invoke some aspects of the submission as I go.

The first point is perhaps a fairly obvious one at the moment around Tasmania's maternal health services being outsourced to or subsumed by private providers. The precariousness of these arrangements and the impacts when they fail have been made stark with the withdrawal of Healthscope's maternity services in Tasmania. As we know, St Helen's Private Hospital closed in June of 2023, taking with it the state's only inpatient perinatal mental health unit at the time, comprising eight mother-baby suites. In early 2025, Healthscope announced the forthcoming closure of its maternity services at Hobart Private Hospital, equating to a loss of care for 500 to 600 births annually.

I will talk about how the landscape of maternal health services in Tasmania is functioning during this period of attrition, but I first want to recognise the origins of Hobart Private [Hospital]. The hospital opened in 1999, following the sale of the Royal's Queen Alex maternity wing by the Tony Rundle government to ASX-listed Australian Hospital Care Limited. The Queen Alex wing was a relocation of Hobart's first maternity hospital, the Queen Alex in Battery Point, where 57,000 Tasmanians were born between 1908 and 1980. The sale of such a significant piece of public health system infrastructure to a commercial operator was controversial at the time, with many Tasmanians believing this key health asset should remain in the public domain.

Healthscope's closures at the St Helen's and Hobart Private sites offer a clear example of the risk to local communities when governments relinquish responsibility for core components of the health system. When those components pertain to maternal health, perinatal mental health and reproductive health, as they do currently in Tasmania, we are forced to confront the gendered nature of our predicament. We need to ask how is it that health care for pregnant women and babies, services that are fundamental to every Tasmanian community, have, to such a significant degree, become the domain of private operators, situated outside mainstream public health care and subject to the whims of company directors?

I would suggest this partly goes back to the historical idea that women's health, particularly women's reproductive health, is an obscure specialist domain, despite the fact that about half the population have uteruses. We see the legacy with Women's Health Tas with clients still describing encounters with GPs who are not equipped to provide pregnancy advice or antenatal care, or are not trained to deliver a full range of contraceptive options or are not able or willing to refer women for terminations.

This tendency to sequester women's health services away from mainstream public health service delivery, including in planning and funding arrangements, has left the Tasmanian Government financially reliant, and increasingly unsustainably so, on commercial operators to deliver what should be core public health care for Tasmanian communities, including antenatal care, birth units and perinatal mental health services.

My second point is on how maternal health services are functioning through this period of attrition and the ongoing reliance on federal funding to patch up the Tasmanian system. If we look at how services have shifted in Tasmania during this period, following the St Helen's closure, the Tasmanian Government opened an interim three-bed mother-baby unit at the RHH [Royal Hobart Hospital]. We're told that in practice this has two beds only because of space required for a nurse's station. We're told it has been unable to accommodate women experiencing acute mental ill health due to a lack of safety features. Given the wait times associated with accessing the mother-baby unit, even in its eight-bed iteration at St Helen's, we know there are women and families suffering now, some at crisis point due to the insufficiency of inpatient services.

Following the St Helen's closure, the state Government announced funding for a Tresillian-run, four-bed mother-baby centre in Launceston due to open in May of this year, along with a statewide Tresillian parenting support phone line. How that phone line differs from the existing Child Health and Parenting Service Parent Line we are not clear on.

The Federal Government also stepped in to support outpatient service capacity, funding the Gidget Foundation Australia to establish a local service model operating out of the Peacock Centre. In the south this is a face-to-face service and elsewhere in the state it's a telehealth model. We're told by a practitioner the recent wait time to access the service has been about three months, which in the context of perinatal anxiety or depression is concerning, particularly given those community-based services are aiming to prevent an escalation of ill health and potentially be able to prevent people needing inpatient acute services.

Regarding the Hobart Private closure, we don't know the extent to which the state Government attempted a rescue plan, but we do know they put pressure on the Federal Government to step in, and they did, announcing a $6 million package that will be used to

expand birth units at the RHH and at Calvary Private Hospital [Calvary Lenah Valley Hospital], apparently taking Calvary's annual births capacity from around 390 to 1000.

If you're familiar with the Calvary site in Lenah Valley, it's not clear how expansion at this scale will be achieved nor do we know the time frame for when those beds will open.

Alongside the federal funding announcement, the state Government announced it would move the interim mother-baby unit from the RHH to the medical precinct planned for St Johns Park in New Town and said it would have more than three beds. It won't be 11 or 12. Again, we don't have a time frame for those beds. And that service would need to operate at minimum four beds to bring the statewide mother-baby unit capacity back up to the eight beds that existed during St Helen's days. Noting that the eight-bed service was oversubscribed with long wait times and considered insufficient to meet population need. To actually expand perinatal inpatient capacity statewide, they would need to open more than four beds at St Johns Park.

At the same time, the state Government announced it will offer $15,000 to midwives who relocate from interstate or overseas to work in the Tasmanian system to bolster the very stretched local workforce. Though I note the midwife shortage is a national and international problem, too, so we don't know how that will play out.

Additionally, they will support a fast track midwifery qualification and look at employing student midwives while they're qualifying. I don't believe there are further public details as yet for those schemes. I also want to note we've been told in recent times the perinatal and infant mental health service generally has been propped up by the Federal Government in north and north-west regions of Tasmania, with funding for at least 2.5 workers based out of the Launceston General Hospital. This may also be the case in the south, but we do not specifically have that information. Those workers have said the arrangement ends on 30 June this year [2025], and so far they have heard nothing about future plans for the service.

I can only speculate this funding was derived from the National Health Reform Agreement, which ends on 30 June this year [2025] and which has seen the Australian Government contribute significant funds to public hospital services in the states and territories to support better coordinated care. I think what is not clear to Tasmanians and what is concerning is the extent to which the Federal Government is propping up the Tasmanian health system and specifically maternal health services through short-term and bailout funding.

Where does this leave Tasmanians who still need those essential services when the short-term agreements end? For as long as we are reliant on patched-in, federal funding, Tasmania is not building a long-term sustainable health system of our own, instead delivering services built on temporary foundations with temporary workforces. When you consider this alongside the issue of privatisation of maternal health services, we come back to that central question of why is Tasmania not investing in its own public health system?

My third point is on the extent to which Tasmania may be falling behind national frameworks for maternal health care, particularly for key population groups. This really came out of our research report Talking About Having a Baby in Tasmania. I have a copy of it here, but it is also available from our website. A finding from that research was that not all pregnant people in Tasmania have equal access to safety, choice and inclusion in maternal health care.

This was a lived experience study that asked participants from around the state to share what was good about their experience of pregnancy, birth and postnatal services and what could have been better. To share a few outcomes, bearing in mind that the project offered a snapshot of personal experience rather than being a population level study, Aboriginal research participants said there was no recognition of their Aboriginality at any point during their pregnancy care journey.

Participants who relied on public health services had less access to birth education and antenatal classes, to mental health support, pelvic floor physio, fewer ultrasounds in pregnancy and less continuity of care than participants accessing private maternity care. Culturally and linguistically diverse participants reported finding it difficult to access culturally sensitive and relevant support, particularly in relation to sleep practices.

A participant for whom English was an additional language said the language barrier was not addressed for her and that she felt disadvantaged by not having a full understanding of the medical language being used. She said she was not offered an interpreter or multicultural social worker at the hospital, despite later learning these services exist.

Participants living in regional and rural areas had fewer pregnancy care pathways, care models and birth settings available to them and travelled significantly farther to access maternal health services. A non-binary participant reported being misgendered throughout their pregnancy care journey and were advised that hospital staff would struggle with correct pronoun use. Participants with mental health conditions said pregnancy care providers had limited awareness of their mental health history and needs despite being provided with records. One participant felt her mental health history was used against her following a traumatic birth experience to minimise what had occurred.

I do want to be clear these outcomes chiefly reflect system level limitations rather than insufficiencies in the work of our maternal healthcare workforce, who are by and large providing a high standard of care delivery in the context of significant workforce shortages and other environmental stresses. What these outcomes do suggest is that Tasmanians are yet to benefit from the kind of targeted maternal health approaches for key population groups recommended by national frameworks, such as the woman-centred care strategy and the clinical practice guidelines for pregnancy care.

For example, why does Tasmania not have a community-led Aboriginal maternal health framework when you look at the many such initiatives interstate, including the successful birthing on country models? Given that pressures on the Tasmanian health system are not likely to be relieved anytime soon, how can we generate the capacity and commitment to move Tasmania forward in line with national standards and contemporary best practice so that all pregnant people have access to safe and responsive, high-quality maternal health care. We have made detailed recommendations in our submission to this Committee and in our Talking About Having a Baby In Tasmania report and we encourage you to consider these as you formulate your conclusions from this inquiry.

We also refer you to the 38 recommendations stemming from the independent investigation into the RHH maternity services that was conducted last year and note the significant alignment between these recommendations and those that emerged from our research.

CHAIR - Thank you very much for such detailed evidence. I know how much work goes into preparing not only the read submission but what you've shared with us today. It's a very rich evidence base for us to draw from and we're fortunate to be able to learn from and draw from your experience as practitioners as you said, Elinor, in finalising our recommendations and report writing.

I'm really grateful to have Women's Health Tasmania here because in our submissions so far in the Committee, we've heard very little from the public on reproductive health and abortion services. I'm really glad that both of you, Lucinda and Jo, could share such detailed information and if it's okay with you guys, I'd like to start a few questions in that field, not to discount what you've shared with us, Elinor, but particularly on abortion services.

The information you've shared is really important. You said something Lucinda that I think was really important: that we've got an access system here that we can be proud of. I agree with that and not to make the Committee too political, because I did say at the outset, the Committee works really great because we have our political party hats off, but there have been times where there have been conservative health ministers who have actively worked within the system to decrease access to abortion services through our public health system.

As you said, legislation is one part, but it doesn't actually affect the service system just like legislation can dictate things on criminal law or anti-discrimination law, but it doesn't change culture and change communities. That's the work of all of us as community members.

Have you any insights for the Committee on recommendations we might be able to make, evidence that you would like us to hear on how we safeguard what we've got now, albeit that it needs improvement, but how we safeguard public access abortion services in the event that in the future, there's another highly conservative health minister who might seek to diminish access to services in Tasmania.

Ms FLANAGAN - We're doing a lot of work in that area and actually doing quite a bit funded by a philanthropist; out of concern about what is happening internationally in regards to abortion access and then some moves within Australia to limit abortion access. We feel some of the most important strategies moving forward - supporting the community of health practitioners who work in this area so they feel connected and confident in the work they do and also educating and working with the community on this important health service.

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We run workshops for health practitioners on pregnancy choices and reproductive coercion, which are really well evaluated. And we also run abortion access advocacy workshops for community members. The goal of that is just to tell them about the health service and what it's like, some basic facts and figures so they can be support people in their community and break down the stigma in silence about the procedure.

What we're finding is that health practitioners are re-enrolling for the same training program because there aren't other spaces for them to have these conversations and networks and that kind of stuff. There's definitely a high need for the work.

CHAIR - Thank you.

Sorry, I felt like I cut you off then.

Ms FLANAGAN - I think those are all protective actions because if we reduce stigma successfully and the procedure is seen as a normal health service, which is our goal, and all the conversations around 'how do we make this better, how do we make it compassionate care, how do we make it person-centred, how do we make it high quality?' - it just moves it away from the old access fight.

CHAIR - Yes, it would be nice if we didn't have to keep having that access fight. That's right.

My other question is about some of what you both shared and your written submission. I remember that debate very well when abortion was decriminalised in Tasmania and the requirement for health practitioners, if they are conscientious objectors, to refer a patient elsewhere. The evidence you gave about potentially giving bad advice or extending the time was really compelling. Thank you for sharing that.

Recognising there's a massive shortage of GP access now, my question is on that timeliness of access to services. Somebody could be waiting weeks to get into a GP then find out they're a conscientious objector and potentially, be waiting weeks to see someone else in that practice or elsewhere, if they can even get services. It's two questions and then I'll open it up to the Committee.

Could you elaborate about how we might improve the system in terms of there being a way for GPs in particular to advertise, I suppose, they are a conscientious objector so nobody's time is taken up in an appointment that's not going to be what that person needs going into that appointment Whether that's a legislative fix or something in regulation or elsewhere around how we can make sure with the shortage of appointments that we're making sure people are seeing GPs who will actually give them the service and referrals they need.

What happens if someone turns up to the hospital and the example you gave in the written submission on the person who found out on New Year's Eve they were pregnant. This is just a lack of knowledge of my own - what happens if somebody just turns up to any hospital and they're below nine weeks or they're below 12 weeks, can they access services or do they have to have referrals? That's like a double-barrelled question and then we'll open it up to Anita and Nick.

Ms FLANAGAN - The issue is some GPs might be very clear they are conscientious objectors for faith reasons or whatever and possibly wouldn't have any problem telling people and would be upfront. But not everybody does recognise that's what they are. What they are doing is making judgments about the person coming in the door about whether she should be given access to an abortion or not.

CHAIR - On an individual basis.

Ms FLANAGAN - On an individual basis and we see that at GP level and also in the hospital system where you might hear a clinician say, 'I'm willing to provide abortions if there's a medical reason, but for social reasons I only go to this gestation limit.' They're making decisions for the woman about her reasons, the gestation limit -

CHAIR - But they might not identify that as a conscientious objection.

Ms FLANAGAN - No, they wouldn't object necessarily. I guess the point is, it's only relatively recently we've been having community conversations about these things and there's a massive role for health promotion here on educating the community and the health workforce on this.

CHAIR - Okay, thank you.

Ms SHANNON - Can you repeat the second question?

CHAIR - What happens if someone turns up to the hospital, goes to a few things, GP access, closure of services, as you said, and that's demonstrated in that example you gave in the written submission on someone finding out on New Year's Eve.

Ms SHANNON - Yes, apologies for asking for that. I can actually tell you what happened in an actual instance.

About a year ago, a couple rocked up to Women's Health Tasmania and they had been told by their GP to go to the hospital because he didn't do that. The hospital does that. We had no information about how far along the woman was. There was no information about that.

This couple came to us and they said they had gone down to emergency, had explained what they were there for, had been asked by a health professional there if they were sure about their decision and then given information about Women's Health Tasmania and then they came to us. We were, of course, able to go on Pregnancy Choices Tasmania, find the closest GP who can provide abortion care and that way they're able to access the pathway.

As far as I'm aware, if you go to the hospital without a GP referral, they can't assist. That particular situation could have potentially been handled better by the health professional who was there.

Ms FLANAGAN - We also hear stories of people turning up at the hospital. They've been referred by a GP but they don't have their blood tests and dating scans done, so the hospital can't assist them anyway.

CHAIR - Because they don't know what gestational week they're at.

Ms FLANAGAN - Yes, or the person is still making a decision about what they want to do and they've been referred in. This again speaks to the need for professional development in the GP workforce.

Mr STREET - Rather than what the medical professional did at the emergency department you said could have been handled better, what is the ideal approach?

Ms SHANNON - Well, providing to them a little bit of information about what they can access, but then how they will access it. Just explaining to them that the first step is a GP whenever you are pregnant. No matter what you are going to do, whether you are going to continue a pregnancy or end a pregnancy, the first step is always a GP. That is your access point into the system basically. They did not do the wrong thing, but they could have made one less stop.

Mr STREET - They could have taken a step out.

Ms SHANNON - Yes, they could have taken a step out.

Ms DOW - Thank you, each of you, for such detailed presentations to this Committee. The preparation you have done before presenting to us today is really impressive. I really appreciate it and your submission is really, really thorough as well. Could you identify the areas across Tasmania where it is the most difficult, or whether it is an absence altogether of the ability to access a medical termination across Tasmania?

Ms FLANAGAN - I think our submission lists the areas that we call 'deserts'. Off the top of my head, it is around the central coast, the west coast, the far north-east and south of Hobart, the areas where there are GP shortages in addition.

Ms SHANNON - And to add some detail, I was looking at this just recently because I was trying to develop a sort of case study about what it looks like if you are trying to access on the west coast for instance. There is an MTOP [Medical Termination of Pregnancy] provider on the west coast, but there is no access to ultrasound and so, if a person presented to that GP seeking a medication termination, they would have to have their first appointment with the GP. They might be able to get their blood tests done, but then that person would still need to go to Burnie because that is the closest place where there is an ultrasound and you must have an ultrasound before you have a medication termination.

CHAIR - That was my next question; they will not accept a midwife or doctor assessing gestational weeks by hand, which also -

Ms SHANNON - Yes, but it is also about ruling out ectopic pregnancy, which would be very important if you were going to have your termination on the west coast because, yes, you just want to make sure that it is the safest it can be.

Ms DOW - Thank you. One of the recommendations you made and whether you might elaborate on a bit more, was recommendation 28, which probably falls to Elinor. This was on working in consultation with women and birthing parents and maternal healthcare providers to develop a strategy to reduce the prevalence and severity of birth trauma in Tasmania. Is there anything more you wanted to add to that for the Committee or put on the record today?

That is something we will probably put as one of our recommendations as a Committee, given the clear issues there are with birth trauma in Tasmania, particularly in regional areas. Is there anything more you wanted to add to that for us?

Ms HEARD - Thanks so much for that question. What was really clear in our Talking About Having a Baby in Tasmania research was that for the women and birthing people who had an experience of birth trauma, it was very much a dual experience. There were the originating events that were traumatic in the experience of delivering their baby, but following that there was a second component of trauma in the failure of the people responsible for their care in those settings to really be able to recognise and respond appropriately to the experience.

Sometimes, that was in the birth unit itself and at other times was later on when people had chosen to make a formal complaint or to raise an issue around some formal recourse with the hospital. Almost universally, people felt their experience was minimised or denied and there

was a degree of concern there around liability as part of that inability to kind of adequately respond to the concern or to the complaint.

For some of the individuals, it is possible that experience might not have been a lasting trauma if the ability of the healthcare providers themselves to respond in a compassionate way to the incident had happened at the time. There were opportunities to divert or lessen the experience of distress that weren't being taken in those settings.

Our recommendation, therefore, was around not only looking at the originating birth traumas and any factors in the birth care settings which might relate to provision of compassionate and person-centred care, it could also relate to issues around consent. There were concerning incidents where consent wasn't secured before interventions took place.

The second part that we felt was really important was also the provision of appropriate responses when a traumatic birth occurred. A really early opportunity there would be to institute birth debriefing in hospitals. The participants in our research who had had debriefing opportunities felt really positive about them. That's another opportunity there within birth settings that some midwives and some birth units are doing already, that would be fantastic to see expanded.

Ms DOW - Thank you very much.

CHAIR - I wanted to go to one other part of your written submission, which is pharmacy prescribing. I understand that's still in its pilot stage in Tasmania - UTI medication and now the contraceptive pill in limited circumstances. I know it's still pilot, and no doubt the government will do some kind of review around extension of that. Other states have added to the medications that pharmacists can provide. I wondered if you'd like to put anything on the record around that change in Tasmania: how you think it's been received and how it might benefit from continuation or otherwise, or how Tasmanians might benefit from its continuation or otherwise.

Ms FLANAGAN - It's a good initiative in that it increases access for people to be able to collect scripts, particularly in an environment in which they can't get appointments with their GPs. It's important to note that it doesn't lower the cost for them. The way it is organised, they don't get access to the PBS [Pharmaceutical Benefits Scheme] benefit, and they have to pay for an appointment with the pharmacist in order to begin the process.

We haven't been able to do a comparison of costs, but it's probably pretty similar in terms of whether they go to the GP or the pharmacist. That's a really important point, because the cost of contraception is a massive barrier to the use of contraception. There's a lot of discussion going on nationally and internationally about the provision of free contraception and the value of that. In countries where they've done it they're seeing a decline in the need for termination services, of course. It just makes sense that would be something that we looked at.

CHAIR - It must be part of the picture.

Ms FLANAGAN - What has been done here around the provision of long-acting reversible contraceptives is a great first step, but we do need to be able to talk to the community about them. Australia's take-up of long-acting reversible contraceptives is lower than European countries, because the public doesn't understand them.

CHAIR - Now we're close to time. I just wondered if there's anything else that you'd like to share.

Ms FLANAGAN - We've talked a lot about gender today and the important impact of gender on how health systems serve individuals and about how individuals react to health services. It would make sense that gender be considered carefully in health service planning and resourcing. Tasmania's Health and Wellbeing for Women Action Plan expired two years ago. Tasmania is the only Australian state not to have a women's health strategy. If we don't have strategic plans, we're vulnerable to unexpected challenges, inconsistent performance and the poor use of resources.

That's the final point we want to make today. We call on the state Government to develop a women's health strategy for Tasmania, ideally with the following focus area - I understand they'd need to consult, but these are our ideas - sexual and reproductive health, maternal health, chronic health, mental health, and health responses to domestic and family violence and sexual violence. It's important to note that part of this work has been done or is being worked on, but it's happening in silos. The Government could bring it together in a cohesive way and use it to invest strategically in public infrastructure.

CHAIR - It's a great suggestion, thank you. I think we do have a Health minister who is focused on women's health. Just since the establishment of this Committee, there have already been some changes. You mentioned the Royal review. We heard from the minister this morning that they are potentially looking at publicly funded homebirth, which we are the only state without, and other things as well. I think a women's health plan would be a great addition to the work that's happening across Government, and we will definitely consider it in our recommendations. Thank you very much for appearing.

I have to quickly read another formal bit into the *Hansard*, which is: thank you for your appearance; what you have said today to us is protected by parliamentary privilege. Once you leave the table please be aware that that privilege does not attach to comments you may make to anyone, including the media, even if you are just repeating what you said to us.

That is our closing statement, but thanks again so much for all of your really important evidence and insights.

The witnesses withdrew.

The Committee suspended at 12.52 p.m.

The Committee resumed at 12.57 p.m.

CHAIR (Ms Haddad) - Thank you very much and welcome to today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you for your written submission, which we have all received and read. Could you, please, first of all, state your name and the role in which you are appearing today?

Dr VAVREK - Natasha Vavrek. I am a GP and owner of The Bubble Tasmania women's health clinic.

CHAIR - Thank you very much. Can I confirm that you have received and read the guide sent to you by our Committee Secretary?

Dr VAVREK - Yes.

CHAIR - Thank you. I will just remind you from that guide that the hearing is covered by what is called parliamentary privilege. That means that you can speak with freedom and without fear of being sued or questioned in any court or place outside of parliament. You can basically share with us whatever you would like to, in any way that you would like to. The only exception to that is the protection doesn't extend to statements you make that could be considered defamatory and you repeat them outside of these hearings, even if it's just repeating them to others or in the media. Does that make sense?

Dr VAVREK - Yes.

CHAIR - Thank you. That said, we are a public hearing, so there might be people watching online. We have members of the public and the media come into the room. There are not any here today yet, but there might be people watching online. If you wish to give any evidence in private, you can do that. Just make that request at any time during the proceedings and we will have a short meeting to go into what is called an in-camera session.

I am going to read a statement to you and ask that you agree to it before we move into the hearing.

Dr NATASHA VAVREK WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED VIA WEBEX.

CHAIR - Thank you very much for that. We have also agreed to give a short sensitive content statement at the beginning of each session, recognising that people might be watching online that might be affected by the things the Committee is hearing. I'll quickly do that now.

We recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians, which may be a trigger for individuals listening to or participating in the proceedings. We encourage anyone impacted by the content during this hearing to contact services including Lifeline on 13 11 44, Tresillian's Parent Helpline on 1300 827 282, Parent Helpline, or PANDA's national helpline on 1300 726 306. Those resources are available on the Committee's website.

I will just introduce the Committee. You also have a friend online. Joining us from the north west - that's our colleague Anita Dow, who is a member for Braddon on the north-west coast. At the table you have myself, Ella Haddad; I am a member for Clark and Chair of the Committee, and I am joined at the table by Nic Street, member for Franklin. We have some apologies from other Committee members today, but they do have your written submission; they will read the transcripts. We are represented by all parties and independents and every area of the state as well. It's very much an apolitical Committee that is just keen on hearing a strong evidence base.

With all of those formalities out of the way, would you like to start with an opening statement?

Dr VAVREK - Okay. I didn't have anything prepared, but I can wing it. Thank you for inviting me to be part of this. As a GP who has worked in the Tasmanian community for well over a decade now, as a business owner of a large women's health clinic across the state, and also as a mother myself who has gone through the Tasmanian health system, I feel that I have a lot to bring to this Inquiry, into services that are available. What I have seen over the years is that we are severely lacking in terms of services and support in Tasmania, which was part of the reason why I opened The Bubble Tasmania, in order to provide that service to the community.

What I saw was that women were lacking spaces to share their issues. They were also lacking specialist services in this space. As a GP myself, I saw how little we were educated in the space in terms of maternal and paediatric services. When I went through my own difficulties with my two pregnancies, throughout and afterwards, even myself, as a GP who was working in this space, didn't know where to go or who to talk to about that. That really was the driving force to create this type of service, because before we opened our clinic, there was no other clinic of this kind, not only in Tasmania but in Australia. I'm very passionate about this space, and I hope that I can provide the evidence and information that you're requiring today.

CHAIR - Thank you very much for that description of how your business works, and also thank you for generously sharing your own story in your written submission. It's a really powerful and generous thing for anyone to do, but particularly in the context of you establishing The Bubble, both north and south. It's really powerful for us to hear and be able to learn from that story.

I wondered if you'd like to elaborate a little bit further about the multidisciplinary aspects of The Bubble, and how and why that's important for the patients that you see.

Dr VAVREK - We do see such a wide range of patients, but if we're talking particularly about mums-to-be and mothers and fathers and the whole family unit, the main goal was to create a one-stop shop and everything underneath one roof. I don't know who of you there are parents yourselves, but when you go through that stage of your life where you're trying for a pregnancy, going through a pregnancy, and going through the postpartum space, it is far easier to have everything under one roof than to have a segmented service.

When we have specialists and practitioners working together under one roof, then we can provide a far superior service for our patients and our families, and we can refer to one another and discuss cases in that multidisciplinary nature. When that happens, we have better outcomes for our patients and better outcomes for our families and communities.

At The Bubble, it was very important for me to include mental health services. You can't go through a journey like parenthood or having young children without something changing with your mental health. Whether that's mild, moderate or severe, most families will go through some form of deterioration of their mental health.

If we can have, under one roof, GPs who specialise in families and postpartum care particularly - if we can have lactation consultants to help with breastfeeding issues, if we can have pelvic floor physiotherapists to help with those common pelvic floor issues, if we can have the psychologists available to help our patients, we can better support that family unit.

What we have found is that a lot of the time families need support in, you know, breastfeeding, in infant sleep support, in the cry, fuss and irritability of their infants. When that is not well managed, mental health suffers.

We can get in there and help with those breastfeeding concerns. We can help with those sleep problems, their growth concerns, and help manage maternal and paternal mental health in that respect. Then also we have the psychologists and that extra help that's necessary when a patient's mental health is not met with those extra services.

Being multidisciplinary is so important because then patients feel like, 'Okay, well, this is where I go. I know where I need to go.' When you're sleep-deprived, tired, perhaps you're having some difficulties in terms of that pregnancy, you don't have the capacity to be going out and looking for those services. If you know there's just this one place that I can go to, where I can get all these services under one roof, then it's going to make the journey far easier for women. When I think back to my own journey as a mother and as a mother-to-be, I didn't even know where to go. I didn't know where to start. A lot of the time, even as a GP myself, I didn't know who to refer people to - mainly because we didn't have those services.

As it is at the moment, I'm the only GP lactation consultant in the whole of Tasmania.

CHAIR - Really? Wow.

Dr VAVREK - I just passed my exams late last year. We just don't have the services, but if we look at Victoria, there is a huge proportion of GP, doctor lactation consultants. We do have nurse lactation consultants in Tasmania, which is fantastic, but there is only a small handful, and being a GP lactation consultant is a whole other spectrum because we can do prescribing and we can diagnose. If we had more GP lactation consultants, more doctors, GPs who specialise in the perinatal space, we'd take pressure off the public health system, we'd take pressure off that small cohort that already do exist who are only getting burnt out.

Certainly, our business has exploded. We only opened four years ago in Launceston and two years ago in Hobart and we have run out of space in the north. We have no space to offer more sessions and our doctors are booked out well in advance. We don't have a shortage of staff, we have a lot more than most GP surgeries. It just goes to show that women are wanting this service in our community and they now know they can just come to us for these kinds of services. There is still so much more that could be done.

We are a private billing practice because the rebates are simply not enough. That's another barrier for a lot of families - the financial barriers of accessing services. If they can't

afford private services, then they get lumped into the public system and that can be a long wait. When we have breastfeeding mothers who are having issues that need to wait to see someone, then they very well may end their journey early.

CHAIR - Yes, and stop feeding.

Dr VAVREK - Yes, absolutely. It also means that when a patient - if we go back to the multidisciplinary comment - if one of my colleagues has a patient who comes in, they may not do breastfeeding medicine but they know, 'Okay, I'm doing this baby's six-week check, the baby is not growing, the mother is showing signs of breastfeeding difficulty,' then they can just walk out of that room and book an appointment with me the next day, we have emergency spots for this type of thing, then I can interact. If I then see the patient is suffering from some mental health issues that are a bit beyond my scope, then I can book them with our psychologist that week. They are the positives of working under one roof with a diverse team.

CHAIR - Yes, it is a really positive explanation, thank you, of the value to patients in particular, of multidisciplinary practices.

In the interactions that you've had with the public health system, what do you think the public system could learn from your experience of providing a multidisciplinary practice? Could you identify any barriers to the public system from providing a multidisciplinary offering to Tasmanian women in particular?

Dr VAVREK - I mean, discussing the public health system - it's a loaded question really that you've given me because there are so many issues with the public system. I think it does come down to lack of primary care services in our community. If we had adequate primary care services, adequate access to GPs who are the primary physicians when it comes to the family unit, we would have less pressure on the hospital system.

When we talk about pregnancy care, particularly at the moment - maternity care services have been in the news a lot - I am primarily based here in the north of the state and, although we haven't had a maternity private hospital since 2016 - we only have two private obstetricians - now, when I have to tell patients who pay private obstetric cover that they can't access a private obstetrician, even though they can pay that and they have been paying those fees, their other option is to then go down the public health system. That puts a strain on the public health system for people who have been paying and expected to go down the private health system and that's a further stress on the public health system.

We also, for - antenatal care of low-risk women used to be bread and butter medicine for the GP, and it's something that GPs have done for a very long time. Over the years, the hospital systems were able to provide really great Midwifery Group Practice and midwifery services and the low-risk care in the GP setting slowly shifted into the hospital setting. There are still some GPs like myself who dabble in shared care, but now, with the public system being so inundated and very few midwives - and we've had a huge exodus of midwives leaving and they rely on a lot of locum - we need to bring that focus back into primary care, but we can't because GPs are inundated.

What we provide is a shared care service, we take on a lot of low-risk pregnancies in the GP setting and we look after patients, which means that they're not needing to go to the hospital for those appointments. They can be seen with their GP and this is something that all GPs

should be able to do, but over time it's kind of been this push and shove between the hospital. I do think there's a lot more scope for more training of GPs, which wouldn't take much at all.

I know that our public hospitals, particularly up here in the north, are very supportive of the GP shared care model because it means when we look after a patient in pregnancy, they go to the hospital they have an appointment at 16 weeks, 20 weeks, 24, 28, 32, then they go 34, 36, 37, 38, 39, and then term 40, 41. That is a lot of appointments we can keep people out of the hospital system. I think a little more collaboration with our GPs and primary health sector could certainly help in that respect, but then, in saying that, we know that our GPs are so overloaded, how do they possibly fit those patients in?

It's a difficult one, but what we have proven is that a private business like The Bubble Tasmania has been able to help take the load off the public health system and work collaboratively with them to provide services for people who are able to pay that extra gap with the GP. Then that leaves it so those patients in our community who are unable to pay those gaps, it gives them the space to access those services through the public health system.

Mr STREET - Off the back of that while we're talking about the gap, in percentage terms, how much would the GP Medicare rebate need to rise to make your businesses financially sustainable without having to charge a gap?

Dr VAVREK - It's a great question. I think to begin with, it would need to at least raise to be equal with what the AMA [Australian Medical Association] suggested rates are. At the moment, and obviously this has been in the news a lot - about 9 out of 10 GP visits being bulk billed in the next decade or so. If I was to go to a fully bulk-billing model at my clinic, all of my doctors, including myself, would be taking between a 30 and 40 per cent pay cut. It would need to be risen by at least 30 to 40 per cent in order for GPs to be taking home what we're essentially worth and to be able to pay the bills of running a clinic.

Mr STREET - Just in your opinion, is the low rate of rebate one of the reasons we have a GP shortage at the minute as well because medical students are making the decision to - there was a figure quoted to me about the percentage of medical students coming out of university choosing to become a GP -

CHAIR - It's diminishing every year.

Mr STREET - It's going down every year, but the drop being significant. Is the rebate and the financial sustainability of being a GP and running your own clinic one of the biggest problems we have?

Dr VAVREK - Absolutely, 100 per cent. It all comes down to the rebate. I can't in good conscience tell a medical student now in 2025 that it is a good pathway to take to be a GP. It is really hard. You cannot be a GP and not get involved in the political landscape that being a GP has become at the moment. The feeling of being devalued, the feeling that a lot of us feel like we are being pushed out of the space. There seems to be more attention on nurse practitioners and pharmacists taking on more of a role and doing jobs that we're meant to be doing, yet not needing to do the level of study and have that commitment that we do. It's not a great space to be working in and the conversation between many GPs does have that depressing note to it. I have a lot of colleagues who have dropped out of general practice and moved on to different areas or, in fact, are retraining in other specialties.

I must admit that has been something that has crossed my mind, but general practice is just not sexy enough for our medical students, and why would you come into it when the conversation every day and the news is that we are not getting paid? We have to remember, we are a private business. If I asked any of you to take a 40 per cent pay cut simply because the government says it's a good thing for the community, would you really do it? With the fees that we have to pay in terms of indemnity and CPD [Continuing Professional Development]. Also, as a clinic owner, the amount that it costs to run a clinic - we're not like any other office, we have special security needs for our patient files, software et cetera. I mean, those costs of that, the cost of living, the cost of running a small business only goes up and up, and that has to be reflected in the gap to the patient. So, if the rebate was to rise, then we wouldn't have to pass on such a gap to that patient.

I don't like to dwell on the negative so much, so a positive is that, yes, we've had an increase in the rebate for IUD [intrauterine contraceptive device] insertions and so IUDs, also known as long-acting reversible contraceptives, or LARCs, are the number one recommended form of contraception or control of heavy menstrual bleeding in the world. Every country recommends them. Yet in Australia we do have one of the lowest rates of insertion. I think a lot of that did come down to costs, so having that rebate rise, so the patient gets more back is fantastic. That means I don't have to increase my gap for IUD insertions for at least the next five years which, as it has been every 12 months we do have to increase that to keep up with the rising costs. So now that can be passed onto the patient and we'll be able to freeze any kinds of increases on pricing for that. It would be really great to see that in other aspects.

We do a lot of pregnancy care, as I mentioned, and when we see a patient for pregnancy care and antenatal care, we charge a certain item number - that's a 16,500. Now, 16,500 has a $20 less rebate compared to an equivalent time-based number. As a clinic that does mostly shared care, and a lot of pregnancy care, from a business perspective, it's better to charge that 36 so the patient gets more back, but if we get audited, we could be in trouble because of that. So, we have to charge that 16,500 and pass on that extra $20 to the patient just because they're pregnant. I mean, this is a great example of Medicare misogyny, right? And another way that women and access to these services are quite often limited because of these costings.

CHAIR - Natasha, even though that's obviously in the Federal Government's domain, it's not outside our scope to make some recommendations about that kind of thing. I think it is medical misogyny. I heard from obstetricians recently, not at the Committee but elsewhere, that the surgical band, in terms of the payment of MBS [Medicare Benefits Schedule] for caesarean is two bands lower than any joint replacement performed by an orthopaedic surgeon. It's arguably just as complex and there's always going to be at least two patients, possibly more if it's multiple births at the end of it, which adds to the complexity. It's beyond our scope as a state Parliament to affect those things, but it's not beyond our ability to mention them in our report.

Dr VAVREK - Absolutely. Particularly if we're looking at maternity services in Tasmania where - how can we help with that and how can we maybe bring a little more of that maternity service model into primary care? Or, if we could make it more affordable for women and increase that rebate for women that would help us as a state. So, I would really welcome some recommendations on that space.

Mr STREET - Just to be clear, I'm not trying to make a political point as a Liberal member with the Labor Federal Government because this has been both sides of politics, federally. What I'm interested in, is taking pressure off the public health system in Tasmania.

CHAIR - Yes, that's right.

Dr VAVREK - Yes, and that is - taking pressure off the public health system can be done if we support our primary care physicians who are our GPs in the community. Not just GPs, but allied health because if we have more access to allied health, i.e., physiotherapists, psychologists - we'd have less of that severity and chronicity of conditions.

CHAIR - Acute health need.

Dr VAVREK - Exactly.

Ms DOW - You've probably answered my question, but you talk a lot about the fact that you have women and families come from other areas in Tasmania, so the north west where I'm based, and the east coast as well. You've talked about the challenges in providing practice and, obviously, the funding model and the long-term liability of your business in your submission. Have you given any consideration to a type of hub-and-spoke model out into those regional areas? Do you ever see a day where you may have a presence, for example, on the north west coast, providing those services to women where they are absolutely needed?

Dr VAVREK - Yes, Anita, I always say that if I had a dollar for every time someone asked me to open on the north west coast, I would have enough money to open a clinic on the north west coast. It used to be the five-year plan, now that's pushed out to the 10-year plan, but I would love to see a service on the north west coast. We have a huge proportion of women travelling that far to see us.

Telehealth services have made a huge difference in that we only need to see them face-to-face once every 12 months. We can have ongoing scope of care through telehealth services, that's fantastic and I hope those item numbers don't ever go. There is a huge need. Tasmania has a population that is spread far and wide. Servicing Launceston and Hobart has helped manage a lot of those people, but, as you mentioned, the north west coast and the east coast are a huge part of the population. I have actually put submissions forward, proposals forward to the Federal Government on both sides, discussing outreach programs that our clinic could provide to these communities in terms of not just general services, but also IUD clinics, antenatal services, mental health services and so on.

I think from a business perspective, to open a standalone clinic, there may be some difficulty in doing that in terms of staffing and costs, but providing outreach clinics is certainly doable. I have enough doctors and allied health in the team that have expressed interest in providing outreach services.

Ms DOW - Fantastic. Thank you very much.

Dr VAVREK - You're welcome.

CHAIR - Natasha, before we finish up, I wanted to go to your written submission. You've mentioned towards the end the difference, administratively, in accessing the Women's Health Fund versus the Youth Health Fund. I wondered if you would like to expand on that at all?

Dr VAVREK - I feel like this is something that could very easily be fixed, but for some reason it hasn't. Years ago when we opened the clinic, I tried to address it. Essentially, for a woman needing to access termination services and then insertion of a LARC, a long-acting reversible contraceptive, whether that is an IUD or an Implanon there, if you're over 25 there is a pool of money, the Women's Health Fund, that is very easily accessible if you have financial hardship. All that a woman has to do in order to access this is they make their appointment, just say, 'I have had an unexpected pregnancy, I want to terminate'. They come in and see me, we have a chat, I kind of gauge their financial situation and that may be that I notice they're on a healthcare card or, I had one patient who had to catch three buses to get to see me and so I explored that a little further. Then I just say, 'There is this funding that is available and I can access that for you'. I fill out a one-page form, very easy to fill out, and we submit that. The fee is paid to us out of the Women's Health Fund and the patient does not have to pay anything. She can also take that paperwork to the pharmacy and the Women's Health Fund will pay for the medication. Then she can come back and I can put an IUD in her and that is all fully funded. It is a very easy way of doing it.

The Youth Health, the Link, way of doing it - if you're under 25, you have to organise a meeting with someone that is trained to do this paperwork, that might be a counsellor or a social worker who works through that service. Say you are a 16-year-old, you've just found out you're pregnant, you're freaking out, the first thing you think about is not 'I need to find out what services are available to fund this for me because I have little money' - but they have to do that first. They might call us, and if they book in with us and they come and actually see me in the room, then that kind of voids everything. I cannot fill any paperwork out for them. They have to get that paperwork and that discussion done before any appointment with the doctor. Sometimes, particularly for medical terminations, they're very time sensitive. They have to get the ultrasound and get the medication in before nine weeks. For some women, we've got them coming into the clinic at eight weeks and six days, so there's not much time for them to organise those appointments.

Then the other thing is, if you're a 16 year old, 17 year old, maybe even younger - you really don't want to be discussing this with too many people. To go to talk to someone else before you've even seen the doctor to discuss why you need financial help in this situation is embarrassing; it's demoralising. It's just another step in this process that doesn't need to happen. If we've got enough trust in our GPs who are providing this service to make that decision, we should be able to make that decision for under 25s.

In my opinion, I say it should be a very easy thing to do. Yes, there's that argument that when they book in, your staff should tell them to contact this person to organise funding, and yes, we can do that, but we also have to remember that some of them, they're young, they may not know what that means. Once again, they're embarrassed, they want to limit it to who knows what's going on. It's just a barrier, another step to make.

Mr STREET - Twenty-five is such an arbitrary number as well.

Dr VAVREK - I know right? I have met with the Link youth group, and they can't really help in that situation. I've spoken to Michelle O'Byrne about this, I've spoken to Bridget Archer about this, but it doesn't really go anywhere. I feel like it's something that could easily-

CHAIR - That first form that you described, the one that you fill in to access the Women's Health Fund, does that go directly to Women's Health Tasmania administering the fund or does it go to the state health department?

Dr VAVREK - I think it goes to Women's Health Tasmania. They have access to that funding. I don't know what they do from their point.

CHAIR - My understanding is they administer that fund and the Link Youth Health Service administers the Youth Health Fund. We might do a bit more investigation as a Committee into why there is that extra step, whether it's an organisational choice by the Link Youth Health Service or whether it was a requirement under the legislation back when abortion was decriminalised, I'm not sure.

It's really good to hear that practical description of how it affects your patients, particularly when, as you said, it's so time sensitive. If that patient saw you at eight weeks and six days and couldn't get in, then they're looking at not being able to have medical termination at all and having to go down a surgical termination pathway, which is a totally different proposition for someone that young as well. It would be really scary, I imagine, to be facing that.

Dr VAVREK - Absolutely. It doesn't matter what age you are, going through that whole termination process is a scary and daunting process.

CHAIR - It's very useful for us to hear that practical example from your practice. Is there anything that you would like to share with us that hasn't come up in our conversation that we've missed out on or that's sprung to mind?

Dr VAVREK - As I mentioned earlier, I'm a GP lactation consultant and I'm very passionate about breastfeeding. I think a lot of women experience issues with breastfeeding and end their journeys early because of the lack of services in that space that we have and the lack of education. I'd love to see more in this space, particularly the postpartum area. I know we've heard a lot about menopause in recent years and how there's been lack of education for GPs in menopause. I would say there's as equally the same amount or lack of education for GPs in postpartum care, which includes breastfeeding.

I shudder to think of the advice that I used to give to women in my days fresh out as a newly minted GP - sleep-deprived mothers coming in and just those comments. You think you know it all and you don't. These days there has been extra training that has come out which myself and a number of my doctors at the clinic and midwives have done, which looks at infant care, breastfeeding, feeding in general, tongue ties, infant irritability, cry-fuss issues, and sleeping - all through an evidence-based lens.

We know so much more in this space and are providing 60 to 90 minute appointments to address a lot of these concerns. The parents can help reduce that maternal mental health load that we see so much, which then can really take on a life of its own and really become quite

severe mental health disorders. If there were more services or more training for GPs in this space, I think we'd see a huge reduction in maternal mental health problems.

CHAIR - That's great. Thank you very much for everything you've shared with us today. If you do think of anything else afterwards that you would like to raise with us, please get back in touch with us through Mary, who you've had contact with. We're really grateful to be able to hear about your experience. Thank you for the work that you're doing supporting so many people through your two clinics.

Dr VAVREK - My absolute pleasure.

The witness withdrew.

The Committee at 1.33 p.m.

The Committee resumed at 2.36 p.m.

CHAIR (Ms Haddad) - Good afternoon and welcome to today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you for your written submission, which all Committee members have received and read. We look forward to exploring it with you both further.

Could I ask each of you just to individually state your name and the role in which you are appearing before the Committee today? Maybe Cate, you're biggest on our screen right now, Do you want to go first?

Ms GRANT - My name is Cate Grant. I'm a birth and postpartum doula. I provide non-medical birth support, and childbirth education, during pregnancy, birth and the postpartum period and I'm also here as part of the Birth in Tasmania advocacy group.

Ms JUDD - Hello, my name is Ayla Judd, I'm here representing Birth in Tasmania. We are a consumer advocacy group made-up of members state-wide. Personally, I'm a postpartum doula and remedial massage therapist, so I look after new mums.

CHAIR - Thank you very much. Can I confirm that you've both received and read the guide sent to you by the Committee Secretariat?

Witnesses - Yes.

CHAIR - Thank you. I'll just remind you of the pertinent part of that document, which is that this hearing is covered by what's called parliamentary privilege. What that means is that you are able to speak to us with freedom, share whatever it is you would like to share with us in whichever way you would like to do that, without any fear of being sued or questioned in any court or place outside of Parliament.

The only exception to that is the protection doesn't extend to any statements that you make that might be considered defamatory, if you then go on to repeat them either in the media or to others outside of these proceedings.

It's a public hearing. We don't have any members of the public in the room right now, but we know that people have been watching online and members of the public may come in during the afternoon, including media. If at some point during what you share with us, you'd like to share information privately, that's an option available to you as well. Just make that request and we can move into what's called an in camera session. The public broadcast stops, but there's still a written transcript taken by Hansard, but then that's not published, it's not part of the public *Hansard* release.

I'll just introduce the members of the Committee. My name is Ella Haddad, I'm a member for Clark in the South of Tasmania and Chair of the Committee. At the table with me is Nic Street who is a member for Franklin. Anita Dow is with you online, Anita is a member for Braddon.

We've got a number of apologies from Committee members who are unwell or unable to join us today, but the Committee is represented by members of all political parties and

independents and all parts of the state and those members who are absent today still have your written submission and they will contribute to our report writing.

I'll just quickly read our sensitive content statement that we've agreed to read as a Committee for any members of the public who are accessing this hearing today or reading the *Hansard* later. We recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings. As a Committee, we encourage anyone impacted by the content matter during this hearing or afterwards to contact services and supports, including Lifeline, Tresillian's Tasmania's Parent Helpline and PANDA'S National Helpline, and those and other resources are listed on the Committee's website on the Parliament of Tasmania website.

Ms CATE GRANT, BIRTH AND POSTPARTUM DOULA, and **Ms AYLA JUDD** POSTPARTUM DOULA, WERE CALLED, MADE THE STATUTORY DECLARATION, AND WERE EXAMINED VIA WEBEX.

CHAIR - Thank you very much. That's all of the formal parts to swear you in completed. We'd like to just invite either or both of you if you would like to start with an opening statement.

Ms JUDD - Thank you so much. I would like to start by acknowledging the people of the Kanamaluka, the traditional owners of the land upon which I am today. I pay my respects to Aboriginal elders past and present. I acknowledge the maternal wisdom passed down through the matrilineal lines across all cultures and embrace the knowledge and traditions shared between women for millennia.

We really appreciate that this Inquiry is happening and would like to thank you for investing your time and resources into investigating the current Tasmanian maternity services. We would also like to thank you for inviting us to speak for Tasmanian consumers today. We know that it can be difficult to speak about difficult birth experiences or to share them publicly, so we hope that we can help to have women's voices heard.

Birth in Tasmania is a volunteer maternity consumer organisation that advocates for women to feel safe, respected, and empowered in birth and beyond. While we know that some women achieve wonderful births in Tasmania, unfortunately, we constantly hear from women that are disrespected, disempowered, and even assaulted in childbirth. This needs to change.

The way a woman experiences her pregnancy, birth, and postpartum will stay with her for a lifetime. This transition through matrescence is massive and not only affects the mother and her mental and physical wellbeing, but also her baby, the entire family unit, and her close community. Supporting mothers to feel held and celebrated during this transformative time is quite literally shaping our future.

Our organisation currently has four objectives that we are advocating for. These have been chosen because we believe they can make a huge impact to the way that women are treated in childbirth, which will hopefully lead to better birth experiences and higher satisfaction from mothers.

Firstly, informed consent training for all maternity staff. Many of the traumatic stories that we hear from women stem from providers not understanding how to gain basic informed

consent from women. It seems to be common practice that interventions are carried out without properly asking women, let alone adequately informing them of the risks and the benefits or the option of saying no. Maternity Consumer Network, together with Human Rights in Childbirth, offers a fantastic consent training that has been specifically designed for maternity care.

Our second objective is to expand Maternity Group Practice programs. Only 17 per cent of women in Tasmania have access to a known midwife throughout their pregnancy and birth. However, we know that most women want this gold standard of care. These programs are often difficult to access due to the lack of capacity, or women are devastatingly risked out for ridiculous reasons.

Thirdly, require each individual hospital to be transparent in their maternity data. Women and their families cannot make adequate decisions about their care if hospital statistics and policies are hidden from them.

Lastly, Tasmania does not have a publicly-funded homebirth centre and is now the only state or territory that does not have a publicly-funded homebirth program. Homebirth provides women continuity of care with an autonomous midwife in the comfort and safety of their own homes. We hope that this Inquiry finds that supporting homebirth in Tasmania is a viable option and should be part of the solution to the current maternity crisis.

Thank you again for the invitation. We really look forward to discussing our group's objectives and answering your questions today

CHAIR - Thank you so much, Ayla. Cate, did you want to start with an opening statement as well, or we will move to questions?

Ms GRANT - No, I am happy to go ahead with the hearing, thank you.

CHAIR - Lovely, thank you. I might start with a question before opening it up to all of my colleagues, that's around your second recommendation, the expansion of Midwifery Group Practice (MGP). We have heard really compelling evidence from many people across the life of this Committee - individuals as well as directly from midwives and other health professionals - around the importance of continuity of care. I just wondered if you were able to share from your experience your understanding of the eligibility criteria.

You touched on, Ayla, in your opening statement, that not everybody is accepted into a group practice setting for their pregnancy. It would be good to hear a little bit about what those eligibility criteria are and how they are applied, and whether they are applied differently in different hospitals. Is that something that you've been exposed to that you're able to share?

Ms GRANT - Midwifery Group Practice, that's something - we have talked about who is going to talk about what. Obviously, it's a gold standard of care and the model of care that most women want to get into for their pregnancy because they get to have two known midwives supporting them through their pregnancy, their birth - one of them will be at the birth - and in their postpartum. Some of the reasons that clients aren't able to access MGP is because of lack of availability of midwives. That's a really big one. There is just not enough midwifery to go around in the in that model of care.

Other things - like gestational diabetes - that can be given as a reason for women not being able to access the service. Often, if there are a couple of risk factors, like if someone has gestational diabetes and is planning a vaginal birth after a caesarean, there may be those sort of considerations. In that kind of context, the women, if they have midwifery group care, they still have the support of the obstetric-led teams. They can have extra appointments to assess their risk factors and how they're travelling, but they're often told that they cannot get into those services. Lack of availability is a big one.

CHAIR - From a clinical perspective, is there a reason why risk factors would, for want of a better phrase, class someone out of getting into an MGP versus added risk factors meaning they are more suitable to be receiving continuity of care through a Midwifery Group Practice?

Ms GRANT - I can't speak from a medical viewpoint because that's not my remit, but things that women have told me is that they feel safer in an MGP model because they know their care providers. They know that there are other obstetric services available to them. They are often are frustrated at being funnelled into a higher risk model of care which involves more obstetric appointments with different registrars. They don't get to see the one obstetrician throughout their care. Having a midwifery-led care model would often help with women not falling through the cracks, because they see the one provider the whole way through, and they are more likely to pick up on any anomalies in their in their presentation.

CHAIR - You have expressed it really well in your written submission that, in no other area, particularly in healthcare, do we see very - if you're going through an oncology treatment pathway, you're probably going to see the same people over and over again. If you're going through other medical treatments, you're probably going to see the same providers, but when it comes to prenatal care and labour, it's not the case. We have heard stories from women who say, if there is a risk factor that's identified, they are told at each different appointment, 'We'll check that out next time'. Then they see someone different next time and they say, 'Yes, we will look at that next time', and that goes on and on and throughout their pregnancy. Thank you for sharing that.

Ms GRANT - Or one provider says something is a risk factor and another one, in their opinion, says it's not an issue. There was a study done last year on MGP or continuity of care in Queensland and it showed that if continuity of care models were increased, the capacity was increased, the cost of obstetric care would go down because people who don't need that service are not being funnelled into that service. Therefore, you have lower risks for the people who do need the service because they're getting seen in a timely manner.

Ms DOW - Thank you both for presenting to our Committee today and for your submission. You've talked a lot in your submission and then in your recommendations about the importance of homebirths and public homebirths being available in Tasmania. I wondered if you might just provide some key reasons to the Committee again today as to why you think that's beneficial and perhaps some examples. You talk about those being available in regional areas as well, which currently isn't available in Tasmania, and some of the benefits that you would see from the work that you've done with Tasmanian women around having those services available in regional areas, please.

Ms JUDD - Thank you, Anita. Yes, I suppose having a homebirth and private endorsed midwives is just like a phenomenal option as a provider for women. We're blessed here in Launceston. We have Australia's oldest birthing centre. It's 42 years old; the Launceston Birth

Centre. We have Australia's voted top best midwife, Jaimee Smith, leading that birth centre here in Launceston. Their statistics are just phenomenal at the satisfaction from the women over a 27-year collation of their statistics, their caesarean rate is 5.1 per cent.

Ms GRANT - That compares with 49 per cent at the Royal Hobart Hospital currently -

CHAIR - Wow, that's a massive difference.

Ms GRANT - which is higher than the similar hospitals at 36 per cent. Sorry to interrupt there.

Ms JUDD - Yes. Jaimee has gathered that figure over 42 years. Australia-wide, the caesarean rate is 27 per cent over the 42 years and their caesarean rate is 5.1 per cent. If we're looking at - like it's a different timeframe period.

Having that relationship-based care for women, having the relationship with that privately endorsed midwife antenatally right through to the birth and six weeks postpartum. Just that relationship-based care, I think we can learn a lot from what they're doing.

What happened in the 90s; how it was funded for three years and how so many women flocked to use that service and then, unfortunately, the funding stopped. I understand it is an insurance issue as well. Hopefully, we can learn from the no-fault policy that is happening in New Zealand that could hopefully be popped to put something into play, here in Australia. Just the satisfaction and the relationship care that comes from having homebirth and just a privately endorsed midwife as a provider is phenomenal for families.

Ms GRANT - I think it's important to recognise that homebirth is the norm in so many countries around the world, and publicly-funded homebirth in New Zealand, in the UK, in Scandinavian countries. Homebirth is safe for most women. Women who have homebirths have lower intervention rates and express greater levels of care than the women in medical models of care. That's really important and I think Tasmanian women deserve that.

The other thing, Ella, that I think you're aware of is the birth house project that Rashelle's [Szoke] trying to get up and running in Hobart, which is similar to the Launceston birth house. It's a project that's been on the agenda for a couple of years and she's working towards that. That would be a great option too. That's an independent service where healthcare practitioners, whether it's midwives, obstetricians, other allied health service providers can use the space to provide care to women. Women can effectively hire a room within that space to birth their baby. It's a middle ground between having a homebirth, a private homebirth at home, or a hospital birth, but still have access to transferring to a hospital if a greater level of care is needed during that birth. There are lots of good options out there that we can look at funding and expanding.

Ms DOW - It's not in your submission, but it's of interest to me. How many doulas are there across Tasmania practising in the community? Do you know?

Ms GRANT - How many hands have you got? You can count them on one hand probably. I am the only full-time birth doula, as far as I know, in southern Tasmania. There's a couple of other part-time doulas as birth doulas and there's a few in the north and north west.

There's more postpartum doulas because that's an area of need and it suits a lot of people with younger children too, not being on call.

Ms JUDD - To add, it's a very growing space. Having people for that emotional and practical support for postpartum is beautiful and just to support people. A lot of things are out of scope for a doula, but being able to direct people to the best professionals that are going to help them along the way. That's a big job of being a postpartum doula and knowing who's at the IBCRC [International Board Certified Lactation Conultant], who's the GP that specialises in a particular topic and being able to connect families with the appropriate healthcare provider. A big part of our job is education and just connecting through the community.

Ms GRANT - On my part, I was going to say too, education is a large part of it, providing clients with evidence-based support because there's a lot of information out there and that's not always accurate and it's not always evidence-based. Something that myself and my fellow birth doulas pride ourselves on is providing accurate, accessible information that is evidence-based for our clients so that they can make informed decisions and that leads on to one of our other topics of maternity statistics and being able to access that information. Should we move on to that?

CHAIR - Sure, go for it.

Before we do, I might quickly share with you both. We did have the minister and her department here this morning and, as Anita said, we've heard a lot of advocacy for an expansion of homebirth services in Tasmania, particularly publicly funded homebirth. The minister shared with the Committee that her department is working on a paper that's almost ready to reach the secretary's desk around looking at publicly funded homebirth. My rudimentary understanding of it is that if it was publicly funded, it would alleviate some of those insurance issues that you alluded to Ayla because they'd be THS employees, and they've had some initial discussions as well with Hobart birth house proponents.

That's a positive step forward, having a Health minister that's interested in women's health and is already having some of those discussions and doing some of that research that will inevitably also form part of our recommendations based on the evidence we've heard. We did tour the Launceston birth house as a Committee when we were up north earlier this year.

Ms JUDD - Phenomenal, so good.

CHAIR - It was lovely. Such a beautiful space.

Data is something we've heard lots of evidence about too. We're very keen to hear about your recommendation around that.

Ms GRANT - As we know, the Tasmanian Perinatal Data Collection collects information on demographic, medical and obstetric information on mothers and babies, including information on the labour, the birth, the condition of the baby at the birth. That information is available. It's a requirement of *Obstetric and Paediatric Mortality and Morbidity Act 1994*, but it's not accessible to women in an easily accessible form.

Tasmania Data Collection Guidelines says that it is available and provides a link. That link doesn't work and I've contacted the Institute of Health and Welfare to try and get them to

dig down into the data that is available. Haven't heard back yet, but a lot of women don't have the time and resources to be able to do those sorts of things, to find out information about intervention rates, about caesarean rates, about instrumental birth rates at various hospitals. Those are the sort of things that they need to make informed decisions about the model of care that they want to be supported by. It's essential.

As I said earlier, the maternity inquiry report last year found that the RHH performed on par with its peer hospitals for most aspects of labour including induction, assisted births, episiotomy rates, epidural use and postpartum haemorrhage. That's kind of meaningless, because we don't actually know what those rates are.

Maybe it's reassuring to know that it's on par. Maybe those statistics are actually horrendous and women are going, 'Well, hang on a minute, that doesn't sound very good to me.' The fact that with early planned caesarean rates at the RHH, for caesareans without medical or obstetric indication, the RHH's rates are 49 per cent. That's well above the 36 per cent of peer hospitals and well above the World Health Organisation's expectation of around 30 per cent, or less.

CHAIR - Is that for planned caesar, did you say, or for emergency caesar?

Ms GRANT - For planned caesars, without medical or obstetric indication. That's something that needs to be looked into as well. Why are women choosing or consenting to a planned caesar if there's no medical indication for it? No doubt there's lots of reasons around that as well.

The RHH's induction rates, particularly for first-time mothers, are very high. The caesarean rates for first-time mothers are very high - higher than the World Health Organisation's statistics suggest they should be. No-one goes into a birth wanting a high-intervention birth. No client ever says to me, 'I'm really keen to have an episiotomy or an induction.' Everyone wants a non-intervention birth, and they want to feel safe. They need to feel safe to go forward as well women and well families. Being able to have this information would provide people with the opportunity to make informed decisions before they get there.

CHAIR - Thank you. While the Committee has heard lots of positive evidence around homebirthing, we've also heard some concerning evidence around freebirthing. I note that you've gone to that in your written submission as well. It's difficult to gather numbers of freebirths in Tasmania, obviously, because it's not a medically recommended or recorded way of birthing. I wondered whether, through your organisation or through your work as doulas, whether you have any comments to make around why people might make that choice, as opposed to a homebirthing choice or a hospital-based birth? And what the risks are.

Ms GRANT - Yes. Professor Hannah Dahlen, in her research a couple of years ago, looked at why women choose to birth outside the medical system. Predominantly, that's around feelings of safety. They feel safe at home; they don't feel safe within the medical system. Often, it's because they can't get a homebirth midwife due to a lack of availability. They're the two big drivers for it.

CHAIR - Anita, did you have any other areas you'd like to go to with Cate or Ayla?

Ms DOW - The only thing that I picked up on, in your section around continuity of care, is the referral process to a midwife. Currently there are procedures you have to have done around bloods and ultrasounds prior to being referred to a midwife. I just wanted some comments from you about the benefits that you would see in the opportunity to see a midwife prior to that for women, and what feedback you've had from Tasmanian women about that.

Ms JUDD - As a postpartum doula, I'm more in the seeing mums in the later stages, the season of postpartum - so feel free to jump in, Cate. The benefit of seeing a midwife earlier, before tests are done, Anita?

Ms DOW - That's what's being intimated in the submission - that it would be good to have that opportunity prior to those things taking place, just as part of the continuum of care. It was something that I picked up in your submission.

Ms GRANT - To speak to that, I'd say that, coming back to continuity of care, if a woman doesn't see a midwife and is not in a midwifery program where she has a regular midwife that she can talk to about issues that come up within her pregnancy, and they are going through various testing, they're not going to feel supported and safe in going through those processes of testing for whatever scans and tests might be recommended. As we said before, women are often seeing various obstetricians at different appointments, getting various information.

I have had clients recently that had anomalies that popped up in some of their scans. One obstetrician said, 'Yes, we will need to investigate that further.' It takes time. They have no-one to talk to about their concerns and what the implications might be. They go to Dr Google. These are intelligent, educated people, but still, it's stressful having that lack of support through that. The next doctor, six weeks later, says, 'Oh, no, that's not a problem at all.' If they had a midwife to support them through that, who could provide reassurance and continuity of information, that would be very helpful.

Ms DOW - Thank you. That's what I was after, just some examples of how benefit would be gleaned from that, so thank you very much.

Ms GRANT - I believe also, when we're making informed decisions about things and data collection, it's all well and good to have statistics on intervention rates but we also need to have data and collect information on women's experiences of their birth and their maternity care. Their care, as we know, affects women profoundly going forward.

I have sometimes 70- or 80-year-old women, when I talk to them and tell them what I do, end up telling me their birth stories from 30, 40, 50, 60 years ago. In tears, they'll say, 'I never had the chance to talk about that.' It stays with them so profoundly. It affects people's sense of self, their parenting, their intimate relationships. By collecting that information about how they feel about their birth, it would allow practitioners to understand the wider consequences of their medical recommendations beyond the outcome in the birth suite of the operating theatre. I think there's a huge disconnect there. Yes, I think that would be very useful information to have.

CHAIR - Thank you. That is very in line with a lot of the evidence that the Committee has heard. Was there anything else that either of you would like to share with us that you haven't covered?

Ms JUDD - Just to touch on informed consent training for maternity staff - what is the latest with that area?

CHAIR - We've heard a lot of evidence around the need for it. I don't know what is currently provided, but it's certainly something the Committee has heard - the need for training, but also a lot of personal stories about consent being sought during labour and question marks over whether consent or informed consent or even consent was given. We've certainly heard a lot of very deeply personal stories from individual members of the public who have shared their experience with us. I can't kind of pre-empt what our recommendations will be, but I imagine that we'll go to that evidence in our report writing stage. I know that it's something that is kind of a concern for many, including health professionals as well.

Ms JUDD - I suppose just, as a goal, having the consent training from a consumer point of view, so I suppose turning the attention to Better Births with Consent Training from the Maternity Consumer Network. Having it from a consumer point of view, and that particular training is with a human rights lawyer and a psychologist and the midwife as well. Just having it consumer-focused.

CHAIR - We did hear from Maternity Consumer - I have forgotten the full name of the organisation, but Alecia's organisation, but we did hear from her and she told us about the training she's been providing in both Queensland and, I believe, parts of New South Wales as well. That evidence has all been shared with the Committee as well and was really interesting.

Ms JUDD - So good. Yes, I think there's the Engender Equality training that's happening down in Hobart, but I think that might be more family violence focused, which is still an important topic. I suppose having this training from Better Births with Consent Training is designed for consent training in the maternity space. That would be a really strong recommendation from our organisation, that that's really investigated. You can jump on their website and you can book in the training. It's really straightforward and accessible.

CHAIR - That's great. Thank you very much for raising that as well. Alright, we might bring things to a close. I'll just read out the closing statement as well, which is that, as advised at the beginning of the evidence, what you've said to us today is protected by parliamentary privilege. Once you leave the table, please be aware that privilege doesn't attach to comments that might be considered defamatory if you make those comments to others or repeat those comments to others, including the media.

Thank you both again for giving your time to us today. If there are other things that come to mind after we've finished up that you'd like to share with us then please do get in touch with us through Mary, who you've had contact with to set up today's hearing. We'll keep you posted as we move to the next stage of writing and tabling the report in Parliament.

The witnesses withdrew.

The Committee suspended at 3.12 p.m.

The Committee resumed at 3.18 p.m.

CHAIR (Ms Haddad) - Good afternoon, hello and welcome. Thank you for attending today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services. Could I ask each of you in turn just to state your name, your role, and the capacity that you're appearing before us today?

Ms BANKS - Georgia Banks. My capacity is General Manager of Hobart Private Hospital.

Mr La SPINA - Tino La Spina. I'm the CEO of Healthscope.

Mr HEWISON - Chris Hewison. I'm the State Manager for Tasmania and Victoria for Healthscope.

CHAIR - Fantastic. Thank you very much. Can I confirm that you've received and read the guide sent to you by Mary, our Committee Secretary?

WITNESSES - Yes.

CHAIR - Just to remind you, the pertinent parts of that are that you're covered in this hearing by what's called parliamentary privilege. That means you can share anything you want with us in any way that you want to share that with us. You can speak freely, with freedom, and without fear of being sued or questioned in any court or place outside of Parliament. The only exception to that is that protection is not accorded to you if statements that you make could be considered defamatory and then you repeat them outside of these parliamentary proceedings.

This hearing is a public hearing. There could be members of the public or media attending physically or be watching online. If at some stage during the hearing you wish to provide information to us in private, that's available to you as well. Just mention that at the time. We'll have a short deliberative meeting to move into an in camera session and we can hear anything you would like to share with us privately in that way.

I'll introduce the Committee. My name is Ella Haddad. I'm the Chair of the Committee and member for Clark, which is southern Hobart metro area. This is my colleague Nic Street, who's a member for Franklin, which also has parts of metro Hobart and some regional parts of southern Tasmania. Anita Dow has joined us online, Anita is a member for Braddon and is based in Burnie. We have apologies from our other Committee members, two members for Bass and another member for Clark.

We have all political parties and independents represented on this Committee, so it's very much about hearing an evidence base. It's not about political argy-bargy, it's about hearing the challenges that are out there in the Tasmanian community for maternity, and paediatric and reproductive health services, and making an informed report and recommendations to government.

Ms GEORGIA BANKS, GENERAL MANAGER, HOBART PRIVATE HOSPITAL; **Mr TINO La SPINA**, CEO, HEALTHSCOPE; and **Mr CHRISTOPHER HEWISON**, VICTORIA/TASMANIA STATE MANAGER, HEALTHSCOPE, WERE CALLED, MADE THE STATUTORY DECLARATION, AND WERE EXAMINED.

CHAIR - Great, thank you very much. As a Committee we recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians, which may be traumatising or a trigger for individuals listening to or participating in these proceedings either today or later. As a Committee, we encourage anyone impacted in that way to contact services including Lifeline, Tresillian, and PANDA. Those resources are available on the Committee's website on the Parliament of Tasmania website. That's all the formalities done and we'd really like just the opportunity to hand to you if you'd like to make an opening statement of any kind and then move into a discussion.

Mr La SPINA - Thank you, Chair and Committee members. Thanks for the opportunity to speak with you today. I'll take a couple of minutes just to take you through a brief opening statement, if that's okay, and then we look forward to answering your questions.

My name is Tino La Spina. I'm the CEO of Healthscope. I'm joined by my colleagues Chris Hewison, who's State Manager for Tasmania and Victoria, and Georgia Banks, who is General Manager of Hobart Private Hospital and remains a registered nurse after 33 years.

CHAIR - Great, that's good.

Mr La SPINA - We want to begin by acknowledging the concern that the decision to cease maternity services at Hobart Private Hospital has caused for many Tasmanian women, families, and healthcare professionals. We recognise that maternity care is a deeply personal and essential service, and we recognise the distress this transition has created. We also want to extend our deepest appreciation to our dedicated midwives, nurses, doctors, and other staff who have worked tirelessly to support mothers and their babies under sometimes challenging circumstances.

The decision to cease maternity services at Hobart Private Hospital was not made lightly. It follows a long and thorough review of the service's operational viability, particularly in the face of critical workforce shortages. Despite extensive local, national, and international recruitment efforts, including the appointment of a talent acquisition manager, we've been unable to secure the midwifery workforce required to sustain a safe, high-quality maternity service. At times, up to half of our midwifery workforce has been reliant on agency staff flown in from the mainland, which is unsustainable both financially and in terms of continuity of care. We also note that this is a challenge around the country, with recent public reporting citing figures provided by the National Association of Specialist Obstetricians and Gynaecologists showing that by the end of 2025, 18 private maternity units across Australia will have closed in the past seven years.

We understand the importance of a smooth transition for families and we're working closely with the Tasmanian Government, Calvary Health, and the Royal Hobart Hospital to ensure that expectant mothers have clear options for their care. We're committed to making this process as orderly and transparent as possible, ensuring minimal disruption to those affected. We want to assure families that any expectant mothers due to give birth prior to 21 August will receive the same high-quality care they expect from Hobart Private [Hospital]. For those with later due dates, we're working closely with their treating obstetricians to ensure a safe and supported transfer of care to alternative providers.

Whilst this decision marks a difficult change, it does not signal a retreat from our commitment to provide outstanding quality healthcare for Tasmanians. Healthscope remains dedicated to growing and enhancing services at Hobart Private Hospital. Our focus is on strengthening other critical specialties including gynaecology, surgical services, and cardiology, ensuring that Hobart Private remains a cornerstone of high-quality private healthcare in Tasmania. We appreciate the concerns raised by the community and will continue to work in good faith with all stakeholders to navigate this transition responsibly and with the utmost care for patients and staff.

Finally, I'd like to thank you for the opportunity to appear here today and we welcome your questions.

CHAIR - Great. Thank you very much and as I said before we began the formal part of the hearing, we are grateful for you being able to appear at short notice. By chance, the Committee was actually in session on the day of the announcement of the closure of maternity services at the Hobart Private. The timing is quite of the essence that this Committee is happening and we recognise that it wouldn't have been a decision made lightly as you described.

You touched on workforce shortages. That is something that the Committee has heard a lot of evidence about, particularly in midwifery, but also in obstetrics and other healthcare professions that have a role to play in maternity services. I understand that's a nationwide problem. What would you nominate as some of the solutions do you think to those workforce challenges for Tasmania and elsewhere? Is it specifically around midwifery care or is it broader than that from your experience?

Ms BANKS - Great question, in terms of midwifery specifically, obviously, some of the challenges we've faced have been securing any workforces. Tino described reaching out broadly, internationally with - just as a comparison, we've been able to successfully recruit over 20 staff, or 20 FTEs, into other domains within our workforce, but for maternity we've just not been able to secure - we managed to secure one special care nursery registered nurse, but no midwives into our portfolio despite all of those different campaigns. Unfortunately, the lack of tertiary education within Hobart has, I think, contributed to it. Sourcing midwives locally to then be able to on-train has been an ongoing challenge for Hobart.

Mr STREET - When did the university stop offering the midwifery course?

CHAIR - I can't remember, we have heard that information. Do you know?

Mr STREET - I'm new to this Committee so that's why -

Ms BANKS - Are you? I'm actually new to Hobart in the last nine months. I started in July, and came down and have just recently been appointed to the role permanently, which is wonderful. It's great to be here. I'm learning lots about Hobart and Tasmania, but I do think it has been absent for several years.

CHAIR - We did hear this morning from the minister, she's already in negotiations with UTAS. She was on this Committee until Mr Street joined the Committee when Mrs Petrusma joined the Cabinet, so she was here for the first day of the hearing. As a Committee, we're quite glad that we know there's a Health minister there with women's health as something that's high

on her list. She's already commenced some communications with UTAS, which is really good to hear.

Is there anything else you'd like to share with the Committee generally about the costs of providing maternity services in a private hospital setting, how and why - or I could be wrong in assuming this - that it is less economically viable than some other specialties, and what those pressures are from the perspective of running a private hospital.

Mr La SPINA - Or maybe I could start by saying the decision to cease maternity services was a difficult decision, but it wasn't on the financial side of it. It was it was really about being able to get access to the workforce. We do have maternity services elsewhere in the Healthscope network that we offer. It just became completely unsustainable really.

CHAIR - Just due to workforce.

Mr La SPINA - I do think that one of the other things we have, and it's not to ignore the financials - it's been well publicised that Healthscope, along with other private hospital operators, has been working hard to get fair funding from private health insurers. We've seen the payout of private health insurers go from pre-COVID levels of around 90 per cent of their premium income would be paid out, to well below 80 per cent. Effectively, that's just a redistribution. The system has the capacity to pay, but it's not funding hospitals well enough.

Mr STREET - My private health premiums aren't going down. Somebody else is getting that 10 per cent.

Mr La SPINA - That's exactly the point. My hypothesis is that the system has enough money within it to be able to go around and provide everyone a fair return. It's just not being distributed appropriately at the moment. I think that that's a very fair observation.

CHAIR - Yes, it is.

Mr La SPINA - For clarity, I've been in the role for a grand total of two weeks.

CHAIR - Wow, okay.

Mr La SPINA - This is my second week and I've been with Healthscope for two months. I've certainly had the wonderful opportunity to go and see the staff at Hobart Private, including our wonderful staff in the maternity ward. It's obviously a tough decision, but they've been quite stoic and very supportive of the transition.

Mr STREET - As a member of the Liberal Party, I'm not massive on Government or Parliament intervention, but what levers are there to ensure that private health funds are distributing?

Mr La SPINA - Helpfully, at the federal level we had the federal Health minister seek to intervene, and basically sent a message to the health insurers to come together with the private hospital operators to seek fair funding. If they can't work it out, then the federal minister is taking advice on what regulatory action he can take as well. I think that that's going to be good.

CHAIR - That's good to hear. It's something that we've heard as well from private obstetricians that the rate of people choosing private births is declining, not just in Tasmania but nationwide, due to those insurance costs jumping. They went up five-fold, I think, for obstetricians, the personal insurance cost to them in terms of liability insurance.

Mr La SPINA - It's not something that's limited to maternity itself. It goes beyond that into all private services, to be honest. I think it's a real challenge for the industry moving forward in fact, and what sort of model of care that we're going to be going down.

CHAIR - Are you happy to share a bit more about those insurance challenges with those private insurers? Obviously, a lot of this is in the Federal Government's scope, not the state parliament's capacity to influence. We can nonetheless make comment about federal issues in our report and make recommendations about that. We've certainly heard a lot from health professionals comments around Medicare rates, for example. If there's anything in particular that you'd like to share with us about those challenges with the private insurance industry.

Mr La SPINA - I think just reiterating that there was a period of time pre-COVID where the hospitals and the insurers were both able to make a fair return. There weren't super returns, that's not what we're talking about here. It was enough to be able to reinvest back into the system. What you have when you have a redistribution, the way it's happened now, I'd say over a billion dollars is gone from the hospitals to the insurers. That's a billion dollars, that kind of translates into a very difficult reinvestment environment back into the system.

I accept that you have insurers out there with particularly different views on models of care and whatever. I think that that tension there with the hospital system is not a bad thing because I think we should all be thinking about different models of care moving forward. Ultimately, I guess I'm used to having a dyad-type model of care where management and clinical decisions - clinical decisions and clinical pathways need to be made by clinical experts, not by insurers. That's the bit that concerns me personally moving forward, which is why I actually joined Healthscope. I have people with medical backgrounds: my son is a doctor, my daughter is a registered nurse, and I just want to make sure that the system going forward is better for them than what we have got now.

CHAIR - Is informed by clinicians. We would hate to see Australia go down an American model where it's insurers making decisions about whether surgeries are even allowable or not under insurance, with no clinical relationship with the patient or maybe even training.

Mr La SPINA - That's an insightful comment. It's not difficult to see how we get from where we are now to that sort of model. It's a very slippery slope and once it starts, it is pretty hard to stop, so I would agree with that.

Ms DOW - Thanks, Ella, and thanks very much for presenting to our Committee today. I have a couple of questions in relation to the cessation of providing maternity services. I wondered, when you speak about the challenges that you had with recruiting midwives, did you offer any incentives or any sort of recruitment packages or anything around trying to get midwives to come and work at your hospital?

Ms BANKS - Yes, I am happy to answer that one, Anita, thank you. We certainly did. What we have seen over the time - and obviously I can only talk to Hobart more specifically

in recent times - we've seen our workforce become highly casualised. If we look back on the data we can see that really over the last two to five years, we have an older workforce. Many of our midwives have been there a very long time with us, which is amazing. I think, Tino, you heard that today. There are lots of people who have been there 30 plus years. I think that it is a lifestyle choice as they start to become more casualised.

In terms of offering them - obviously, we're offering extra shifts, offering penalties for additional shifts, when we got to a point of 45 per cent of the workforce being casual, they'd really made their decision to have lifestyle over working set rosters. What we can say is that many of those decisions were made around penalty shifts, afternoons and night duties. Not so much weekends, we usually have no concern with that, but it was the decision not to take on those particular shifts and hence going casual.

In terms of part of the recruitment packages, we certainly had relocation allowances, we had accommodation provided, sponsorship of visas. They were some of the methods that we looked at to try and employ people, certainly in the timeframe that I have been there.

Mr La SPINA - Even the ones that did come to work, they were at penalty rates. They are not what you would call at ordinary time rate.

Ms DOW - Of those staff, some obviously may retire I suppose, but are most of them transitioning across to other employment opportunities? Are you able to provide the Committee with an update on that please?

Ms BANKS - Yes, thanks, Anita. We are looking forward to our first working group led by Sally Badcock. That has just dropped into our diaries for tomorrow. We welcome that opportunity to work with the Government and also Calvary [Lenah Valley Hospital] and the Royal [Hobart Hospital]. Stakeholders have come together to really look at that transition plan.

Our date being 27 August for the final service, it is a long transition period of time. We've had very early engagement with Calvary, which has been fantastic and very welcomed. We look forward to being together around the table to really transition the service. Our doctors are very engaged and keen to understand exactly what that looks like, because obviously the women in the community that we are servicing right now, as they transition, they will need those midwives to be able to transition that service successfully across to Calvary. Not all will go to Calvary, there will be a smaller proportion that will need to be managed and cared for at the Royal. Doing that really well is going to be a great starting point. We look forward to that tomorrow.

Ms DOW - Following on from that, did you have a Midwifery Group Practice model that was implemented at the hospital, and will that continuity of care continue for those mothers and families in that as they transition to whichever setting they have chosen to transition to?

Ms BANKS - That's a good question. The midwifery model of care, if I'm correct - and I was able to do some work with Francine Douce, who was able to explain to me the models of care and some of the transition that they've done at the Royal. It sounds incredible. We had some early conversations about that model. At Hobart Private, and I would imagine also at Calvary Lenah Valley, it's an obstetric-led model. The patients and the women are seeing the obstetricians for their antenatal care and seeing midwives within Hobart Private for some of

those classes. We don't see that changing at all. That model would transition over, led by the obstetricians, across to Calvary. Does that answer your question?

Ms DOW - I think so. Not entirely, but that's okay. The other thing I wanted to ask you before I hand back to you, Ella, is that this Committee is looking at not just maternal service provision in the state, but also reproductive services and other women's health services. I wanted to seek confirmation from you today that there won't be any other changes, particularly around gynaecological services provided by the Hobart Private. Could you provide any further information on that?

Ms BANKS - Yes, I'm more than happy to. That is something - we have a very large gynaecology service at Hobart Private, serviced by over 13 different providers. In my early conversations with all of those gynaecologists and obstetricians, the obstetric component will transition, but the gynaecology services at this stage, they have all requested to maintain their current lists. We don't see any change to that service provision with the exception of some later term terminations that occur at Hobart Private in that obstetric model. Beyond 16 weeks we would not be able to - that's more of an obstetric termination which would need to then be managed, we imagine, at the Royal Hobart.

In terms of all of our other services, for women and particularly related to gynaecology, it's quite extensive, with urogynaecology, gynaecological oncology services, general gynaecology, and also the terminations that we do with all providers.

CHAIR - Thank you for that. I wanted to drill down on that as well. I'm glad that Anita began that line of questioning - and I say this with, hand on heart, no criticism of Calvary; my babies were both born at Calvary and I had a great experience with both of them. I suppose there will be some changes in terms of women's expectations around reproductive health services in particular and possibly around things like tubal ligation and contraceptive choices. I think some of those things might be handled slightly differently. We can ask Calvary that too. I don't expect to answer on behalf of Calvary. In terms of those termination services that are available currently, will Healthscope still be able to manage through the gynaecological services part terminations up to 16 weeks?

Ms BANKS - Absolutely.

CHAIR - Then beyond 16, they will go to the Royal.

Ms BANKS - They will need to go to the Royal and be managed in that model. Yes, we would absolutely plan to continue all of those services as we currently do.

Mr La SPINA - Do you want to talk about how many?

Ms BANKS - In terms of late term terminations, we've run our data set over the last two years and it's about one per quarter.

CHAIR - Quite low.

Ms BANKS - Yes, very, very low numbers.

CHAIR - You've each had experiences in other states as well. Is there anything you can expand upon about how other states deal with gestational timeframes around termination services, surgical terminations, if that's within your knowledge? We've heard from a community provider today, a community health service, that it is different from state to state in terms of what is available up to nine weeks or 12 weeks or 16 weeks or beyond.

Ms BANKS - Obviously, Victoria was home up until recently and I believe actually Tasmania up to 16 weeks is beyond Victorian -

CHAIR - Is it? Okay.

Ms BANKS - I don't want to speak 100 per cent, but I do know knowing 16 weeks here for Hobart, I do believe it's lower for Melbourne, but I would obviously have to verify that. That is something that we do a lot of termination - speak to that freely - we do a lot of terminations those, that part of the community, can access that service very rapidly through multiple range of gynaecologists.

We see that continuing obviously and our IVF [in vitro fertilization] services and, Anita, you did mention reproductive services, so just came back to that in my head. We do quite a lot of the IVF pickups, and again, we've been in contact with those obs/gynies and they're planning on continuing that service with us at Hobart.

CHAIR - Coming back to the transition of workforce, for those that do transition across to Calvary, do you anticipate it will be a challenge to maintain a workforce up until your closure date in August and are there contingency plans in place for that?

Ms BANKS - Obviously, with a highly casualised workforce that we have right now, that's something in our planning that we've thought extensively and have quite extensive mapping and trigger points for an escalation if we were to get to that point. We're working with our staff and the unions collectively right now, doing individual meetings to understand exactly what they all would prefer in terms of the outcome. We've interviewed 20 of the 24 permanent staff at this stage and they've all expressed a desire - all bar one - to go to Calvary with their treating obstetricians. One has actually requested to go to the Royal and seeking opportunities there.

We would expect - and certainly the feedback from my doctors is - that they would be expecting to go to Calvary. In terms of that transition plan, the unknown part of that is the casual workforce, and I believe that Calvary can certainly talk to that. Leah [Magliano], the Director of Clinical Services, has been quite open in terms of the fact that they've already started to interview and on board some of the casuals.

We actually haven't seen any change to our workforce at this stage, and we've got some very busy months of delivery still ahead of us so we obviously are using that workforce. What I can say is we've been running between four and six full time equivalent agency nurses, fly-in, fly-out service. They're generally booked from six to 12 weeks in terms of their contracts. We have that continuing.

CHAIR - That will cover that period?

Ms BANKS - It will continue to cover, but what we will need to work with is not wanting to obviously increase that agency cohort because then you start to lose that continuity of care and working with those obstetricians so that's going to be really important that we're doing those conversations.

Mr La SPINA - I think that working group represents an opportunity, especially for Tasmania just to keep the workforce because right now all we can tell our people is that they won't have a job at a particular point in time and they'll need to find employment.

I think there's a way, and credit to Georgia who's been working with some of her peers as well, to come together and try to give each individual a pathway, so, 'here is next' rather than 'good luck and we hope you get a job.' Because it would be fair to say that people are going to look for opportunities wherever they may be right. I think, it would be a shame if Tasmanians lost some of that workforce. I think that would be a real shame.

CHAIR - In terms of other - and it might be a question for you Tino around other regional locations where maternity services have been closed. Am I right in thinking that in Darwin, Healthscope had to close down as well? I don't know if there's others as well, where there's been a loss of workforce outside of that midwifery workforce, whether there's been a loss of private obstetricians, in other regional locations that have lost maternity services?

Mr La SPINA - I'm not able to comment on that, to be honest. No, but I can take that one on notice and come back to you. I couldn't tell you that.

CHAIR - That's okay. That's totally fine. Thank you. Nic or Anita, did you have any other -

Ms DOW - I just had one more question, Ella, and that was really just at the point in time where you made the decision that it was untenable really to continue on due to your short staffing levels, did you make any request to the state Government for assistance, whether that be financial or whether that be about acquiring staff or was there any sort of representation made to the state Government about that?

Mr HEWISON - Yes. Hi, it's Chris Hewison, and I'll answer that. In about August last year [2024], we entered dialogue with the Government, the Department of Health, and, in fact, a couple of meetings with the former, one meeting with the former Health minister and certainly one meeting with the current. We commenced those discussions saying that it was becoming a difficult challenge for us to continue to staff maternity services, as Tino and Georgia have highlighted, and essentially as the months from August, September or thereabouts went into November, December [2024], it was becoming our view that there was really room in Hobart for probably one private provider and also the Royal. We came to that view at that time on the basis of the estimated birth numbers that we're seeing. We've seen a decline obviously at Hobart over the last few years and we were forecasting this year to be yet again approximately another 40 to 50 lower than 2024.

It was becoming quite clear that those workforce challenges weren't going away, as Tino highlighted in his opening statement, and we were not being successful in attracting those midwives, then coupled with lower patient demand through the birth rate seen across Tasmania, led us to that decision. The Government and the Department of Health were involved and engaged in those conversations since about August, September [2024] along the way.

Ms DOW - You said that it's about 500 birth deliveries a year currently, what numbers were you looking at say five years ago or how has that declined? Are you able to provide some examples of that?

Mr HEWISON -Just pre-COVID, approximately 600 last year [2024] down to about 520, and this year [2025] forecast to be around that 470 mark, approximately.

Ms DOW - Okay, thank you.

CHAIR - That kind of does align with what we've heard from obstetricians around just the lower uptake of private birthing options because of the cost of private health insurance to consumers as well, I think, that they are seeing their numbers drop as well.

Nic, did you have any other questions you wanted to go to?

Was there anything else that you wanted the Committee to hear that you think would be useful to our terms of reference, which, as Anita said, covers reproductive, maternal and paediatric health services, if there's anything you'd like to share beyond what we've talked about?

WITNESSES - No.

CHAIR - If you think of something afterwards, it's inevitable that that does happen, please feel free to get back in touch with us through Mary, who you've heard from, our secretariat support. As I said, we're really grateful to have been able to hear from you. We know it's a massive challenge for Tasmanian women, but we don't underestimate that it would have been a huge challenge for your organisation as well. We hope that that transition can be as smooth as possible. It's really positive to hear about the gynaecological services that will be continuing, particularly around termination of pregnancy and other things as well.

Mr La SPINA - Having been there today and met the people who are with us, dedicated people who are still dedicated and delivering that service, personally, what I'd like to see is a smooth transition for them as well and to give them certainty moving forward. That would be something that I think this working group that's coming together, if that could happen, I would feel really good about that and I think it'd be fantastic for Tasmania as well, as I said earlier.

CHAIR - Thanks very much.

The witnesses withdrew.

The Committee suspended at 3.55 p.m.

The Committee resumed at 4.12 p.m.

CHAIR (Ms Haddad) - Good afternoon, and hello. Welcome to today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you for giving us your time and appearing with us here today. Could I just ask each of you in turn just to state your name and the role in which you're appearing today?

Ms SALISBURY - I'm Kris Salisbury. I'm the National Director of Clinical Governance and Chief Nurse for Calvary Health Care.

Ms MAGLIANO - I'm Leah Magliano. I'm the Director of Clinical Services for Calvary Hobart.

Ms EVANS - I'm Melissa Evans. I'm the Regional CEO for Tasmania.

CHAIR - Great, thank you very much. Can I confirm that you've received and read the guide sent to you by our Committee Secretary?

WITNESSES - Yes.

CHAIR - I'll just remind you of the pertinent part of that, which is that today's hearing is covered by parliamentary privilege. What that means is that you can speak freely, you can say whatever it is you would like for us to hear in any way that you would like to, without any fear of being sued or questioned in any court or place outside of Parliament. The only exception to that is that protection doesn't extend to statements that you make that could be considered defamatory, if you repeat them outside of these proceedings.

It's a public hearing. There're no members of the public here right now, but we have had people, including media, attend at other times and there could be members of the public or media watching online. If you do wish to give any evidence in private, if during the conversation there's something that you feel needs to not be publicly broadcast, just make that request of us. We can move into what's called an in camera session and we can hear evidence from you in that way.

I'll just introduce the Committee to you. I'm Ella Haddad. I'm the Chair of the Committee and a member for Clark, which is a Hobart southern metro area. This is my colleague, Nic Street, who's member for Franklin, which is also southern Tasmania, rural and urban. Anita Dow is joining us online. Anita is based in Burnie in the north west of Tasmania. We also have apologies from three of our Committee colleagues. The Committee is comprised of people from every political party and independents, and every part of the state. We're really looking for just rich, evidence-based information base that will lead to a robust report to Parliament and Government.

We've also agreed as a Committee to read a short sensitive content into the beginning of each hearing, just recognising that in previous hearings we've heard some really deeply personal stories shared with us by health professionals and individuals.

We recognise, as a Committee, that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for

individuals listening to, participating in or accessing these proceedings later. As a Committee, we encourage anyone impacted in that way to contact support services, including Lifeline, Tresillian, and PANDA. Those details are accessible on the Committee's website, on the Parliament website.

Ms KRIS SALISBURY, NATIONAL DIRECTOR OF CLINICAL GOVERNANCE AND CHIEF NURSE, **Ms LEAH MAGLIANO**, DIRECTOR OF CLINICAL SERVICES and **Ms MELISSA EVANS**, REGIONAL CHIEF OPERATING OFFICER, TASMANIA, CALVARY LENAH VALLEY HOSPITAL WERE CALLED, MADE THE STATUTORY DECLARATION, AND WERE EXAMINED.

CHAIR - Thank you very much. That is all of the formalities completed. Would any, or all of you, like to start with an opening statement?

Ms SALISBURY - I have one on behalf of all three of us. Before I begin, I would like to acknowledge and pay respect to the traditional and original owners of this land, the Muwinina people, on which we are meeting today, and really appreciate and thank you for the invitation to appear at the Select Committee.

Calvary is very proud of our history in Tasmania, where we have been providing healthcare services for more than 80 years. Our maternity services at Calvary Lenah Valley are well known and respected by the community.

Currently, the women's health unit at Lenah Valley supports about 350 births a year, and that includes five delivery suites, nine licenced special care nursery beds, 24 post- and antenatal beds, and that includes a deluxe suite. In addition to Tasmania, Calvary also provides private maternity services in Canberra, New South Wales and South Australia.

The rights of a woman to have a choice and be assured of clinically safe and appropriate care is core to our mission. We were disappointed by the other private provider in Hobart in choosing to cease providing maternity services, while also publicly advising that they'd look to undertake other services. Our goal is to increase our capacity of our maternity services, to meet the needs of these families and to continue to provide them with choice. It is important to Calvary that, while embracing additional maternity services, our current specialties are sustained to continue to meet the broader community healthcare needs as well.

As a not-for-profit, we invest our profits back into the services we deliver. We acknowledge the nursing and midwifery workforce challenges, because we are also experiencing them. We continue to identify creative ways to attract nurses and midwives, including partnering with the education sector.

Guided by the mission, courage and the skill of the Sisters of the Little Company of Mary, we remain highly committed to providing high-quality, safe and compassionate care to families in Tasmania. Thank you.

CHAIR - Thank you very much. Thanks again for sharing your experience with us today. I might start with a question around that workforce challenge that you mentioned, Kris, and we've heard that acutely from other people who have presented to this Committee in the past. Do you want to share with us any more detail around the challenges that you are finding, particularly in recruiting and retaining midwives - which I understand is a problem for

everyone, everywhere - or other health professionals adding to maternity services or having a role to play in maternity services?

Ms SALISBURY - I will hand over to Leah, but it's not just a Tasmanian problem either, we are certainly experiencing it nationally.

Ms MAGLIANO - We have had challenges in recruiting and retaining. We had a period of time where we didn't train students. We have actively trained students over the last two years and we have had issues in retaining them, because students want the bright lights of the tertiary organisation.

We have a very committed body of midwives that have worked very hard at keeping the unit viable and safe for the patients of Hobart. We have a permanent workforce, but we also have a very good casualised workforce. We've had to complement that workforce over the years with agency contracts, to ensure that we have enough midwives to manage the births that we have booked in at Calvary Hobart.

Ms EVANS - We have also introduced some incentive programs as well, to attract midwives to stay with us and to increase their positions from being casual to permanent. That was successful, for a while.

CHAIR - What kind of incentives were they?

Ms MAGLIANO - It was monetary incentive, so bonus sort of structures for them to join the permanent workforce or to work more shifts.

Ms EVANS - A scholarship to do education as well.

CHAIR - Masters in maternal health, that kind of thing?

Ms EVANS - No, the postgrad in midwifery.

CHAIR - We heard from Healthscope that there are about 24 staff, 20 of whom they've been speaking to, who are maybe in active discussions around transitioning across to Calvary. I am wondered if you wanted to share with the Committee how you anticipate that transition to go from a staff perspective and then we'll get to a patient perspective as well.

Ms MAGLIANO - We have interviewed quite a number of Healthscope staff and have had verbal assurances that staff want to move across and that FTE is amounting around 22 FTE, not people, FTE. That's very exciting and that's very good for Calvary Hobart. I think I can't answer that, Ella, until we've had our meetings with the Government and with Healthscope on what that transition looks like obviously. We can't on board all these midwives on 27 August. We will need a transition plan and I believe that will come to light in the next few weeks.

Mr STREET - How many births were there at Calvary last year?

Ms MAGLIANO - We roughly do about 320 a year and that has been standard the last couple of years.

Ms EVANS - Last year it was 383.

Mr STREET - Healthscope indicated that they were looking at about 470 this year [at Hobart Private Hospital]. Now obviously they won't all end up at Calvary?

Ms MAGLIANO - A majority will. The high risk women won't.

Mr STREET - In terms of ability to cater for that increase, is the site at Lenah Valley capable of that increase?

Ms MAGLIANO - In its heyday, Calvary Hobart did up at 800 odd births. That's a long time ago now, but absolutely.

Mr STREET - I declare a conflict of interest. I was one of them, a considerable number of years ago.

CHAIR - I have the same conflict, I wasn't born there, but my babies, both were.

Ms MAGLIANO - We absolutely have the infrastructure to do it and we have plans to improve what is on site at the moment.

CHAIR - Minister Petrusma announced that the federal Health minister, Mark Butler, committed $6 million infrastructure funding that would be shared between increasing capacity at Calvary, at the Royal, and building a mother-baby unit at St John's. I'm no engineer or builder, but $6 million that's a very welcome commitment from the Federal Government, but are you confident that whatever portion of that comes to Calvary will be sufficient to expand your physical capacity?

Ms EVANS - We're hoping it is. We're working with our architects and builders at the moment to understand the costs. At the moment we don't have an actual final dollar value of the building works, plus there is some capital equipment to purchase as well.

CHAIR - It's early days.

Ms EVANS - Yes, it is early days. If you think about it, it has been six weeks since the announcement that Healthscope were deciding to make that decision to cease the services [at the Hobart Private Hospital]. We've worked really quickly with our local builders and architects, plumbers and electricians because once you start making change, you have to make a switchboard upgrade. I'm learning all these new things and we're just to the point where we've got some final drawings we think that we'll be able to price up and understand what that cost will be for us.

CHAIR - Is that moving into another part of the hospital or existing?

Ms EVANS - We have five birth suites. We use four, and the fifth one is from the 1970s, so there's some work to do in there to make it a modern birth suite with a bath, et cetera. That would be our first priority to do. Then there's stuff to do in our special care nursery, the step down stage. And then we're aiming to make two more deluxe suites.

CHAIR - Will you need more birthing suites, or is five enough?

Ms MAGLIANO - Five is enough.

CHAIR - It's not as much of a blunt tool as your physical capacity to double the number of births? It does not work that way?

Ms MAGLIANO - Remember, births are also by caesarean section, so you won't need it; they won't all use the birth suite.

Ms DOW - You've obviously found yourself in the position where you're now going to be taking on additional patient load, which is wonderful that you've been able to do that and provide that service for Tasmanian women and families and babies. In the redevelopments that you have proposed, I think you said you had 24 beds on the ward for postpartum care. Are you looking to increase the number of beds as part of that work that you're doing or you'll maintain that?

Ms MAGLIANO - We won't actually even maintain it. Some of the rooms were used for gynaecological surgery, so there're single bedrooms and they're just not what post-natal women want anymore. They want double rooms with double beds and with their husbands or partners who can stay. Two of those rooms we will earmark to become deluxe birth suites so that 24 may reduce to 20 odd.

Ms DOW - You said that you have had difficulty around staffing as well, but it's obviously something that you don't think is insurmountable. Do you think the increase in patient numbers will be a challenge with the current staffing levels that you have or do you think you'll be able to -

Ms MAGLIANO - It will be a challenge with the current staffing, absolutely. We need the Hobart Private midwives to come across. What I do know is that when you have close to full complement of midwives and lots of birth that attracts other midwives. I'm confident that even if we don't get a full complement of 28 FTE and have to utilise some agency in the interim, in the initial stages, we will attract and recruit other midwives because we will be the private provider in Hobart and the Centre of Excellence for private birthing.

Ms EVANS - We've actually already engaged with the Hobart Private midwives and had a welcome evening so that we could actually show them our suite, introduce them to our nurse unit manager, introduce them to Leah who some of them may or may not have known from Leah's days at Healthscope. We're working really hard to engage people to transition to us and we've been really open with Georgia [Banks] from Healthscope as well around that and now it's working with Healthscope and the Royal and working together about transition plan because we need the midwives to be able to increase the activity.

Whatever we do, it needs to be safe and that's the paramount thing that's in the back of our minds to make sure that we provide a safe service and that transition of nurses and midwives is the really important part, and obviously the obstetricians and the paediatricians, and making sure that we've got everything humming along so it's a really smooth welcome to Calvary as well. We've also met with all the obstetricians and all the paediatricians and the anaesthetists to keep them up to date with what we're doing. It seems like we've been doing this for months.

CHAIR - Because it's been a rapid fire?

Ms EVANS - It has been, but it's been a really nice process because I can see everyone's on the same page, everyone just wants the best service for the Hobart community.

CHAIR - One of the things that's just been raised with me anecdotally in the community, it's not evidence that the Committee has heard directly, but that is around the potential risk of losing obstetricians, basically, and gynaecologists in other regional locations that have lost maternity services. I wondered whether that's something that any of you in a national sense have witnessed in other regional communities or if that's something that's in the thinking of Tasmanians at the moment working in maternity services, whether there's a risk of losing obstetric staff or not really.

Ms MAGLIANO - Certainly not with the doctors that we've spoken through this process. Everyone's highly committed to making this work and working together, and we are well endowed with obstetricians in Hobart.

Ms SALISBURY - I think, probably, where there's a less attractive option that might be a lot further away or driving distance, those sorts of things, there might be more of a risk then. I think within Hobart, given how close things actually are, it is easy. We're going to make it as easy as we possibly can for them. I really believe that they'll come across.

CHAIR - Did many of those obstetricians work across both private providers in any case?

Ms MAGLIANO - Some did. Probably half and half.

Ms DOW - The only thing that I was going to ask was if you could just provide your insight or perspective to the Committee. Some of the feedback that we've had as a Committee is around the fact that some obstetricians are choosing not to take on private practice, whether that be through - obviously for insurance purposes or other things. Is that your experience or have you seen a decline in practicing private obstetricians at Calvary, over the last, say, five years or has it been pretty steady?

Ms MAGLIANO - We've had the same group of obstetricians, bar retirement, really. I can't think of one that stepped out because of insurance or safety, other than retirement. We've lost two this year to retirement.

Ms DOW - Have they been replaced, just out of interest, by new obstetricians or have you just lost those two?

Ms MAGLIANO - We've just had a new one start work with the group that primarily birth with Calvary Hobart.

Ms SALISBURY - I guess the other thing to consider is the fact that the births are dropping across Australia anyway, so there's not necessarily the need for quite the same number as the heyday, potentially.

CHAIR - You were born in the heyday. Does that make you feel special, Nic? I'll start calling you 'Heyday Nic.'

Mr STREET - I'm a 70s child generation.

CHAIR - Just don't tell people. That reminds me though, that we have heard from obstetricians as well that the number of people, not only the birth rate declining, but people choosing a private birth is declining too from their practice perspective, partly due to the cost of private health insurance. The challenges of health insurance payments to hospitals has been raised with us as well. Is there anything that you'd like to share? Obviously, it's more of a federal jurisdiction, but we can nonetheless go to those kind of issues in our report deliberations if there was anything around the insurance industry that you'd like to share. You're like, 'Hold me back.'

Ms SALISBURY - I think, certainly cost is part of it. Fundamentally, women make a decision as to whether they want an obstetric model of care or whether they want a maternity/midwife model of care. There are women that choose one or the other. Cost certainly does come into it, whether that be private health insurance and rebates or gap payments. There is a myriad of reasons why women would choose one over another.

CHAIR - Are you seeing those numbers decline though over time separate to the general birth rate declining?

Ms SALISBURY - Yes, we are.

CHAIR - Nic, did you have any other issues you wanted to canvas?

Mr STREET - No, only to say that that's just yet another cost shift from the Federal Government to the state Government, basically.

CHAIR - It's a challenge, isn't it?

Mr STREET - We were talking to a GP earlier today as well, talking about Medicare rebates. It's exactly the same situation there.

CHAIR - That's really challenging.

Mr STREET - People that can't get into see a GP go to the emergency department, which is a cost shift from the Federal Government to the state Government again.

CHAIR - Not to get too political, but it's a real challenge for both levels of government to deal with. We're hoping that urgent care clinics can play part of the role of alleviating some of that pressure, but it's not the answer to everything. Access to primary care is a massive issue, obviously, across the country.

Was there anything else that we haven't covered that you thought might be useful for the Committee to hear? Either in terms of the current, very live issue for you as an organisation or just generally about maternal health or reproductive or paediatric health, which is also in scope of our Committee?

WITNESSES - No.

CHAIR - Anita, did you have anything else?

Ms DOW - I did just have one more question, Ella. Do you have Midwifery Group Practice model of care at Calvary?

Ms MAGLIANO - No, we don't.

Ms DOW - Those patients that would be transferring across that may have been involved in that at the Hobart Private will not be able to continue – it would be more obstetrics lead or?

Ms MAGLIANO - Hobart Private didn't have Midwifery Group Practice either. They have a Know Your Midwife program, which I know because I wrote the program 10 years or 15 years ago, but that program was coming to an end with the two retirements who were the two doctors who supported it and the current obstetricians don't support it.

That's not to say though, when we're settled, that we can't look at a model of care that might promote continuity of care for women and their families. I'm quite passionate about that. Obviously, it needs to be something that women and their families will use and that obstetricians will support. I guess it's a space we can watch.

CHAIR - That would be really exciting because certainly, from the evidence we've heard, from individual people who have shared their birth experience we hear very positive feedback around the Midwifery Group Practices available in the public system, as well as the Know Your Midwife program and other continuity of care programs. Continuity of care generally is something that has come up a lot in the committees – what we've been exposed to so far. I think introducing something like that down the track at Calvary would, I imagine, be very warmly welcomed by Tasmanian families.

If, after today, you think of something else that comes to mind, it's inevitable that sometimes we reflect on conversations that there's something that you might have liked to share, please feel free to get back in touch with us through Mary, who you've met and dealt with in preparing for today. Likewise, if you're happy for us to come back to you if we get to report writing stage and there's something that we'd like to ask or clarify, would you be happy to receive that?

WITNESSES - Yes.

CHAIR - Excellent.

The witnesses withdrew.

The Committee adjourned at 4.37 p.m.