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Australian primary maternity units: Past, present and future

Amy R. Monk [a,*], Sally Tracy [a,b], Maralyn Foureur [c], Lesley Barclay [d]

[a] The University of Sydney, Sydney Nursing School (M02), NSW 2006, Australia
[b] The Royal Hospital for Women, Centre for Midwifery and Women's Health, Level 1, Barker Street, Randwick, NSW 2031, Australia
[c] The University of Technology, Faculty of Health, Centre for Midwifery, Child and Family Health, PO Box 123, Broadway, Ultimo, NSW 2007, Australia
[d] The University of Sydney, The University Centre for Rural Health, PO Box 3074, Lismore, NSW 2480, Australia

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ABSTRACT

Primary maternity units are commonly those run by midwives who provide care to women with low-risk pregnancies with no obstetric, anaesthetic, laboratory or paediatric support available on-site. In some other countries, primary level maternity units play an important role in offering equitable and accessible maternity care to women with low-risk pregnancies, particularly in rural and remote areas. However there are very few primary maternity units in Australia, largely due to the fact that over the past 200 years, the concept of safety has become inherently linked with the immediate on-site availability of specialist medical support.

The purpose if this paper is to explore the various drivers and barriers to the sustainability of primary maternity units in Australia. It firstly looks at the historical antecedents that shaped primary level maternity services in Australia, from the time of colonisation to now. During this period the space and management of childbirth moved from home and midwifery-led settings to obstetric-led hospitals. Following on from this an analysis of recent political events shows how Australian government policy both supports and undermines the potential of primary maternity units. It is important that researchers, clinicians and policy makers understand the past in order to manage the challenges facing the development and maintenance of midwifery-led maternity services, in particular primary maternity units, in Australia today.

1. Introduction

In Australia, 96.9% of women give birth in hospitals [1]. There are very few primary maternity units (PMUs), that is, maternity units managed by midwives with no obstetric, anaesthetic, laboratory or paediatric support available on site [2]. Primary maternity units provide care for women considered to have low-risk pregnancies who transfer to another site to receive any medical intervention including caesarean section and epidural anaesthesia [2,3]. In some other countries, PMUs (which are often referred to as freestanding or stand-alone midwifery units, as well as freestanding birth centres) play an important role in offering equitable and accessible maternity care to women with low-risk pregnancies [3–7].

This paper aims to encourage researchers, midwives and policy makers to understand the past and present political, professional and social influences on maternity care in order to manage the challenges facing the development and maintenance of primary maternity units in Australia today.

In order to do this, and in light of Mavis Gaff-Smith's comment: "we have to know where we have been in order to know where we are going" [8], this paper briefly explores the historical antecedents of primary maternity units in Australia based on primary and secondary sources of evidence from the disciplines of sociology, midwifery and medicine. The medicalisation of childbirth over time provides context to the muted presence of PMUs today. The evidence presented makes clear the rise in status and increased power of medicine through the process of professionalisation supported by government policy and funding arrangements. In turn, midwifery was subordinated into nursing and medicine over time [9], and the concept of risk management became a central tenet of maternity care [10]. Thus in Australia the concept of safely giving birth became inherently linked with the immediate on-site availability of specialist medical support [11–13].

This paper also explores the more recent political history of Australian PMUs, focussing on the paradoxical effect that recent government agendas and influences have had on maternity care.

* Corresponding author at: Sydney Nursing School (M02), The University of Sydney, NSW 2006, Australia. Tel.: +61 2 9351 0527.
E-mail address: amy.monk@sydney.edu.au (A.R. Monk).

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On the one hand successive government policies developed from the mid 1990s advocated market driven reform agendas within a neoliberal framework, which among other things, promoted both the centralisation and privatisation of maternity services. This led to the closure of many smaller maternity units in rural and remote areas of Australia [14,15]. These changes have left a huge gap in the provision of readily accessible maternity care, and PMUs may be well placed to fill this gap [14]. Paradoxically market-driven agendas also underpinned innovative developments in maternity care which challenged the medical management of childbirth. Maternity consumers and professional groups such as nurses and midwives were supported by the government and were able to play a more pronounced role in the formation of maternity policy [15–17]. As a result a small number of PMUs have been developed in urban and regional settings [13,18]; however they still face the challenge of existing within a culture of childbirth which highly values a medical model of care.

2. History of Australian maternity services

When Australia was first colonised in 1788, most women of the new colony gave birth at home with the assistance of a midwife if they could afford one; if not friends, family and/or neighbours helped [19,20]. Extremely poor and convict women gave birth in convict maternity shelters [20]. Doctors would attend women if called upon by a midwife. However their services were mainly restricted to women who could afford the extra fee [20]. Although the population of the new colony continued to increase after the transportation of convicts ended in 1848, convict maternity shelters closed, leaving a huge gap in the childbirth services available to extremely poor women who could not even afford a midwife [20]. The government of the new colony had directed its focus on the services that could not exist without government support, such as essential communication and transport facilities [21]. The scant health-related legislation that did exist focussed on protecting citizens from contaminated water supplies and hazardous waste disposal [21]. As maternal and child welfare was considered a responsibility of individuals, grants and subsidies encouraged the philanthropic, private and charitable provision of care for women during childbirth. This meant that the state avoided the financial responsibility for maternity care [21]. Doctors became more involved in childbirth as they, along with midwives and other charitable organisations, established their own lying-in homes to cater for the large number of women needing a shelter in which to give birth [22,23]. Competition arose between doctors and midwives regarding the provision of care during childbirth, and in response medicine drove a number of strategies to achieve control over the profitable field of women's health care [9,19,24].

2.1. Competition between medical practitioners and midwives

The most significant strategy was the unification and mobilisation of medical practitioners to further the professionalisation of medicine and in turn wield influence over maternity policy and practice [19]. This is explored in detail by Willis [19] who argues that unification mobilised the medical profession and successful lobbying of the government led to legislative and political changes in its favour giving doctors significant social and political power. For example, the 1908 Federal Bill controlled competition in the medical market place by regulating the supply of medical practitioners and controlling other modes of medicine. The Bill allowed medicine to largely regulate its own practice outside of the control of the state [19].

As a unified profession with state patronage, medicine redirected legitimacy away from midwives and towards themselves by acquiring formal training in midwifery and obstetrics. At the same time the medical profession opposed midwives receiving any of their own formal training unless it was as part of general nursing training, which by the 1900s was already subordinate to medicine [19,21,25]. Formal education for medical practitioners enhanced their power and influence, and their newfound scientific expertise had a very positive effect on their image in the community. As a result they emerged in serious competition to midwives [19,26].

Adding to the demise of the credibility of the midwifery profession and therefore the demise of midwifery-led maternity care was the concern of the Australian government over the welfare of babies and their mothers, brought about by concern over the health of the Australian labour force [19]. The 1904 Royal Commission was conducted to investigate the decline in the birth rate and rise of infant mortality in New South Wales (NSW). Infant mortality and morbidity was attributed to the uncleanliness of midwives, as it was in Britain at that time. It was recommended that the care of women in labour should be restricted to medical practitioners and obstetric nurses [19].

In addition, the government-funded baby bonus in 1912 gave a financial payment to women for every baby they gave birth to [19,20]. The effect of this was two-fold: firstly it encouraged more women to have more babies which helped address the population/labour shortage, and it enabled women to afford assistance during childbirth- whether it was from a medical practitioner or a midwife [19]. Some women used the money to pay for accommodation and midwifery services in midwifery-led maternity hospitals [20]. However the number of births in Australia attended solely by midwives halved in the decade following the introduction of the baby bonus, indicating that most women put this money towards the services of medical practitioners in hospitals [19]. As midwives were held accountable for the high rates of puerperal sepsis, one would have expected these rates to reduce as the rates of midwifery care reduced and the involvement of doctors in childbirth increased [27,28]. However the highest rates of puerperal sepsis were among the wealthier women who were attended by doctors in childbirth, and the rates of maternal and infant mortality remained the same until sulphur drugs were introduced in 1936, followed by antibiotics in 1945 [19,20,28]. Such was the perception that medical practitioners were necessary for safe childbirth that even deaths from puerperal sepsis failed to dampen the enthusiasm for medical management of childbirth.

The involvement of medical practitioners in childbirth continued to increase, and by the mid 1930s, most women had a doctor in attendance for childbirth [19,20,27]. It took longer for medical dominance to extend to smaller rural and remote communities. As Gaff-Smith observed; "Prior to World War II there was hardly a community, no matter how small, in suburban, rural, remote or outback Australia where such midwifery care did not provide a mantle of safety for mothers" [8]. Women were attended by midwives either in maternity homes run by midwives or midwives' own homes, because there was a shortage of medical practitioners in rural and remote areas [29–31]. However after the Second World War, many of the small midwifery-led hospitals in rural and remote areas were closed and replaced by larger district hospitals some distance away [8,20,31]. It was believed that larger hospitals could provide better access to doctors, antibiotics and blood transfusions and therefore provide a safer environment for women to give birth [8,20,27]. Women themselves also agitated local governments for more hospital maternity beds – partly due to their belief that it was safer to give birth with a doctor in a hospital and partly because of the appeal of staying in a hospital away from their domestic responsibilities [32].

The final element which saw the demise of autonomous midwifery care and the rise of private obstetric power was the