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DISCUSSION

Twenty-five years since the Shearman Report: How far have we come? Are we there yet?

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ABSTRACT

Background: In 1989, the first major state-wide report into maternity services, known as the Shearman Report after its author, was released in New South Wales, the most populous state in Australia.
Aim: This paper reflects upon the report and tracks the progress of five of its key recommendations. The recommendations are still some of the major issues facing maternity services across the country. These are: community-based maternity care, rural maternity services, hospital visiting rights for privately practising midwives, obstetric intervention, and midwifery continuity of maternity care.
Findings: In some ways, much has changed in 25 years including the terminology used in the report, the importance of midwifery continuity of care and the woman-centred nature of many services. However, in other ways, there is still a long way to go to address these major issues. Despite more than a quarter of a century, many recommendations have not been fulfilled, especially access to care in rural areas, rates of obstetric intervention, and the issue of visiting rights for privately practising midwives which has gone backwards.
Conclusion: A continued and renewed effort is needed to ensure that the forward thinking recommendations of the Shearman Report are ultimately realised for all women and their families.

1. Introduction

Over the past 25 years, Australian maternity services have been influenced by a number of state and national reviews and reports (see Fig. 1). The first of these was released in New South Wales (NSW), the most populous state, in 1989.[1] The report was a result of a Ministerial Task Force established in 1987 to address issues in maternity care in NSW. In the preceding years, concern had been mounting over the increasing medicalisation of childbirth and the limited rights and capacity of women to participate in decision-making regarding their pregnancy and birth care. Childbirth had become increasingly medicalised and pathological, women had little or no say in their care and there were few specific services for women from minority or disadvantaged groups. During the 1960s and 70s it was quite normal that medical doctors and the health system determined women's childbearing needs.[2] However, pressure from the vocal women's movement that challenged medical dominance and views of safety, and the professionalisation of midwives, meant greater autonomy for childbearing women.[3,4] It was in this highly charged environment in mid 1980s that it was evident that change was needed – hence a number of reviews occurred, the first of these was the result of the Ministerial Task Force.

The Taskforce, chaired by obstetrician Dr. Rodney Shearman, began a dialogue between maternity care providers, health service planners and the women of NSW. This involved consumer satisfaction surveys, over 2500 people attending 30 public and 28 provider forums, visits to 30 maternity units, and nearly 300 written submissions from interested parties. In 1989, the *Final Report of the Ministerial Task Force on Obstetric Service in NSW* was released, commonly known as the Shearman Report.[1]

The Shearman Report advocated several important principles that lay the foundation of the report. These were that women had a right to equitable access to quality maternity care, should participate in decision-making about their care and that of their babies, and that they should be cared for by professionals who work in collaboration with each other. A redistribution of hospital beds was proposed to accommodate populations in the south and

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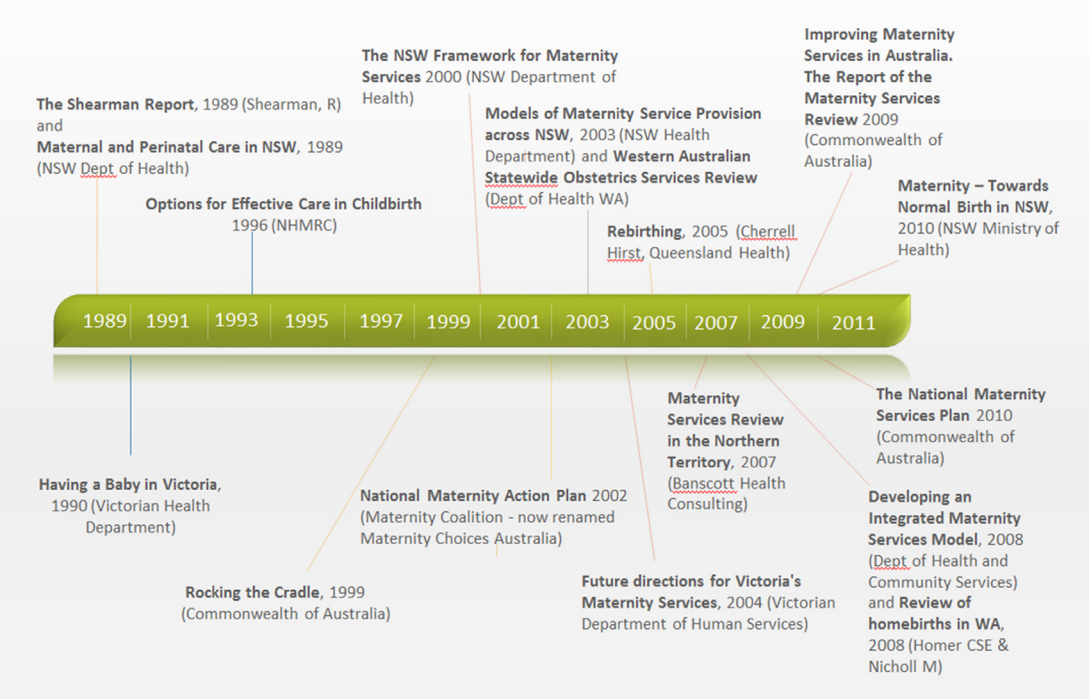

Fig. 1. Timeline of maternity service reports in Australia.

west of Sydney, and more neonatal services and community support were suggested. The need for equity of antenatal care services – especially for disadvantaged populations, and those that did not speak English as a first language, were highlighted. The professional skills of obstetricians and midwives were examined, and systems of continuing professional development suggested.

Most importantly, this report recommended that birth be approached as a natural event which was somewhat at odds with the prevailing environment of pathology. This meant the need to provide more home-like rooms and units, increasing numbers of birth centres, and a careful monitoring of medical intervention rates which were on the rise. The report also suggested that postnatal care of well women could be moved out of the hospital setting and community midwifery care be expanded.

Much has happened in more than 25 years since the release of the Shearman Report. Some aspects of maternity care have changed considerably while other issues are remarkably similar and the medical intervention rates have escalated beyond what anyone probably foreshadowed at the time. In the intervening years, more than 16 major state or national reports have been published into maternity services in Australia many of which have recommended similar issues (see Fig. 1).

The aim of this Commentary is to reflect upon the Shearman Report and specifically track the progress of five key recommendations in NSW that were made in 1989 through to 2015. The recommendations pertain to some of the major issues that have been addressed through many of the other reports, that is, community-based maternity care, rural maternity services, hospital visiting rights for privately practising midwives, obstetric intervention, and midwifery continuity of maternity care. The final part of the Commentary proffers some views as to the lack of movement in some critical areas and poses some challenges for policy makers, professional organisations, clinician and consumers of how to move forward.

1.1. Community-based maternity care

> Recommendation 3.4: That the extension of existing public hospital antenatal clinics to the community be encouraged and the problems affecting access to public hospital clinics (e.g. transport) be addressed (p. 162).

The Shearman Report recommended the expansion of community-based maternity care through the utilisation of outreach services in community health centres, and child and family health centres (previously called 'early childhood centres'). It was recognised that women in rural areas in particular had issues with transport and access to services, so to help ease this problem it was recommended that midwives working in the community could provide antenatal care, and that health services investigate after-hours antenatal services.

Similar recommendations regarding the expansion of outreach clinics and postnatal early discharge programmes were apparent in subsequent state and national reports. For example, the NSW Framework for Maternity Services (2000)[5] (the 'NSW Framework report') and the National Maternity Services Plan (2010)[6] both recommended improved access to community-based antenatal and postnatal services.

There are currently no 2015 data on how many NSW hospitals have community-based antenatal clinics or other services that specifically address access. However, 11 years after the Shearman Report, the NSW Framework report[5] showed that the 72 public hospitals in NSW (which was the majority providing maternity care at the time) had an early discharge and/or community midwifery programme that cared for postnatal women and babies, although it was unclear as to how many midwives working in the community provided antenatal care in addition to postnatal care.

Caring for pregnant and postnatal women in community settings and in their homes supports ease of women's access to