



**LEGISLATIVE ASSEMBLY FOR THE
AUSTRALIAN CAPITAL TERRITORY**

**STANDING COMMITTEE ON HEALTH
AND COMMUNITY WELLBEING**

(Reference: [Inquiry into Raising Children in the ACT](#))

Members:

**MS J CLAY (Chair)
MR J MILLIGAN (Deputy Chair)
MR M PETTERSSON**

PROOF TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 28 MAY 2024

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**Secretary to the committee:
Ms K Langham (Ph: 620 75498)**

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

WITNESSES

BOWLES, DR DEVIN, Chief Executive Officer, ACT Council of Social Services. **25**

CULLEN, MS MICHELLE, Chronic Conditions Network Coordinator, Health Care Consumers’ Association **41**

LAMB, MS JESSICA, Senior Policy Officer, Health Care Consumers’ Association **41**

SETH-PURDIE, DR ROBYN SHERYL, Senior Policy Advisor, ACT Council of Social Services **25**

WEATHERSTONE, MS ALISON, Chief Midwife, Australian College of Midwives **33**

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Amended 20 May 2013

The committee met at 3.40 pm.

BOWLES, DR DEVIN, Chief Executive Officer, ACT Council of Social Services
SETH-PURDIE, DR ROBYN SHERYL, Senior Policy Advisor, ACT Council of Social Services

THE CHAIR: Good afternoon and welcome to the public hearings of the Standing Committee on Health and Community Wellbeing for our inquiry into raising children in the ACT. Today we will be hearing from a wide range of witnesses who made submissions to our inquiry. The committee wishes to acknowledge the traditional custodians of the land we are meeting on, the Ngunnawal people. The committee wishes to acknowledge and respect their continuing culture and the contribution they make to the life of the city and this region. We would also like to acknowledge and welcome any other Aboriginal and Torres Strait Islander people who may be attending today's event or who may be watching.

The proceedings will be recorded and will be transcribed by Hansard. They will be published and they are also being broadcast and webstreamed live. If you take any question on notice, if you can just say, "I'll take that on notice", that helps our marvellous secretariat track down the answers. We recognise that some of the issues raised in today's inquiry will be sensitive. The secretariat has some information on support organisations available for any witnesses who want to have a chat about that. For anyone who's attending or watching, we do have some support lines available that we can assist you with

I am pleased to welcome ACTCOSS, the ACT Council of Social Services. Thank you very much for joining us. I remind you of the responsibilities and the rights that are accorded with parliamentary privilege. Could you please advise whether you are happy to abide by the rights and responsibilities in the privilege statement?

Dr Bowles: I am happy to.

Dr Seth-Purdie: Yes.

THE CHAIR: That is excellent. We have received an excellent and very detailed submission from ACTCOSS. Do you want to make a brief opening statement, or should we go straight to questions?

Dr Bowles: If I may, I would like to make a brief opening statement. I think families know when they are capable of having children in a way that is going to be conducive to that child's development and flourishing. Part of the reason for diminished birth rates is that many families recognise that the conditions are simply not very good. Our submission really focuses on what it is that we can do as a community to optimise the flourishing of children from the time of conception through childhood so that (1) those children can flourish and (2), having the secondary benefit, ensuring that families that want to have children feel able to do so responsibly.

THE CHAIR: Thank you very much for that opening statement. Thank you also for such in-depth submission. They are always so well researched, and we really appreciate

the work. There was a lot in your submission—which I was probably expecting—on housing, access to public housing and affordability, transport and the cost of food. I wanted to narrow in on one of the smaller recommendations which has not come up so much in this hearing so far. There's a recommendation in here for universal free early childhood education and free primary public schools. Can you tell me what that would look like and what sort of difference that would make to families and to people maybe deciding whether or not to have a family here?

Dr Bowles: I think there are a number of costs associated with public school which you do not necessarily think of when you think of the public school model. The costs have recently been estimated to be something like \$80,000 per child over the life course of their being a public student. It comes from a variety of sources, including fees for excursions and fees for lots of little things. As a parent, we were recently invited to allow our children to participate in an incursion—so someone was going to come into the school—and that was going to have a fee associated with it. The purpose of the incursion was to teach math in a way that demonstrated that it was widely applicable throughout life and to make it fun. I would have thought that teaching math in such a way was a basic of public schools and not something that required additional parental input in terms of a financial contribution.

THE CHAIR: Yes, that is certainly a barrier. Tell me about free early childhood education.

Dr Seth-Purdie: The Royal Australian College of Physicians have been working on child health inequities. This is one of their important recommendations. It recognised that, unless you have some way of addressing the harms that are caused by poverty, the social and economic determinant of health gaps in young children, you are doomed to limiting the prospects for the healthy development—cognitive, social and otherwise—of those children as they grow. Allowing universal access to services like early childhood education is one way of limiting the gaps that otherwise occur in development.

Families who are more advantaged in terms of their social and economic situation will, through the conditions at home and at the sort of educational and other facilities they are able to afford, produce faster developmental growth, higher levels of achievement—cognitive, social and physical. By allowing this access to universal childhood education at a free level for everybody, you minimise the consequences of gaps in the conditions that govern childhood development.

THE CHAIR: That really has quite a profound effect multi-generationally too, I would imagine, and has a huge impact for the individual family seeking that access to education.

Dr Seth-Purdie: Yes; absolutely. It also affects the ability of more disadvantaged families to have both parents working.

THE CHAIR: Yes; absolutely. Thank you very much.

MR MILLIGAN: In your report, you have talked quite extensively about parental paid leave. One of your recommendation is that the ACT government develop and

implement policies to increase access to parental paid leave, flexible work arrangements et cetera. Could you talk a little bit to that and possibly talk about what's currently on offer now, particularly as you make reference to the ACT public service, and where it could go further?

Dr Bowles: In addition to what the ACT government can do for the workforce that it directly employs, which is important, there's a larger piece around what the ACT government can do around other workforces that it may not employ directly. I think here of the community sector in the ACT, which is a largely feminised workforce. I believe it is the third-largest employer by sector in the ACT. I will be blunt: most of the organisations are funded by the ACT government in such a way that, while they want to be able to offer parental leave conditions that are above the bare minimum required by legislation, many of them cannot. We are not very far above the minimum. They look with envy on their public sector colleagues and the parental leave conditions that are available there. So there is certainly room for improvement in parental leave conditions in the public service as well.

But I think the ACT government should take responsibility as the steward of the community sector and enable that sector to offer much better parental leave conditions to its employees. I note that this sector represents one of the greatest concentrations of women in the workforce in the ACT. So, it is not just an area where the ACT government has a particular responsibility; it is an ideal place for an intervention.

Dr Seth-Purdie: I would just add something that is not in our submission. If you look at the risk factors to child development, being born in a family where the gap between siblings is less than two years is a risk factor. Everything else being equal, that is a risk factor. That leads me to conclude that the best policy would be to allow two years of parental leave or financial support for one-on-one care in out-of-home care, the CEC, to ensure the best conditions for child development. So two years leave would be ideal.

MR MILLIGAN: And currently it is six months?

Dr Seth-Purdie: Yes. Even in Scandinavian countries, I think one and a half years would be the maximum. But, keeping in mind the evidence from child development, two years would seem to be ideal.

THE CHAIR: I believe the WHO recommends two years as well.

MR PETTERSSON: I was hoping you could talk to the committee about the high cost of housing and what effect that has on a decision to form families and have children. In particular, could you provide some detail on the prevalence of overcrowding in housing in the ACT?

Dr Bowles: I will take the question on notice regarding prevalence of overcrowding. Do you have that?

Dr Seth-Purdie: No, I do not have that, but I do have something about the risk factors involved in overcrowding.

MR PETTERSSON: That would be good, too.

Dr Seth-Purdie: More than two persons in a bedroom represents overcrowding, according to some of the evidence on child developmental risk factors.

Dr Bowles: I think there are two issues at play. One is: how many families become overcrowded or have children in conditions which are overcrowded? But then I think there is a less obvious issue, which is: how many families curtail having children or having the number of children that they wish because of the inability to obtain housing that would enable them not to be overcrowded? I suspect that number is quite high. There are reports pretty regularly in the media about young people delaying parenthood or thinking that they will not pursue parenthood because of their view that they will not ever be able to afford a house. Certainly, in some sectors in the community, there is a view that it is appropriate to wait until you have a mortgage to have a family. For many young people, they are just not expecting to get to that point in life because of intergenerational inequity.

Then I think there is a second thing where people recognise that the rental market in Canberra can be a fairly volatile place, where you may be asked to move once a year. I think implicitly people recognise that moving is traumatic, especially if you have a small child or multiple small children and you are asking them potentially even to move schools because of that. I think overcrowding is an issue in and of itself, but the threat of overcrowding is also a major issue in causing people to delay or perhaps not have the families that they want.

Dr Seth-Purdie: It turned up in the survey that is cited in our submission. It was the fourth most important factor listed as an obstacle to having a child or another child.

THE CHAIR: Housing costs are pretty worrying, but I am also worried about transport costs. These look like they have been getting worse since the cost-of-living inquiry. I think some of the figures you have in your submission were that fuel and transport costs were up 37 per cent and 23 per cent. Given that they are already a pretty big chunk of most people's budgets, that is pretty worrying. You mentioned that you thought there were already quite a lot of people who were not driving because they could not afford the petrol. So they have a car and they probably built their life on having a car, but they are not driving that car. Can you talk me through the impact of that?

Dr Bowles: Across the board, people are making some pretty difficult decisions about what their life will not involve anymore. That includes a range of things, from driving their car for non-essential purposes to maybe even driving their car at all. It includes things like eating less healthily or not heating their homes to the temperature that is consistent with health—which is pertinent at this time of year.

THE CHAIR: What could government do to help with any of those costs in a way that would be appropriate for governments? We do not have a particularly useful public transport system, for instance. What are the key things we could do to help relieve some of those cost pressures and make sure that people are able to do what they need to do and make them feel a bit more stable with their families?

Dr Bowles: We make a number of recommendations around cost of living in our *Cost of living report*. I can provide that to this committee if you wish. Things around

reducing transport costs for those who are struggling with income is one key. Energy costs are a really big factor. So finding a way to reduce energy costs, especially for those people who are struggling, is really important. As the ACT navigates the clean energy transition—and good on the ACT for doing that—that means things like incentivizing landlords to do more around the thermal efficiencies of the places that they rent and that kind of thing.

THE CHAIR: Better insulation and things like that are really helpful. For the people who do not have access to public transport and suddenly find that they cannot drive a car, what is happening now? Do they just stop participating?

Dr Seth-Purdie: I think that is the answer. I cannot really give you definitive evidence on that. But, in terms of what the government could do, it might be possible to have some sort of electric car-sharing arrangement for very poorly situated families, so that if they want to take their children to sporting events or other important occasions or if they want to go shopping for goods that they could not carry on public transport, or at times when public transport is not available, there might be some access to shared facilities that could help out.

MR MILLIGAN: In your report you talk about the cost of education, and you made reference to \$80,000. I take it that is through the lifespan of the kid going to public education through paying for extra excursions and the like. In one of your recommendations you suggested that public education should be totally free. Do you mean that those additional costs should be covered by the government?

Dr Bowles: Yes.

MR MILLIGAN: And for that not to be means-tested or would that just be purely free to all public education students?

Dr Bowles: I think from an administrative point of view it would be easiest just to make it across the board.

MR MILLIGAN: It would be interesting to see what the cost of that would be to the government budget. So you would not consider means-testing it, possibly?

Dr Bowles: Part of the idea, philosophically, about public education is that it provides a level playing field so that every child can have access to a high-quality education that prepares them to reach their potential in life. I think means-testing in that regard would probably be fairly administratively complicated. I note that, even now, administrative arrangements are fairly intense. If a family has a couple of children in school, they may be approached to pay separately for 15 or 20 different incursion and excursion fees of \$10 each. To be honest, I wonder how much it costs the school to collect that money in the first place. But also, I think from a philosophical perspective, having all of the students in the same boat, so that we are not discouraging families that are better off from engaging in the public system, is important.

Dr Seth-Purdie: I would like to add that Australia is a signatory to the UN Convention on Economic, Social and Cultural Rights, which mentions pre-primary education as a fundamental and progressive movement towards free education at higher levels as

countries can afford it.

MR MILLIGAN: Thank you.

MR PETTERSSON: Once you have made the decision to have kids and you are starting to raise them here in Canberra, generally speaking, what is that experience like? Are the services that are available to new parents up to scratch?

Dr Bowles: I think it is fair to say that it is fairly mixed. There are a lot of services that are potentially available if you can afford them and if you have the means to access them readily. If you are a well-off person with a sufficient amount of leave, you are in not the worst position at all. However, I would note that the isolation of parents is often a pretty intense set of feelings. I know that some services to assist with the mental health of parents could do with additional resourcing.

I think, though, if you are less well-off then Canberra can be a very daunting place to raise children. This is partly because of where you can find to live in a way that is not overcrowded. That is your first hurdle. Your second hurdle is the high cost of living generally. In particular, if you are reliant on public transport, your ability to provide the full breadth of stimulation for your child that you might wish to is pretty limited. Public transportation, if you are in an outer suburb and you are trying to get a child to a sporting event on a weekend, can eat up a whole lot of your weekend doing that. If you have two kids then you might have to make some choices. I think the answer to your question really has an income-based lens to it.

MR PETTERSSON: Something that has been raised with the committee that I thought was a particularly interesting observation that I had not clocked is that a lot of people leave Canberra to start their families. Canberra being the transitory place it is, they come here for work and then, when they make the decision to have kids, they go back to where they originally moved from. What can we put in place here in the ACT to build those support networks such that people do not feel like they need to move back?

Dr Bowles: That is a great question. I know that in Canberra, because a lot of people have moved here for work, it means they have left the natural support systems of their extended families, who can often very happily provide willing day care, be that in a regular sort of way or just one-off babysitting in an emergency. We combine a workforce that is more lacking in that than probably most cities in Australia with infrastructure for looking after kids which is not as strong as it really should be. If you are wanting to put your child down for day care, be prepared to wait. If your employment rests on you being able to find day care, you are in real trouble.

I can well understand people deciding to move back to their natural support systems. I think there is maybe a wider piece around community and social isolation, around how well we facilitate people building networks once they get here. I remember that, when I was a small child, I went to people's houses with my mother because she was looking after them one or two days a week while their parents were working. I do not see that sort of behaviour happening much. It is something that, potentially, those early groups like mothers' groups or parents' groups with newborns could become, but we have not taken that step. We are a workforce that is isolated from parents or other extended family, and we have not, as a community, done the work to build either formal or

informal supports to replace that.

MR PETTERSSON: Thanks.

Dr Seth-Purdie: In addition to that, I want to go back to the question on access to universal, free early childhood education. That, I think, could play an important role in reversing that trend. One way of doing that would be to spread the availability of those early childhood centres, which is limited at present. There are only five that give access to services from birth up to about eight years. That seems like an excellent model. That will gather parents in; parents will become involved in those centres. That gives them the opportunity to help each other out as they get to know each other.

MR PETTERSSON: Thank you.

THE CHAIR: Robyn and Devin, thank you so much for coming in today. Before we finish, is there anything that we did not get to that you would like to raise with us or tell us?

Dr Seth-Purdie: I am just curious as to why you dealt with the factors affecting the raising of children, as opposed to the production of children.

THE CHAIR: We went through a number of linguistic models on how to phrase this inquiry. I think we settled on the wording “raising children”. We did not want to make it some kind of possession of children. We did not want it to be “have children” because that seemed a little bit like adults had a right over children. I am not sure that we had any particular science behind how we phrased the inquiry. We are looking at the factors that might help or hinder people who might want to have children. We were not coming with any judgemental lens on whether people should do that or not. We just wanted to know what is getting in the way of decisions that people might otherwise be making.

Dr Seth-Purdie: There was a program on global roaming just a weekend ago, which dealt with the issues very well.

THE CHAIR: Yes.

Dr Seth-Purdie: It was Jennifer somebody; I have forgotten. She was a demographer. I thought she dealt with it very well.

THE CHAIR: I will check it out; thank you. Thank you so much for your time today. I do not think you took a question on notice, unless you particularly want to get back to us about anything. I think you answered it.

Dr Bowles: Okay; thank you.

THE CHAIR: We will send you the transcript. Have a little look and tell us if we have incorrectly transcribed anything.

Dr Bowles: Thank you very much.

Short suspension.

WEATHERSTONE, MS ALISON, Chief Midwife, Australian College of Midwives

THE CHAIR: We welcome our witness from the Australian College of Midwives. Thank you for joining us. Alison, I just want to remind you of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement that I am hoping we have circulated to you. Have you had a chance to read that and do you agree with that statement?

Ms Weatherstone: I have, and I do agree. Thank you.

THE CHAIR: Excellent. Thank you very much. Do you want to make a brief opening statement or should we jump straight into questions based on your submission?

Ms Weatherstone: I am happy for you to jump straight in. My instruction was not to prepare a statement. Thank you.

THE CHAIR: That is great. We do have quite short sessions. I think it is sometimes more useful to have the conversation.

Ms Weatherstone: Sure.

THE CHAIR: I will check in at the end to make sure if there is anything that we did not get to that you would like covered. Alison, I was particularly drawn by the prominence you gave to midwifery-led continuity of care and the role that that might play not only in people's decisions but also in their experience and how good the experience of birthing and having children can be. Can you tell us a little bit about why that is important and how the ACT could do it better?

Ms Weatherstone: Absolutely. Thank you. Continuity of midwifery-led care, or continuity of the carer, is where you have care by a known midwife throughout the pregnancy, antenatal, intrapartum—which is labour and birth—and postnatal period. The benefit of that is that women do not have to retell their story and midwives, as autonomous health practitioners under really great governance frameworks and consultation and referral guidelines, are able to refer to the multidisciplinary healthcare team as required. It is appropriate for all women, regardless of risk.

What we are seeing through evidence and literature is that the more vulnerable and priority populations receive more benefit from accessing continuity of midwifery care. What we know from research is that continuity of midwifery care reduces the likelihood of stillbirth and pre-term birth. You are more likely to have a healthy birth weight baby, born at term. You are more likely to breastfeed or initiate breastfeeding early. There is less likely to be intervention at birth. By that, I mean you are less likely to require a caesarean section or forceps or a vacuum birth. Women are more satisfied with their birth experience. A lot comes from not having to retell their story, and it is a relationship of trust.

What we have seen recently—and we are awaiting the report of the New South Wales inquiry into birth trauma that is expected any week now—is that consumers are consistently asking for access to continuity of midwifery care. In the ACT your rates

are about 30 per cent access. This varies across Australia. On average, between 10 and 24 per cent of women can access this model of care.

It is also 22 per cent cheaper for the healthcare system, and midwives have a lot more satisfaction working in this model. It is a 24/7 on-call system, where the woman can contact her midwife at any point of the day and night. It really keeps people out of the hospital environment as well, and women are more likely to disclose discreet issues such as family and domestic violence—those sorts of things. Where there are other complications, such as gestational diabetes, we have seen more compliance with care because they are getting that wraparound, individual antenatal education that you do not have to fit into Monday to Friday or into a group session. It is also providing care in the home, so it is out of the hospital model. Regarding access, we know that a lot of women do not want to attend, or avoid attending, hospital and big clinical environments.

THE CHAIR: Yes, it certainly is a very powerful tool that achieves a lot. About 30 per cent of women can access this now. We have got some pretty good commitments. I brought forward a little bit of work to help set those commitments. That is meant to increase to offering it to 50 per cent of women by 2028 and then getting to three-quarters of women after that. How do you think we are tracking? Are we likely to be able to offer that level of care? Is it that government has not budgeted enough or is it that government cannot attract enough midwives? What is the hold-up?

Ms Weatherstone: I think it is multifaceted, but one of the major contributors is lack of dedicated midwifery leadership. It is a primary maternity care model that sits in an acute care tertiary system. There are a number of factors. For example, funding is activity based currently. A hospital is paid more on intervention, so there are almost perverse incentives there. Through scope of practice review and primary healthcare reform, and especially primary maternity care reform, ACN are calling for bundled funding for maternity services, which means that then it is centred around the woman and their individual needs.

There is a workforce for midwifery, and we know there are challenges within it. It is a matter of rethinking the way you deliver that model of care. You can often pivot an existing workforce into a different model of care if you have leaders that understand the model and the benefits of it. Often it can be too overwhelming to think: how do we actually shift from our fragmented standard care to a continuity model? The alternative is to really encourage the use of graduate and early career midwives in these models. Previously, there was a school of thought where you had to be really experienced to work in continuity because of the autonomy. But with really well supported models you can actually implement these sorts of programs.

The other thing I would say is that access to privately practising midwives and increasing visiting access to hospitals is essential. If you look at the Medicare-funded births for privately practising midwives, the ACT data up until 2023 said that there were four. In comparison, there have been over 4,000 Medicare-funded births in Queensland. I think it is about rethinking how we do business.

THE CHAIR: There were four Medicare-funded—

Ms Weatherstone: That means a woman who has accessed birth outside of the hospital

system, with a privately practising midwife. That talks to access to publicly funded homebirth models, which I know is also in your maternity strategy.

THE CHAIR: Understood. Thank you.

MR MILLIGAN: This is all news to me, obviously. My son is 25, so it has been some time since we have raised a young child. I am really keen to hear a lot more about this midwifery continuity of care. Who offers this care? Where is it available? How do people find out about it? It is all news to me. I would like to get a greater understanding of what it is, because it sounds like an ideal program that we really should be supporting.

Ms Weatherstone: It is definitely an ideal program. Again, there are a number of factors that contribute to it. I think there is an opportunity to increase awareness and have a campaign around what access women have to models of care. It would be really beneficial to have forward-facing data from the existing hospital systems. It is a matter of looking at the clientele and the needs—how many women are birthing in those areas. It is about starting small and gradually increasing access to continuity.

There is also the recent announcement of removal of collaborative arrangements. They will be removing that barrier for women to have to go to their GP before they refer to a midwifery group practice or a case-led model of care, which is also about continuity.

There are a lot of rural areas in Australia that are starting to increase access to these models of care, which is really important for women living in rural, regional and remote areas. Obviously, that is not as much of a challenge in the ACT. It is about looking at your existing models of care. I would start with the priority population—women with disability, Aboriginal and Torres Strait Islander women, women who are having teen pregnancies or who might have drug and alcohol or mental health issues, and other perinatal mental health challenges. That is a really good place to start, and have very specific, targeted groups accessing these models of care. It is then just a matter of raising awareness.

Over the last 12 months, the Australian College of Midwives has spent a lot of time raising the awareness of what is an endorsed midwife. A lot of people think that midwifery still comes under nursing. It is about knowing that we have endorsed midwives who have qualifications for scheduled medicines, and they can, under their own authority, prescribe certain diagnostics, pathology and medications. Increasing the number of endorsed midwives in the ACT would also be a great thing to do.

THE CHAIR: I have had a little look at this area before, so this is an excellent area for me to dig into. It sounds like, with our continuity of care, it should be available to all women; but, while we are building up to that level, it is probably of most benefit to women in higher risk pregnancies. Is that, broadly speaking, where we are?

Ms Weatherstone: Absolutely. Traditionally, it has been rolled out to the low-risk population groups in and across Australia. That has just been an old way of thinking. There is so much evidence to say that all women should access it. In looking at the terms of reference for your inquiry, and the priority groups, this is a perfect opportunity to increase access to continuity of midwifery care.

There are some other challenges with the model that are worth pointing out. Ideally, you would have six weeks of postnatal care after you have had a baby. Some hospitals and health services reduce that to two weeks, purely because of workforce issues. It is really important that that is extended to six weeks and six days, which is where the MBS funding currently cuts out. The other factor has just gone from my mind, but it will come back to me.

THE CHAIR: You talked about endorsed midwives, and the fact that endorsed midwives can do prescriptions. Can they prescribe Syntocinon for homebirths? Are the endorsed midwives able to do that?

Ms Weatherstone: They certainly can; it falls within their scope of practice. Each state and territory currently has slightly different nuances to the drugs and poisons act. What we are hoping to see out of the scope of practice review led by Professor Mark Cormack is a move towards harmonisation of the poisons act so that a midwife can prescribe everything within scope. The thing with Oxytocin in the homebirth setting is that it does not fall under PBS, and that is because it has not been registered as a PBS-listed drug.

In the hospital, currently, there are not a lot of endorsed midwives being utilised to their full scope of practice in the public sector. There is an under-realised opportunity there to increase the use of endorsed midwives in public hospitals. That should then allow them, through credentialing, to prescribe. It takes the pressure off doctors having to do it, because we know that often a midwife knows exactly what they need for that woman. They are often just passing a piece of paper to the doctor, saying, “Can you sign here?” because they are the authorising health professional. It makes perfect sense to include midwives in that.

THE CHAIR: In the private system they are allowed to work to their scope of practice, but in the public system we are not allowing that?

Ms Weatherstone: I would probably need to clarify that. The private system is another can of worms.

THE CHAIR: Sure. We will stick with public, if that is okay.

Ms Weatherstone: It actually does need picking apart, but often it is not. In the public sector, we are not using endorsed midwives to their full scope of practice in terms of their prescribing ability. As a privately practising midwife, working independently, they can prescribe, whereas midwives working in a private hospital in maternity have even more reduced scope.

THE CHAIR: In our public hospital system, which is under a bit of strain, they are legally qualified to do certain things, like prescribe things, but the hospital system is not allowing them to do that and is requiring them to get the involvement of a doctor in that activity. Is that correct?

Ms Weatherstone: Yes. There are some medications that a nurse and a midwife can initiate through prescribing. There are others that they cannot, and they need a doctor’s authorisation. I have remembered what I was going to say earlier. Do you want me to add that?

THE CHAIR: Please do, yes.

Ms Weatherstone: It is also important, with continuity of midwifery care, that the end point for women is as early as possible in the first trimester. Often, because of either staffing or access, some facilities are waiting until a woman is 20 weeks, and that is after they have had their morphology scan and they have a viable pregnancy, to bring them into continuity. You are missing that massive opportunity to develop that relationship with women, because if things go wrong in pregnancy, it is really important to have continuity of care, for miscarriage, early pregnancy loss or perinatal loss. That provides the best support for a woman in their subsequent pregnancy. Also, it is an opportunity to talk about contraception and family planning.

THE CHAIR: There was something else you said that I wrote down. You spoke about us having a lack of forward-facing data from our hospitals. Tell me a little bit about that. What is it and how would it help?

Ms Weatherstone: What we are seeing currently in Australia is an induction of labour rate for first-time mothers sitting at around 44 per cent, which is quite alarming. Our caesarean section rate nationally is 38 per cent. The World Health Organisation says that anything above 10 per cent does not necessarily have a positive, direct impact on maternal and neonatal outcomes. In Australia, we have over double the World Health Organisation targets for caesarean section.

We know that these sorts of things implicate a child's wellbeing in their first 2,000 days. It also sets them up for how they will be, as healthy adults. We know that a lot of the care that a woman receives through their pregnancy, as well as their labour and birth experience, can impact chronic disease in later life.

If a woman had actual, informed consent and decision-making, and was provided with information on how to access the model of care that is best for them, they should be able to access data for each individual birthing facility as to the induction rates, the caesarean section rates and the models of care that are available to them. Currently, that data is not easily available for consumers.

THE CHAIR: This would help women and birthing people to actually make informed decisions?

Ms Weatherstone: Yes, absolutely.

THE CHAIR: They could actually choose risk in a better way than perhaps they are at the moment?

Ms Weatherstone: Absolutely, yes.

MR MILLIGAN: Continuing on with that, how do people find out the information on this model of care or where to go? Is there any consultation or meetings that they can have, even before considering having a child?

Ms Weatherstone: Often it is by word of mouth. Women do not know what they do

not know. Unless they have accessed and experienced that model of care, often they do not know what they are missing out on. There is also an opportunity through private health. A lot of people think that they need to get their money's worth from their private health, if that is what they have. That leads to having private obstetric-led care, which is also about continuity, I should point out. But we know that the outcomes are vastly different to midwifery-led models of care. Women need to know that the model is available, to start with, in their area.

The other thing is that, because women cannot access continuity of care, the minute you are pregnant, you have to book into this model. Often those positions fill up really quickly. By the time you are halfway through your first trimester, it is too late to book into midwifery-led care, and you are left with no choice but to go with the standard hospital system or whatever else is available at the time, which is really unfortunate.

MR MILLIGAN: There is limited space, I take it?

Ms Weatherstone: Correct.

MR MILLIGAN: Why is there limited space? Is it due to funding? Do we not have enough midwives?

Ms Weatherstone: Yes. That wraps back into the first question. Hospitals have not committed to increasing continuity of midwifery care. If they have a case load of, for example, six midwives, they take four women a month. You cannot take more than that, by the time you provide comprehensive care to women, 24 hours a day. You will not always see every woman every day, but you are available to them. You take a case load of approximately 40 women per year; so only 240 women will access that model.

THE CHAIR: So there is a lack of midwives. The real benefit of this model of care is the outcomes for women and birthing people and the babies.

Ms Weatherstone: Yes.

THE CHAIR: You mentioned that it is much cheaper than emergency health care, and other forms of medical care that support birth. Can you talk me through that?

Ms Weatherstone: Sure. Often you have reduced lengths of stay. A woman will have her baby and can discharge anywhere from four to six hours, if everything is normal. Straightaway, that reduces the cost to the healthcare system. They have access in that immediate postnatal period to their known midwife, who goes and visits them in the home. Because of the reduced intervention, if you have a vaginal birth, that attracts about \$4,000 in funding, whereas if you have a caesarean section it costs \$10,000. There is a significant difference in cost, just with mode of birth.

On top of that, care in the home uses less resources and there is less waste. We know that, if you have a homebirth, it is a lot more of a sustainable climate option than having significant clinical waste, with single-use plastics and devices in a hospital. Because you are having that continuity of care, you are less likely to have a re-admission to hospital and you will pick up on interventions a lot quicker. If someone is having a breastfeeding challenge or they are developing mastitis, sepsis or something like that,

or an infection, a midwife will pick up on that because they are seeing the woman regularly, rather than have them discharged from hospital, they go out into the community and then present back to ED if there is an issue.

THE CHAIR: That makes a huge amount of sense. It sounds like we would also be relieving pressure on our EDs and our hospital system itself by keeping healthy people out of hospital.

Ms Weatherstone: Absolutely. Just on that note, we need to rethink how we do things. Midwives have a role to play in ED as well. While we have this continuity of midwifery care model, it is great to have midwives attached to GP practices in the private sector; a GP can then automatically refer to a midwife or midwifery-led care in the community. Also, midwives in emergency departments would be amazing for all of those early pregnancy related or sexual and reproductive health related matters that come through.

THE CHAIR: Is there anything that we have not got to that you would like to tell us about or that you think we should be mindful of?

Ms Weatherstone: Yes. I would like to do a bit of a shout-out for the Baby Friendly Health Initiative. That is where hospitals are accredited to the 10 steps to successful breastfeeding. It is a World Health Organisation initiative. ACM actually oversees the accreditation process. It is part of the National Breastfeeding Strategy which, unfortunately, does not have an implementation plan. We are really only sitting at around 23 per cent of hospitals taking up the FHI.

In Tasmania, they actually mandate the FHI as part of any birthing facility. If you have a baby-friendly hospital accredited facility, a woman is more likely to breastfeed. We know that reduces allergies in children; it is more likely to stabilise weight and reduce obesity. Even the act of breastfeeding reduces the chance of a woman having breast cancer in later life.

It is about attaching to key national strategies that we actually have—the woman-centred care strategy and the national breastfeeding implementation plan. We should be leveraging the programs that we have to support that, as it will improve outcomes for women and babies.

The other thing I want to point out is that there has been a recent review of the national roadmap for improving the health of people with disability. Midwifery was largely absent from that key document. Looking again at your terms of reference, we need to look at women with disability who are having children, and at where children are born with a disability that will later have an impact on the health system. It is important to have that access to continuity of care.

THE CHAIR: We have certainly seen in submissions that women and birthing people with a disability are in a very different position here on a lot of measures.

Ms Weatherstone: Yes.

THE CHAIR: It is worrying that that is another absence in that plan.

Ms Weatherstone: I have one more point to make. It is really important to look at midwifery leadership, and to look at it as a standalone profession to nursing. It would be incredible to have midwives and midwifery leadership at all levels of leadership, from the midwifery manager, all the way up to the executive director of nursing and midwifery. We should split those, and have the executive director of midwifery and have a chief midwife for the territory. That would then prioritise midwifery-led care and those models of care. You are more likely to hit all of the targets in your national maternity strategy.

THE CHAIR: We need a chief midwife for the ACT to make sure that we implement our goals?

Ms Weatherstone: Correct, yes.

THE CHAIR: Thank you very much, Alison, for your time today and for your excellent information. My daughter is 10, so this has been a delightfully nostalgic walk-through of times past. I do not think there were any questions taken on notice. We will send you a copy of the transcript; make sure that we have not mis-attributed anything in that. On behalf of our committee, thank you so much.

Ms Weatherstone: Thank you very much for having me. I am happy to take any questions at any time.

CULLEN, MS MICHELLE, Chronic Conditions Network Coordinator, Health Care Consumers' Association

LAMB, MS JESSICA, Senior Policy Officer, Health Care Consumers' Association

THE CHAIR: On behalf of the committee, welcome to our hearing. We are joined by the Health Care Consumers' Association. Michelle and Jessica, I believe we have sent you a privilege statement which contains the rights and responsibilities of parliamentary privilege. Have you both read that and are you both happy to comply with the conditions of that?

Ms Cullen: Yes.

Ms Lamb: Yes.

THE CHAIR: Great. Before we start, would you like to make a brief opening statement or should we go straight to questions?

Ms Lamb: Go straight to questions. The instructions said to not prepare a statement, so I have not done that. I hope that is all right.

THE CHAIR: That is great. We have really short hearing times. We received over 80 submissions and we are trying very hard to speak to as many people as we can. Mr Pettersson, we are going to start with you.

MR PETTERSSON: Thank you. What can the ACT government do to improve continuity of care?

Ms Lamb: That is a huge question. We refer to the HCCA's Kids Interstate Shared Care Project. The report was published in 2020. That had a lot of ideas about how we can improve continuity of care for kids in care interstate, when they need specialist care that is not available in the ACT. We have seen really good results from the continuity of care provided by the new Paediatric Liaison and Navigation Service, which acts as a substitute for continuity when kids need to access care in two district jurisdictions. That has been really positive. Expanding those principles to other services would be great. It is a challenge because there is no great availability of primary care. GPs are difficult to get to. All of my family go to the same GP practice, but we rarely see the same GP twice in a row. We have great services with walk-in centres. Families really value walk-in centres, but there is no chance of continuity of care there. So it does provide challenges. I think Michelle can speak to the challenges for people who are managing chronic conditions and need ongoing care. Michelle?

Ms Cullen: It is a very big topic. My brain went onto a totally different track. One thing for continuity of care would be to expand the birth centre program so that people could have more continuity of care through their preferred option at the birth centres. That would be a good one, because when I went through having children, there was a 50-50 strike rate as to whether you could get into a birth centre program, even if you met all eligibility criteria. Expanding the birth centre program would be good for that. I will go to you, Jess, to finish what you were saying.

Ms Lamb: You mentioned the birth centres. There is the potential for expansion to have a great impact on setting up supports early for parents with disability or illness which prevents them from having an easy time through pregnancy, birth or parenting afterwards. Having a relationship with a clinician from the outset lets them identify and set up supports early so that parents do not have challenges later on and struggle. The ACT's solution, from what we are hearing from consumers, is to review parental rights rather than actually support families to deal with challenges and set up supports early.

MR PETTERSSON: Thank you. For the benefit of the committee, why is it important to have good continuity of care? What are the costs and burdens experienced by children and parents when their pathways to care are complicated or always changing?

Ms Lamb: It is a huge job. It is a full-time job managing chronic conditions. A lot of members of our Chronic Conditions Network will tell you that they have to put in a lot of strategies, they have to put in a lot of hours and they have to use a lot of brainpower to combine all the services that they need to access and transfer messages from one specialist to another specialist. If you have someone coordinating that care—if you have a midwife or a GP that you see regularly and interacts with your specialist provider—then you have support in navigating that and it actually significantly reduces the burden on the family.

Ms Cullen: I have often heard it described as almost needing an air traffic controller in your life. If you have children with different chronic conditions and special needs and you are seeing a number of specialists, you may have relationships with four or five providers. You need to keep all the reports that you need together, keep the funding together, keep the appointments on track and make sure that you are meeting the goals that you are supposed to be meeting over the period of time that you have funding. I am talking a little bit about the NDIS as well. In primary health, for any chronic condition and in any situation where you manage co-morbidities, there are lots of moving pieces for a parent. Having an air traffic controller that is directing the flights and making sure they land safely, to use a metaphor, is absolutely crucial. For me and other parents that I work with in the Chronic Conditions Network and other organisations to get through the load, we need plan management, support coordination and case management. We need an air traffic controller.

MR PETTERSSON: Thank you.

THE CHAIR: Your submission talked in a few different places about having health care in the community rather than in hospitals. It came up in a few contexts. It was about having specialists in community health centres and the difficulties that the NDIS has presented, where it has actually removed some of those community supports. Can you run me through what the ACT could do better to make sure that we have more accessible health care in the community that would help families, prospective parents or people who have children with different needs?

Ms Lamb: In Sydney, at Westmead and maybe out of Randwick—I am not sure—they run a diagnostic day. Children and their families who are on the waitlist are invited. All the specialists are available at the clinic. The children move around the specialists. They see them all. The specialists confer at the end of the day. That is a very efficient way of accessing a diagnosis. It has to be a big and overwhelming day for kids and their

families, but it is a really efficient way for people to access the opinions of all the specialists that they need, and then having them confer and put in place a comprehensive care plan in the diagnosis process for a child.

In the ACT, it is very difficult. If we have access to the right specialists, we are still on the waitlist for six months, 12 months or 18 months. Then we see the specialist and the specialist says, “This part is relevant to me, but I think they actually need to see this person,” so we have to get on the waitlist for six months or 12 months to see that person. It takes forever. It takes families a really long time if they have a kid with complex needs. It is really challenging. It is about having those kinds of co-located clinics in the community. We can see some potential with the community health centres that are being built. If we could make one of those or more of those family hubs where paediatric services, including specialist services, operate often to see families, that would be great.

THE CHAIR: Interesting. Diagnosis day sounds like a really practical model; you have got all the specialists there. What sorts of conditions is that useful for? Is that useful for anything or are there particular screening processes that that would be really good for?

Ms Lamb: That is probably a bigger question than I am qualified to answer.

THE CHAIR: Sure.

Ms Lamb: They probably run different ones. I only know the ones that friends of mine have been to. In those cases, they were cognitive behavioural issues.

Ms Cullen: Yes; that is what I was going to say.

Ms Lamb: But there would be potentially other areas that would be easier, I guess, provided by clinicians who are seeing children regularly and recognising where the needs lie.

Ms Cullen: Yes. In the work that I do with the Chronic Conditions Network—neurodevelopmental delays in children, ADHD, autism and the spectrum of neurodevelopmental conditions—parents are waiting a really long time to go through public services to get any sort of diagnosis. A lot of the time they are deterred by the wait time and go private, which is very expensive.

A lot of people ask me, “What is the value of getting the diagnosis? Why don’t we just go with the idea that they have either autism or ADHD? Why do we even bother getting to that point, when you can’t necessarily guarantee the next step, especially if there is ADHD involved?” As we all know, with the NDIS, autism is more likely to get a funding package and ADHD is not.

There is always a lot of discussion around wait times, costs, psychology services, OT services, speech pathology services and how to get in. Once you do get funding on board, you are on all sorts of waitlists for paediatricians. You cannot get into paediatricians. They have tiny windows of time to take on new clients and then you are waiting a year to get in. And, in that year of time, what are you doing? You are very limited by what you can do and who you can get into, and it is all largely private.

If there was any scope for neurodevelopmental conditions in a community family hub, where there were psychiatrists, psychologists, OTs, speechies and allied health, people would jump on the opportunity to get into an affordable, shorter wait time neurodevelopmental clinic.

THE CHAIR: Yes. It makes a lot of sense, both for diagnosis and for the therapy itself, for the treatment.

Ms Cullen: Absolutely; yes.

THE CHAIR: Thank you.

MR PETTERSSON: As is highlighted in your submission—and it is something I hear frequently from my constituents—all too often young families have to make their way interstate to access specialist services. What are the services that young families, in particular children, need to access interstate most frequently?

Ms Lamb: I do not think we necessarily know the answer to that. What we have at our disposal is anecdotal information from members or members of the public who contact us to talk about particular challenges or issues that they have encountered. HCCA is quite accepting of the reality that the ACT cannot have all the services that everyone needs. Some of them are very specialised. There are only so many clinicians who have those specialties. Attracting them to the ACT is tricky anyway.

I think what we need to recognise is not that we need those services here so much as that we need to actively support families to access those services elsewhere. Once we have accepted that that is a deliberate government policy then we are not attempting to recruit these specialist services, we are not attempting to run clinics here, and we are not flying someone in one day a month and pretending that we offer that service. We have to accept that we do not offer that service and provide the support to people to access that service elsewhere.

MR PETTERSSON: Yes. I appreciate that. I do not disagree, and I think that applies for some services, but are there no services that we can and should identify, saying, “This is a specialty that there is clearly a large demand for that we should be trying to prioritise; we should be trying to find someone for this specialty”?

Ms Lamb: Absolutely. I guarantee that there are. I cannot suggest to you, off the top of my head, what they are. I would be very happy to go away, talk to other people and come back with a list of services.

Ms Cullen: As a starting point, I would say paediatricians. That would cover lots of topics.

Ms Lamb: I know just how much effort ACT Health or CHS has put into recruiting paediatricians too.

Ms Cullen: Okay.

Ms Lamb: I guess we have to recognise the realities of the market as well and, given the realities of the market, what we can do to allow families to be supported to access those services while we are trying to recruit. We perhaps need to change how that is delivered here.

Ms Cullen: Yes.

MR PETTERSSON: Having never accessed these services myself, what does the support look like when you need to travel to, say, Sydney to access a specialist appointment?

Ms Lamb: It is pretty dismal. You can access, I think, \$50 per person per night, up to a maximum of one patient. I think if they are under 18, two adults can go with them as carers. Randwick and Westmead are not cheap places to stay. Even Ronald McDonald House charges you \$60 a night. It does not go far.

Also, a lot of families give up trying to access it because it is a paltry rebate and it is really onerous to access. There are a lot of administrative hoops to jump through. You cannot use your credit card statement as evidence. You have to fill your car up first and get that receipt. Then, when you get back from your trip, you fill your car up again and get that receipt. You then submit both receipts to access rebates for your petrol, up to a maximum of \$110. There are all sorts of hoops to jump through that make it really, really hard for families who, in general, have unreally unwell children, who just do not need to be trying to figure that out.

It also means that families are forced to be separated if they cannot afford to take the whole family to Sydney. They have to leave half the family here. One parent and one child live somewhere else for the duration of their treatment. It is distressing for families, both financially and emotionally.

MR PETTERSSON: Thank you.

THE CHAIR: We have a pretty low rate for bulk-billing GPs here in Canberra. I think we are the lowest in the country. One of the many issues that you have highlighted is the need for better access to GPs. Can you tell me what kinds of problems that is causing for families and how that would help?

Ms Lamb: It is expensive to take your child to the GP. The cost of living is getting harder for families, particularly for families who are on lower incomes. Out-of-pocket costs are growing. Not only do we have the lowest rate of bulk-billing but, across services, not just GPs, we actually pay more out of pocket than other jurisdiction. There are some services where we pay five times as much as other jurisdictions. That is a huge impost financially on people. That is even if you have private health insurance, not that that applies to GPs.

Basically, it makes it very difficult to have continuity of care. Families cannot afford to access GPs all the time because they do not have access to GPs when they want them. You cannot decide one morning, yes, we need to see a GP and they are available. That is why the walk-in centres are so very popular for families, because they can see someone for advice then and there on whether or not they really need to get health care

today. It is like an extra triage centre, and families do use it that way, I think. I know a lot of people who choose to access the walk-in centre before deciding if they need to pursue paying out of pocket for CALM, for out-of-hours GP services or heading to the ED and taking their chances there.

Not having access to GPs puts more pressure on all of those services all the way through. You have to go back to your GP regularly to get your referrals and to get your prescriptions renewed. There are all sorts of ways where we use up our GP's time when we do not necessarily need to, where they could be seeing more patients who have immediate healthcare needs rather than providing the administrative services of the hoops that we have to jump through for the system we have set up.

Ms Cullen: Essentially, sometimes it just comes down to deciding. If it is something that you would ordinarily see a GP for but you are on the fence about it, you go, "I'm going to wait it out a few more days and potentially wait for it to get worse." It is a decision of whether the child sick enough to warrant this cost. I think that is just a horrible decision that parents have to make.

THE CHAIR: Yes. It is always at unseemly times when you are stressed and busy—and it is just one more thing. You mentioned that we are seeing people present to our fairly stretched ER that maybe would not have presented there if they had access to preventative health care. We have certainly seen that with dental as well. Some figures that I saw were that about one in 10 of our ER visits were dental related. Do you think that is a similar story for adults but also for parents seeking care for their children—the lack of access to affordable dental care?

Ms Lamb: Absolutely. Dental care is something that we have been talking about a lot lately. It is a huge issue. It actually has ramifications for all sorts of health issues down the line. Access to preventative care is non-existent in the public system. I think Michelle can speak to that, because she has some experience.

Ms Cullen: My experience with public dental is that I would take my kids every six months to have their check-ups and cleans, and it got to a point where my child needed further dental work under anaesthetic. The dentist said, "You have time to wait; it is not a major issue. Try going through the public system and see what happens"—and it was essentially an 18-month waitlist. The triage system seemed to work like, "It's not bad now. We can see that it is going to get bad. Come back every three months and we will keep a monitor of it, and when it gets bad, you get bumped up the list." It felt to me like we were just going to wait until there was like a dental abscess before it was possible, even though they kind of acknowledged that there was that preventative step needed before this problem turned into a bigger problem. It was just wait times, staffing and the amount of people trying to access it.

In the end, we had to go private, because I could not face the idea of a child getting to the point where he had a dental abscess before he could get in to have the tooth extracted under anaesthetic. We did try—we went down the path—but it just was not going to be feasible. I just imagine what that would be like if you did not have the funds to be able to go private, having to just wait for that. It was really painful for him. I did not have a great experience with the public dental system, needing assistance.

THE CHAIR: Michelle, thank you. You told your story in your submission.

Ms Cullen: Yes, that was me.

THE CHAIR: I have to say that reading that was pretty horrifying—the prospect that you have to leave your child in pain until it is bad enough to get the intervention that everybody already knows is needed.

Ms Cullen: It was confronting.

THE CHAIR: Yes; that was extremely confronting. Thank you for sharing your stories, your expertise and your really valuable time. Is there anything that we did not get to that you would like to tell us?

Ms Cullen: I think we covered most of the stuff in our submission.

THE CHAIR: That is great.

Ms Cullen: How about you, Jess?

Ms Lamb: Off the top of my head, I do not think there is anything specific, off the top of my head. I am very happy to answer more questions if you have any out of session. Otherwise, I would urge you to have a look at our *Kids interstate shared care* report and consider meeting more of those recommendations. There has been such a great response to the Paediatric Liaison and Navigation Service. I think there is a lot of scope there to improve not just services outside the ACT but also the communication and navigation within the ACT for families.

THE CHAIR: Michelle and Jessica, thank you so much. On behalf of our committee, we thank you for coming and we thank broadcasting and Hansard for their assistance. If any member wishes to ask a question on notice, please upload it to the portal as soon as possible and no later than five business days. We will be sending you a transcript. Please let us know if we have misrepresented anything in that transcript. Thank you very much.

The committee adjourned at 5.00 pm.